2021

OFFICE USE ONLY

PICTURE ID: YES/NO TYPE_____BY____

DEMOS CHECKED REFUSED/UNABLE

PERSONAL INFORMATION (Please complete each area)

Patient's Legal Name_____ Date of Birth_____

Home Address_____City_____State_____ Zip_____

Sex: ☐ M ☐ F Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Social Security Number_____ Email Address_____

CELL Phone ( ) _____ ☐ Primary HOME Phone ( )_____ ☐Primary

Occupation_____ Employer Name_____

EMERGENCY CONTACT INFORMATION

Name _____ Phone Number ( ) _____ Relationship_____

PHYSICIAN INFORMATION ***Required to correspond with your Primary Care Physician***

Primary Physician's Name_____ Phone Number ( ) _____

Address_____City_____ State_____ Zip_____

Where you referred by an optometrist? ☐Y ☐N Optometrist's Name: _____

INSURANCE ***This section must be completed in addition to providing a current insurance card.***

Primary MEDICAL Insurance _____ Policy Holder Name _____

Policy Holder's SSN# _____ Policy Holder's Date of Birth _____

Secondary MEDICAL Insurance _____ Policy Holder Name _____

Policy Holder's SSN# _____ Policy Holder's Date of Birth _____

Do you have **VISION Insurance**? ☐Y ☐N Plan Name _____

Policy Holder Name_____Birthdate_____ID/SS#_____

FINANCIAL RESPONSIBILITY

If the patient is a minor (under the age of 18) or someone other than the patient has legal responsibility, (i.e. attorney, trustee, POA, or former spouse) please provide us with a copy of the appropriate court order and/or legal document, and complete the following:

Name of Responsible Party_____ Relationship to patient _____

Ph Number_____Address_____City_____ State____ Zip_____

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS & FINANCIAL AGREEMENT

1. MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to Northwest Eye Surgeons (NWES), for services rendered by NWES. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. NWES accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2. REFERRAL & CO-PAYMENT: I understand if I am covered by an HMO (Including Medicare HMO) that requires a REFERRAL from a Primary Care Physician, I am responsible for obtaining that referral and assuring its arrival in this office. **Northwest Eye Surgeons is not responsible for contacting the Primary Care Physician or obtaining that referral.** If my referral is not in this office at the time of my appointment, I will be asked to sign a Waiver of Insurance Liability, making the patient financially responsible for all charges incurred. These charges are to be paid at the time of service. All co-payments are required at the time of service. Failure to do so can be a violation of my insurance coverage agreement.

3. OTHER INSURANCE: Northwest Eye Surgeons participates in a variety of insurance contracts. I understand I am responsible for contacting my insurance carrier directly for information on covered services or providers. I understand that I am obligated to pay the full charges of all services rendered to me by NWES if I belong to a plan that NWES is not contracted with.

4. NON-COVERED SERVICES: I understand that NWES' contracts with health care service plans (i.e. HMOs, PPOs) relate only to items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plan not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan; and treatment or tests not authorized by the health care service plan.

5. FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by NWES, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to NWES for payment. All benefits under the patient's insurance policies, or any other party liable to the patient, are hereby assigned to Northwest Eye Surgeons. I also understand that by signing below I agree to pay any and all charges on my account that are not covered or have been deemed Patient Responsible by my insurance company. These charges may include but are not limited to co-payments, deductibles, coinsurance, and vision services (such as **REFRACTIONS** and contact lens services). I understand that if I fail to provide valid, current insurance information to Northwest Eye Surgeons before the filing limit, I am responsible for all charges incurred.

_____ _____

Patient Signature or Authorized Party Date

EXPLANATION OF MEDICAL VISIT VERSUS ROUTINE VISIT

MEDICAL BENEFITS: are billed if you are here for medical care, much the same as when you visit a cardiologist for an evaluation or follow-up for a heart condition. Medical care would address such items as:

- Evaluation of an ocular disease, you have been diagnosed with glaucoma, cataract, retina disease; or
- Complaint of red eyes, tearing, burning, floaters, flashes of light; or
- Follow up of an existing condition, such as diabetes, Plaquenil medication for autoimmune disease; or
- Ancillary testing is needed, such as visual field, OCT, etc.

ROUTINE BENEFITS: are billed if you are having a routine visit. Routine visits would address such items as:

- A healthy eye exam, much the same as a "routine physician" or;
- An eyeglass prescription is updated

These definitions are based on the guidelines of your insurance company and vision plans. Northwest Eye Surgeons is contractually obligated to follow them.
Please let us know if you would like any additional clarification on this issue.

_____ _____

Patient Signature or Authorized Party Date

NORTHWEST EYE SURGEONS

Acknowledgement of Receipt of Notice of Privacy Practices

& Permission to Share Health Information

I,_____ have reviewed the Notice of Privacy practices this day.

Patient Signature: _____ Date: _____

Patient Representative: _____ Date: _____

Describe relationship to patient: _____

I was unable to get written acknowledgement from patient/representative due to either unwillingness, emergency or other reason.

_____ _____

Staff Representative Signature Date

Notification of Family and Friends

I authorize Northwest Eye Surgeons to disclose my health information to the following persons:

_____

Name Address Phone

_____

Name Address Phone

_____

Name Address Phone

Patient/Representative (print): _____

Patient/Representative Signature: _____

Describe relationship to patient: _____

NORTHWEST EYE SURGEONS

Name _____ **D.O.B** _____ **Date**_____

REVIEW OF SYSTEMS:	**Circle all that apply or check NONE**	**None**
Eye	Cataract, Glaucoma, Detached Retina, Blindness, Lazy Eye, Eye Injury/Trauma, Corneal Problems, Macular Degeneration	
General	Fever, Weight Loss, Fatigue	
Allergic/Immunologic	Sinus, Itching, Hives, HIV, Herpes Simplex, Herpes Zoster	
Ears, Nose, Throat	Hard of Hearing, Dry Mouth, Vertigo	
Cardiovascular	High Blood Pressure, Heart Attack, Chest Pain, Congestive Heart Failure, A-Fib, High Cholesterol, Palpitations, Pace Maker	
Respiratory	Wheezing, Shortness of Breath, Asthma, COPD, Emphysema	
Gastrointestinal	Nausea, Ulcers, Crohn's, Ulcerative Colitis, GERD, Hepatitis, Reflux	
Musculoskeletal	Joint/Back Pain, Fibromyalgia, Arthritis, Rheumatoid Arthritis, Osteoporosis, Lupus, Psoriatic Arthritis	
Genitourinary	Bladder, Kidney Stones, Prostate Problems History of Flomax, Tamsulosin, Uroxatral, Cardura, Hytrin, Proscar	
Dermatologic	Acne, Growths, Rash, Rosacea, Melanoma	
Neurologic	Numbness, Headache, Seizures, Paralysis, Stroke, Dementia, Alzheimer's, Parkinson's Disease, Multiple Sclerosis	
Psychiatric	Depression, Anxiety, Bipolar Disorder	
Endocrine	Diabetes **Type 1 Type 2**, Thyroid Disease, Grave's Disease, Pituitary Disorder	
Hematology	Bleeding Disorder, Anemia, Blood Clots	
Reproductive	Are you pregnant? Are you breast feeding? Menopause	
Cancer	If yes, which type?	
Other		
Surgical History		

Pneumonia Vaccine	**YES**	**NO**

SOCIAL HISTORY:		**YES**	**NO**
Recreational Drugs			
Alcohol	Occasional Daily Heavy		
Tobacco	Never Quit		
Smoking cessation packet given			

FAMILY HISTORY: *If YES, please indicate family member from the following:*	**YES**	**NO**
M =mother **F** = father **S** = sibling **GM** = grandmother **GF** = grandfather		
Cataracts		
Glaucoma		
Macular Degeneration		
Diabetes		
High Blood Pressure		
Other		

Medication Allergies

Current Medications

Current Eye Medications

OFFICE USE ONLY
Sign back after ROS complete
Signed by Doctor & Tech ONLY