MISSION EYECARE

Date: _____

NEW PATIENT FORM

GENERAL INFORMATION

Payment is due at the time of your examination. Please do not ask to be billed for professional services.

Name: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. _____

Nickname: _____ **Birthdate**: _____ **SSN**: _____

Address: _____ **City**:_____ **State**: _____ **Zip**: _____

Home Phone: _____ **Cell Phone**: _____ **Work Phone**: _____

Email: _____

Occupation: _____ **Employer**:_____

When was your last exam: _____ **By whom?** _____

or how did you find us? ☐ Drive by ☐ Google ☐ Facebook ☐ Other Website: _____

RESPONSIBLE PERSON (for Financial Statement) ☐ Same as above

Relationship to patient: ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Legal Guardian ☐ Other _____

Name of Responsible Person: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms _____

Address: _____ **City**:_____ **State**: _____ **Zip**: _____

Birthdate: _____ **SSN**: _____

Home Phone: _____ **Cell Phone**: _____ **Work Phone:** _____

Email: _____

INSURANCE INFORMATION

Please note that insurance may NOT cover all services in their entirety. All co-pays are due on day of service.

Vision Insurance: _____ **Subscriber Name**: _____
Subscriber SSN/ID#: _____ **Subscriber SSN**: _____
Subscriber Birth Date: _____ **Subscriber Birth Date**: _____
Primary Medical Insurance: _____ **Secondary Medical Insurance**: _____

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AARA INFORMATION

Due to changes in healthcare privacy and healthcare reform laws, we are now required to gather certain information regarding your race and ethnicity. This information is required as part of the American Recovery and Reinvestment Act of 2009 (ARRA).

PRIMARY LANGUAGE PREFERENCE *(select one)*

- ○ English
- ○ Spanish
- ○ Russian
- ○ American Sign Language
- ○ Other_____

RACE *(select one)*

- ○ White
- ○ Asian
- ○ Black or African American
- ○ Native Hawaiian or other Pacific Islander White
- ○ Other_____
- ○ Declined to specify

ETHNICITY *(select one)*

- ○ Not Hispanic or Latino
- ○ Hispanic or Latino
- ○ Unknown
- ○ Declined to answer

HEALTH HISTORY QUESTIONNAIRE

Name: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. _____

Age: _____ **Height**: _____ **Weight**: _____

What is the reason for your visit today? _____

MEDICATIONS

List your medications (include oral contraceptives, aspirin, over the counter medications and home remedies). We are happy to photocopy your list:

Do you have any allergies to medication or medical devices? *(If YES, please explain):*

☐ Yes ☐ No _____

CONTACT LENS USERS ONLY

Please bring your current contact lens prescription or your contact lens box (for each eye if different).

What kind of contacts do you wear?

☐ Soft Disposable ☐ Gas Permeable

☐ Extended Wear ☐ Ortho K

May we request information from your previous doctor? ☐ No ☐ Yes

Which contact lens solution do you use?

_____

Do you have a backup pair of glasses?

☐ No ☐ Yes

Please bring your glasses with you to the appointment.

SOCIAL HISTORY

Please list usage or leave blank if not applicable.

☐ Tobacco_____ ☐ Alcohol _____ ☐ Drugs _____ ☐ I would prefer to discuss with my doctor

MISCELLANEOUS

Are you interested in learning more about…

☐ Refractive surgery options ☐ Corneal molding Are you pregnant or nursing? ☐ YES ☐ NO

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Review of Systems

CARDIOVASCULAR	YES	NO
Heart Attack	□	□
High Blood Pressure	□	□
……..medicated?	□	□
High Cholesterol	□	□
……..medicated?	□	□
Stroke	□	□

MUSCULOSKELETAL		
Rheumatoid Arthritis	□	□
Chronic Joint & Muscle Pain	□	□
Gout	□	□
Myasthenia Gravis	□	□

EYES		
Corneal Transplant	□	□
PRK	□	□
LASIK	□	□
Retinal Detachment	□	□
Cataract	□	□
Macular Degeneration	□	□
Glaucoma	□	□

NEUROLOGICAL		
Chronic Headaches	□	□
Migraines	□	□
with Aura	□	□
Parkinson's Disease	□	□

PSYCHIATRIC		
ADHD	□	□
Anxiety	□	□
Depression	□	□
Other	_____	

IMMUNOLOGIC		
Lupus	□	□
HIV Positive	□	□
Lyme Disease	□	□
….. Plaquenil?	□	□
Herpes Simplex	□	□
Herpes Zoster	□	□
Other	_____	

HEMATOLOGIC/ LYMPHATIC		
Anemia	□	□
Bleeding Disorder	□	□
Hemochromatosis	□	□
Leukemia	□	□
Lymphoma	□	□

GASTROINTESTINAL	YES	NO
Chronic Constipation	□	□
Chronic Diarrhea	□	□
Crohn's Disease	□	□
Diverticulitis	□	□

RESPIRATORY		
Asthma	□	□
Chronic Bronchitis	□	□
Emphysema	□	□
Histoplasmosis	□	□
Sleep Apnea	□	□
Tuberculosis	□	□

GENITOURINARY		
Enlarged Prostate	□	□
Kidney Disorder	□	□

ENDOCRINE		
Diabetes	□	□
……. Type 1	□	□
……. Type 2	□	□
……. Last A1C	□	□
……. Last Blood Sugar	□	□
Hyperthyroidism/ Graves (overactive)	□	□
Hypothyroidism (underactive)	□	□
Hashimotos Thyroiditis	□	□
Polycystic Ovarian Syndrome (P.C.O.S)	□	□

SKIN		
Rosacea	□	□
Acne	□	□
Psoriasis	□	□
….. medicated?	□	□
Albinism	□	□
Melanoma	□	□
Eczema	□	□
Other	_____	

EAR, NOSE, MOUTH THROAT		
Allergies- nasal	□	□
Allergies- eyes	□	□
Chronic Sinus Congestion	□	□

MISSION EYECARE

HIPPA PRIVACY PRACTICE/ CONSENT TO TREAT / ABN

Consent to Treat. I hereby authorize Mission EyeCare (MEC) to treat me/my child.

Requirements at time of service: I understand insurance cards must be presented at time of service or patient will be self-pay until cards are presented or if insurance changes within treatment, cards must be presented before MEC will file claims to new insurance. All co-payments, co-Insurance, deductibles and non-covered services are due at time of service. Not all services are a covered benefit. If your insurance company denies a service, the balance is due within 30 days. Verification of benefits is not a guarantee of payment. We do offer a discount on certain services if paid in full at the time of your appointment and if no insurance is filed.

Assignment of Insurance Benefits: I hereby authorize and assign, my insurance carrier(s), to make payment directly MEC of insurance benefits for services herein specified and otherwise payable to the insured. MEC files both primary and secondary insurance as a courtesy to patients for the companies with which we participate. I understand and agree that I am financially responsible to MEC for all charges incurred regardless of potential insurance benefits including but not limited to co-payments, deductibles, and non-covered services. I understand MEC will not become involved in disputes between the patient and the insurance company. I understand it is my responsibility to verify with my insurance company the physician(s) treating me are covered under my insurance and to get referrals and/or authorization for services.

Minor Patients: Any patient under the age of 18 should be accompanied by a parent/guardian. I understand by signing MEC's financial policy, I am solely responsible for any incurred charges for the below named patient. The parent who brings the child in for care is ultimately responsible for their bill and we will not get involved in support disputes.

Non-Payment: We reserve the right to send an account to collection if not paid in full. If MEC refers your account over to a collection agency you will be responsible for your balance.

1. **Notice of Privacy Practices:** I acknowledge that I have reviewed a copy of MEC Notice of Privacy Practices.
   a) I acknowledge that I have been offered or received a copy of the privacy practices of this office. (HIPAA compliance)
2. **Medicare General Rules (ABN- Advanced Beneficiary Notice):** Our office is a participating provider for Medicare. Medicare requires that you pay the annual deductible toward any qualified services before Medicare will pay for any services. Our doctors accept assignment on your bill and we will file, via electronic transmission or paper claim, directly to Medicare. You will be responsible for any remaining amount they do not pay. As a courtesy to you, we will file any supplemental insurance.

   Special Exceptions
   a) Medicare does not cover eyeglasses or contact lenses unless you have had cataract surgery.
   b) Medicare does not cover the refraction part of the eye exam. Our fee for this is $35.
   c) Medicare does not cover any services without a medical diagnosis. The need for glasses is not considered a medical diagnosis.
   d) Medicare does not cover any digital retinal photo screening. Our fee for this is $39.
3. **Kansas Medicaid Advanced Beneficiary Notice:** This constitutes Notice to you, the beneficiary, that if MEC meets all program requirements and payment is not made by KanCare, you may be held responsible for the charges if your services or materials are not covered by KanCare. This includes but is not limited to the eye exam, frame, lenses, coatings, or medically necessary contacts. *CONTACTS,CONTACT LENS SERVICES AND DIGITAL RETINAL SCREENING ARE NOT A COVERED BENEFIT OF KANCARE (excepUnited Healthcare KanCare).*

Patient's signature (Parent if minor): _____ Date:_____

Disclosures to Friends and/or Family Members
If a designated a family member or other individual may discuss your medical conditions with the doctor, please list below.

I give permission for my PHI to be disclosed for purposes of communicating results, findings z& care decisions to the family members and others listed below:

Name	Relationship	Contact Number

Patient may revoke or modify this specific authorization and that revocation or modification must be in writing.

MISSION EYECARE

HEALTH SCREENING PHOTOS

WHAT ARE EYE HEALTH SCREENING PHOTOS?

This is one of the newest technologies for helping doctors manage the health of the eye. Wide-field, high definition, digital retinal photography allows us to examine, evaluate, and document the retina and the optic nerve.

The retina is the tissue in the back of the eye that is responsible for vision and the optic nerve is the structure that is responsible for transmitting the visual information from the retina to the brain.

WHAT THINGS CAN YOU SEE WITH RETINAL PHOTOGRAPHY?

Retinal photography is extremely useful in detecting eye diseases such as glaucoma, macular degeneration, and retinal disorders, as well as detecting signs of systemic diseases like diabetes and hypertension (high blood pressure).

WHO NEEDS THIS TEST?

Even though many of these eye conditions affect adults, retinal screening photography is recommended for all patients, including children. Retinal photos are helpful in identifying past eye injuries and provide a baseline for monitoring changes in or progression of future eye disorders. The doctors strongly recommend this test for all patients annually.

HOW DOES RETINAL PHOTOGRAPHY WORK?

Retinal photography is easy, comfortable, and takes only a few minutes. Most images can be captured without using dilating drops and can be viewed immediately by the doctor and patient.

Retinal images are stored digitally and are kept as part of your record. The images can be compared year after year at your annual eye examination.

HOW MUCH DOES IT COST?

The fee is $39.00 for both eyes.

EARLY DETECTION AND TREATMENT OF EYE DISEASE IS CRITICAL IN PRESERVING VISION FOR A LIFETIME!

☐ Yes, I choose to have this test performed at this time.

☐ No, I choose to defer this test at this time.

☐ I prefer to discuss with the Doctor prior to the test.

Patient's signature: _____ **Date**: _____

(parental signature needed if under age of 18)