EYE PHYSICIANS, LLC dba NORTHWEST EYE SURGEONS

PERSONAL INFORMATION – Please update or verify the information that we have on file.

Patient's Legal Name____________________________________ Date of Birth________________________

Home Address_________________________________City___________State__________ Zip____________

Sex: ___________ Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Preferred Language: ____ **Race**: ________________________

Ethnic Group: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Social Security Number____________________ Email Address_____________________________________

CELL Phone ( ) _________________ ☐ Primary HOME Phone ( )__________________ ☐Primary

Ok to leave a detailed message? ☐ Yes ☐ No

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________

Were 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 ID# __________________________________ Policy Holder's Date of Birth _______________________

Secondary MEDICAL Insurance ____________________________ Policy Holder Name __________________________

Policy Holder's ID# __________________________________ Policy Holder's Date of Birth _______________________

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

Policy Holder Name_________________________________Birthdate________________ID/SS#____________________

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS & FINANCIAL AGREEMENT

1. MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to Eye Physicians, LLC, dba 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.

6. NO SHOW POLICY: I understand that appointments will be missed but I agree to provide at least 24 hours notice for any appointment that needs to be rescheduled. I understand that if I have more than 2 no show appointments within a 12 month period, I will be charged $25. This fee will be due prior to scheduling any further appointments.

____ __________________________
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

Name:_________________________________DOB:__________

Acknowledgement of Receipt of HIPAA

& Permission to Share Health Information

I, ______________________________ have received/requested a copy of the HIPAA policy.
Print Name

Patient Signature: ____ Date: ________________

Patient Representative: ____________________________________ Date: ________________

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 Relationship Phone

____
Name Relationship Phone

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 Arthitis	
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		

Medication Allergies

Current Medications

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

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

FAMILY HISTORY: **M**= mother **F**= father **S**= sibling **GM**=grandmother **GF**= grandfather

	YES	**NO**
Cataracts		
Glaucoma		
Macular Degeneration		
Diabetes		
High Blood Pressure		
Other		

Current Eye Medications

JDRIVE;FORMS;HISORY1(9/12/2019SB)

Sign back after ROS complete

Signed by Doctor & Tech ONLY