MEDICAL EYE CENTER
OPHTHALMOLOGY &
OPHTHALMIC SURGERY

**NEW PATIENT**
**REGISTRATION FORM**



# Welcome New Patient!

Thank you for choosing Medical Eye Center for your eye examination. To make your first visit as comfortable as possible, we ask that you prepare in advance and bring several items with you to your appointment. If you have any questions, please feel welcome to call us for help.

- **Complete the following forms and bring them with you.** By completing the forms in advance at your home, you have time to look up or verify hard-to-remember dates or facts. Your list of medications is extremely vital to us, so please take time to complete it.
- **Bring all of your current eyeglasses and/or contact lenses**. Please bring all of your current eyewear, including non-prescription reading glasses. It is helpful, but not necessary, to have a copy of your written prescription. **Attention contact lens wearers:** Please be sure to tell us **before you come in** that you are a contact lens wearer so we may discuss our contact lens policies with you.
- **Bring your health insurance card(s) and bring photo I.D.** Please bring your health insurance card so that we may make a copy. If you do not have insurance coverage, payment is expected in full at the time of service, unless you have made other arrangements.
- **Bring written referral or referral number from your doctor, if your health plan requires it.** Some health insurances require a "referral" from your primary care physician. It is your responsibility to understand the terms of your insurance. **Please call your primary care office a week in advance** of your appointment with us to secure your referral. Some insurances offer an annual eye exam benefit without referral. You are welcome to take advantage of that benefit with us, but please note the following; **If you require any testing for pre-existing or newly discovered conditions,** you will have to return with a referral to complete the testing. **We recommend that you secure a referral if you are diabetic, have cataracts or glaucoma, or have been told you are a glaucoma suspect. If you are experiencing eye pain, migraines or have noticed an increase in floaters or experienced a sudden loss of vision, you should secure a referral.**
- **Although we accept most medical insurance plans, it is your responsibility to check with us before your appointment and to call your insurer to verify that we are a plan provider.** Your insurance coverage is a contract between you, your employer (if applicable), and the insurance company; we are not a party to contact. We must emphasize that as healthcare providers, our relationship is with you, not with your insurance company. Before your visit, please contact your insurance company to verify the physician and the facility that you are scheduled with participates with your plan and that the services that you intend to receive are covered. We also accept VISA and MasterCard. Some Insurance plans cover routine eye exams differently than a medical exam. If your plan has this coverage please inform the receptionist at check-in/out. Please be aware that if during the course of a routine exam a medical condition is recognized that requires testing or treatment your examination will not be able to be billed as routine and will be submitted as a medical diagnosis for insurance consideration. Some services require a Prior Authorization, Pre-Certification or Pre-Notification before rendering. Our office will take the responsibility for obtaining those from your insurance carrier.

We look forward to meeting you. Please plan to arrive 10–15 minutes early so that we may review your paperwork and introduce ourselves. We strive to run our schedule on time and will not keep you waiting long. Warmest greetings and welcome to the practice. –Office Staff

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## Patient Information

Name: ☐ Mr. ☐ Ms . ☐ Mrs. ☐ Dr. _____
(First) (Middle) (Last)

SSN:_____-_____-_____ Date of Birth:_____/_____/_____ Sex: ☐ Male ☐ Female

Street Address (or PO Box) :_____

City:_____ State:_____ Zip:_____

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Life Partner

Phone: (H)_____-_____-_____ (W) _____-_____-_____ (Cell) _____-_____-_____

May we leave a message on your home, work, or cell phone regarding appointment reminders? ☐ Yes ☐ No

Email Address:_____

Emergency Contact:_____ Emergency Contact Phone: _____-_____-_____

## Responsible Party Information

Party responsible for patient's bill: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name: ☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr. _____
(First) (Middle) (Last)

SSN:_____-_____-_____ Date of Birth:_____/_____/_____ Sex: ☐ Male ☐ Female

Street Address (or PO Box) :_____

City:_____ State:_____ Zip:_____

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Life Partner

Phone: (H)_____-_____-_____ (W) _____-_____-_____ (Cell) _____-_____-_____

## Your Doctors

Primary Care Physician:_____ Phone: _____-_____-_____

Referring Physician:_____ Phone: _____-_____-_____

Endocrinologist (If any):_____ Phone: _____-_____-_____

I certify that the information above is accurate and true to the best of my knowledge and is only to be used for treatment, billing, & processing of insurance benefits. I will not hold my physician or any member of Medical Eye Center responsible for any errors or omissions that I have made in the completion of this form. I further authorize the release of any necessary information, including medical information, to my insurance company in order to determine insurance benefits to which I may be entitled. This authorization may be revoked by me at any time in writing. I authorize MEC to release and or send medical information regarding my case to other consulting and/or referring physicians. I understand and agree that regardless of my insurance status, I am responsible for the balance on my account for any professional services rendered. I understand that without a proper referral or authorization from my HMO/PPO, I am financially responsible for charges incurred for services rendered by MEC on all dates of services. I also understand that I alone am responsible for obtaining my authorization or referral from my HMO/PPO primary care physician. I understand that I am responsible for charges incurred for services considered to be non-covered by my HMO/PPO.

**Signature**:_____ **Date**:_____/_____/_____

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## Medical and Social History

Patient Name:_____ Account Number:_____ _(office use only)

*Do you currently have problems in the following areas? Check all that apply...*

**Visual Function:**

| | | |
|---|---|---|
| Reading books or newspapers | O Yes | O No |
| Recognizing people when close | O Yes | O No |
| Driving during the day | O Yes | O No |
| Driving at night | O Yes | O No |
| Reading traffic/street signs | O Yes | O No |
| Writing checks/completing forms | O Yes | O No |
| Cooking/hobbies/watching tv | O Yes | O No |

Other:_____

**Eye Conditions:**

| | | |
|---|---|---|
| Eye Disease | O Yes | O No |
| Eye Injury | O Yes | O No |
| Eye Surgery | O Yes | O No |
| Eye Infection | O Yes | O No |
| Drooping Eye Lids | O Yes | O No |
| Crossed/Lazy Eyes | O Yes | O No |

Other:_____

☐ Do wear glasses? If yes, how old is your present pair of glasses? _____

☐ Do wear contact lenses? If yes, how old is your present pair of lenses?_____

Type of contact lenses O rigid O soft O extended wear O other Brand:_____

**Medical History**

| | | | | | |
|---|---|---|---|---|---|
| Diabetes Mellitis | O Yes | O No | Anemia | O Yes | O No |
| Heart Disease | O Yes | O No | Depression | O Yes | O No |
| High Blood Pressure | O Yes | O No | Kidney Disease | O Yes | O No |
| High Cholesterol | O Yes | O No | HIV/AIDS | O Yes | O No |
| Cancer (Type:_____) | O Yes | O No | Stroke | O Yes | O No |
| Arthritis | O Yes | O No | Migraines | O Yes | O No |
| Thyroid Disease | O Yes | O No | Osteoporosis | O Yes | O No |

Other:_____

**Family History**

| | | |
|---|---|---|
| Diabetes Mellitis | O Yes | O No |
| Macular Degeneration | O Yes | O No |
| High Blood Pressure | O Yes | O No |
| Glaucoma | O Yes | O No |
| Cancer (Type:_____) | O Yes | O No |
| Cataracts | O Yes | O No |

Other:_____

**Social History**

| | | |
|---|---|---|
| Alcohol | O Yes | O No |
| Exercise | O Yes | O No |
| Drugs | O Yes | O No |
| Smoking | O Yes | O No |

*Please note any family history for the following: Mother (M), Father (F), Sisters (S), Brothers (B), Grandparents (GP), Aunt (A), Uncle (U)*

If you are a woman, is there a chance you might be pregnant and/or nursing? O Yes O No

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Patient Name:_____ Account Number:_____ (office use only)

**Allergies:**

Do you have any allergies to medication? O Yes O No

If yes, explain severity and reaction:_____

O Seasonal O Latex O Other:_____

List and medications you take (including oral contraceptives, asprin, over the counter medications, supplements and eye drops)

| Medication | Dosage |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

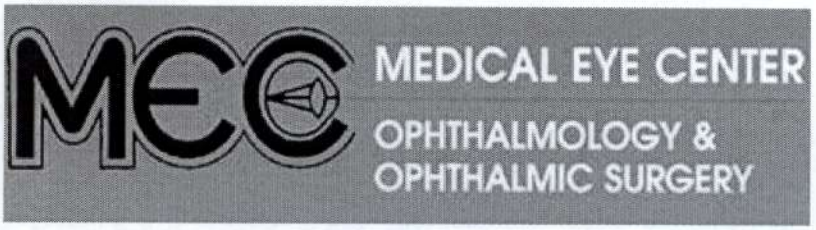
Preferred Pharmacy:_____ Phone:_____

**Systemic Problems:** *(Please check all that apply)*

| | | | |
|---|---|---|---|
| Fatigue | O Yes O No | Pain with Urination | O Yes O No |
| Weight Loss/Gain | O Yes O No | Blood in Urine | O Yes O No |
| Hearing Loss | O Yes O No | Rashes | O Yes O No |
| Sinus Problems | O Yes O No | Dry Skin | O Yes O No |
| Shortness of Breath | O Yes O No | Excessive Thirst | O Yes O No |
| Cough | O Yes O No | Bulging Eyes | O Yes O No |
| Chest Pain | O Yes O No | Headaches | O Yes O No |
| Palpitations | O Yes O No | Depression | O Yes O No |
| Abdominal Pain | O Yes O No | Dizziness | O Yes O No |
| Nausea/Vomiting | O Yes O No | Joint Swelling | O Yes O No |
| Heartburn | O Yes O No | Bleeding/Brusing | O Yes O No |

Other:_____

Patient Signature:_____ Date:_____

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## INSURANCE INFORMATION

**Primary Insurance:**_____

Policy Holder Name _____ DOB ____/_____/_____ SS# _____-_____-_____

Street Address (or PO Box) :_____

City:_____ State:_____ Zip:_____

Policy I.D._____ Group # _____ Member #_____

Co-pay Amount _____ Policy Effective Dates: From_____ To_____

Patient Relation to Policy Holder ☐ Self ☐ Spouse ☐ Child ☐ Other

**Secondary Insurance:** _____

Policy Holder Name _____ DOB ____/_____/_____ SS# _____-_____-_____

Street Address (or PO Box) :_____

City:_____ State:_____ Zip:_____

Policy I.D._____ Group # _____ Member #_____

Co-pay Amount _____ Policy Effective Dates: From_____ To_____

Patient Relation to Policy Holder ☐ Self ☐ Spouse ☐ Child ☐ Other

## BILLING INFORMATION

All professional services rendered are the responsibility of the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. If it is necessary to turn this service over to collection for non-payment after 90 days, then the patient is responsible for the bill, the interest, and collection and attorney fees.

AUTHORIZATION TO PAY BENEFITS TO PROVIDER: I hereby authorize payment directly to the undersigned Provider for my charges.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned Provider to release any information required in the course of my examination or treatment, to my insurance company in writing or by fax.

Signature (Patient or Parent of Minor): _____ Date_____

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## Summary Notice of Privacy Practices

As required by the privacy regulation created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), this is a brief summary of your privacy rights and the privacy practices of Medical Eye Center and its affiliated facilities. Please also read our FULL Notice of Privacy Practices for a full description of our practices and of your rights. Please review this notice carefully.

Medical Eye Center, along with your Primary Care Physician, Referring Physician, & all other Physicians/facilities who participate in your care are allowed to share medical information with each other as part of an organized health care arrangement for treatment, payment, and operational activities. We will use this information in order to provide our patients complete & comprehensive health care services. If you have any questions with either our Summary or Full Notice of Privacy Practices, please contact the Medical Eye Center's Office Manager in Columbia at (410)997-9900 or in Olney at (301) 774-2750.

## Our Commitment

We are committed to protecting your Private Health Information. As health care providers, Medical Eye Center is required by law to keep health information about you private, to give you our Notice about our privacy practices and to follow the practices outlined in our Full Privacy Notice.

## How We May Use and Disclose Your Information

We may use your Private Health Information treatment, payment, and health care operations. Under certain circumstances, Medical Eye Center may also disclose your Private Health Information for other purposes without your written permission. We may give out information about you for public health purposes; to report abuse, neglect, or domestic violence, for health oversight audits or inspection, for certain approved research purposes, for funeral arrangements or organ donations, to government programs, to workers' compensation, and in emergency situations. We may also disclose health information when required by law, such as in response to a request from law enforcement or in response to a court order. We may also contact you for appointment reminders and to tell you possible treatment option and health services. In addition, we may also disclose health information about you to family relatives, friends, or caregivers who may be involved in your care for treatment and payment purposes.

## Your Rights Concerning Your Health Information

You may ask to review or receive copies of your health information. There may be a fee for this service. You may ask us to amend health information in your medical or billing records you believe is incorrect or incomplete. You may request an accounting of certain disclosures we have made from your records. You may request alternate forms of communications. You may ask us to restrict how we use or disclose your Private Health Information. You may complain to us and to the federal government if you believe your privacy rights have been violated. You have a right to a paper copy of our current Full Privacy Notice. We will consider your request, but we may not agree if we are not required by law to do so.

We reserve the right to make changes to this Summary Notice and will post a copy of the current Full Privacy Notice in locations where treatment is provided.

**Signature:**_____ **Date:**_____/_____/_____

## Fee Disclosure Form

Eye Examination Fees

The Medical Eye Center is proud to accept Medicare Assignment and we participate in most insurance plans. There are two components to a comprehensive ophthalmologic examination; the test to determine the need for glasses (called a "refraction") and the medical portion of the eye exam which generally includes testing for cataract, glaucoma, and retinal diseases. A refraction or eye glasses check is a service that is not covered by most insurance companies unless a patient has separate vision coverage or participates in a vision service plan. Our fee for this service has been $45 for the last 6 years and we will attempt not to increase this fee as long as we can. Please check with the office staff as to whether your plan covers the medical portion of the eye exam only or both the medical and vision portion of the exam. If you have no insurance or your insurance company does not cover eye exams our fee is $145.

Motor Vehicle Administration Vision Certification Fees:

The state of Maryland has given ophthalmologists and optometrists the opportunity to complete the vision portion of the motor vehicle license renewal for our patients. The physicians at the Medical Eye Center will be happy to assist you in the process.

1) If your eye examination is performed the same day as the form is filled out there is no charge for us to complete the vision certification.

2) If your eye examination is performed within one year of the date the form is filled out but not on the date of the examination our charge to complete the vision certification is $15.

3) As the MVA requires us to provide the number of degrees of peripheral vision, if you have a medical condition that we feel may limit your visual field a screening 120 point visual field test will be necessary for the completion of your vision certification. Common conditions that may constrict ones visual field include glaucoma, cataracts, macular degeneration, a prior TIA or stroke, or retinal diseases such as diabetic retinopathy. This service to complete the MVA vision certification is not covered by most insurance companies or Medicare but we will provide this test for $35.

4) Commercial Driver's Licenses and Pilot's Licenses require color vision testing as well as binocularity and visual field testing; our fee to fill out a commercial license or pilot license is $45.

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Contact Lens Examination Fees:

Contact lens evaluations and fittings are not part of a complete eye examination but are a separate service which we will be happy to provide. If you wore your contacts in on the day of your examination we will be happy to do your contact lens evaluation. Contact lens fittings generally need to be scheduled after the complete eye exam has show that your eyes may safely wear contacts. Our fees for contact lens services are as follows:

1) Contact lens evaluations with no change in lens type; our fee is $35
2) If your contact lenses are spherical lenses (soft, non-astigmatic, non-bifocal) and you require a refitting of your contacts to another brand or model lens our fee is $75
3) If you require a refitting to a soft toric or bifocal or gas permeable lens our fee is $150
4) If you do not wear contact lenses and request a contact lens fitting, our fees are as follows: spherical lenses (soft, non-astigmatic, non-bifocal) our fee is $150; toric or bifocal soft lenses, $225; gas-permeable spherical, $250; bifocal gas permeable, $300; and keratoconus, $450.

Missed Appointment Fees:

Missed appointments (failure to show up for a scheduled appointment without providing 24 hours notice) increase our practice overhead and make it difficult for other patients to obtain convenient times for their appointment. We charge $25 for missed appointments not cancelled within 24 hours of their scheduled time.

Please understand our practice is a small business and we, like other small businesses, are struggling in this economy. We need to charge the above fees to be able to provide extra services to our patients. Please sign below acknowledging if you elect any of the above services that you understand the fees you will be charged. Thank You.

Patient's Name:_____

Patient's Signature:_____

Date:_____