THE EYECARE CENTER

www.idahoeyecarecenter.com

3363 Merlin Drive
Idaho Falls, ID 83404
(208) 523-0330

345 North 2nd East, Suite 1
Rexburg, ID 83440
(208) 359-2020

Patient Information

Name:_____ Today's Date: _____
Birth Date:_____/_____/_____ SSN:_____-_____-_____ Cell:_____
Home Address:_____ Home:_____
City: _____ State: _____ Zip: _____
Permanent Address:_____ State: _____ Zip: _____
Occupation: _____ Employer: _____
Gender: _____ Marital Status: _____ Name of Spouse: _____
Guardian (If Applicable): _____
Email Address: _____
Race:_____ Preferred Language: _____ Ethnicity: _____
Nearest relative not living with you: _____
Phone Number: _____ Relationship:_____

Insurance Information

Primary Insurance:_____ ID #_____
Policy Holder:_____ Birth Date:_____/_____/_____
Relationship to Patient: _____
Secondary Insurance:_____ ID #_____
Policy Holder:_____ Birth Date:_____/_____/_____
Relationship to Patient: _____

I request that payment of authorized Medicare or other insurance benefits be made on my behalf to The Eyecare Center for any services furnished me by that physician/supplier. I authorized any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. ***Payment for your exam is due at the time of service. Payment for materials is due in full at the time of ordering.*** We reserve the right to charge interest at 19% per month on balances 30 days and older. In the event any balance due hereunder is not paid as agreed, the undersigned jointly and severally agrees to pay all costs incurred in collection of said unpaid balance, including but not limited to attorney's fees.

Signature: _____ Date:_____

Medical History

Do you have any known drug allergies? Y N If yes, explain:_____

Current Medications/Vitamins/Supplements (including oral contraceptives, aspirin, over the counter medications, and home remedies):_____

_____

_____

Family History

Please note any family history (parents, grandparents (maternal or paternal), siblings, children; living or deceased) for the following:

Disease/Condition	Yes	No	?	Relationship to you
Blindness				
Cataract				
Crossed Eyes				
Glaucoma				
Macular Degeneration				
Retina Detachment/Disease				
Diabetes (specify type)				
Other				

Review of Systems

Do you currently or have you ever had any problems in the following areas:

Symptom	Yes	No	Symptom	Yes	No
Loss of Vision			Tired Eyes		
Blurred Vision			Flashes/Floaters in Vision		
Distorted Vision/Halos			Styes or Chalazion		
Loss of Side Vision			Chronic Infection of Eye or Lid		
Double Vision			Glare/Light Sensitivity		
Eye Dryness			Excess Tearing, Watering		
Mucous Discharge			Foreign Body Sensation		
Redness			Burning		
Sandy or Gritty Feeling			Itching		

If you answered YES to any of the above, please explain:_____

_____

_____

_____

_____

The Eyecare Center
Insurance, Financial, & Release of Information Policy

Thank you for choosing ***T*he Eyecare Center** as your provider. We are committed to excellent patient care. The following is an explanation of our financial policy and agreement which must be read and signed prior to any evaluation.

At *The Eyecare Center*, we believe that you deserve the best care. That is why we always present you with the best vision solution possible to treat your personal situation. Each year we provide outstanding care to hundreds of patients. Here are some important things you should know.

Please Initial:

_____ Your vision benefits are based upon a contract made between your employer and an insurance company. If you have any questions regarding your vision benefits, please contact your employer or insurance company directly.

_____ We will bill your insurance company as a courtesy. If insurance does not pay within 90 days, The Eyecare Center reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare, but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is NOT, and cannot be part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

_____ In order to facilitate claims processing, you must provide all insurance policy information and changes to our office. At times, you may need to contact your insurance carrier regarding slow or non-payment of your insurance claim.

_____ You are responsible for knowing what your insurance covers and the providers and network(s) covered under your health insurance plan. Any service provided, but not covered by your insurance company, will be your responsibility to pay.

_____Payment for optical material, i.e. glasses/contact lenses, are due in full at time of ordering.

_____ Insurance co-pays and deductibles must be paid at time of service. After your insurance has determined benefits, any coinsurance amount or non-covered services are the responsibility of the patient or responsible party.

I have read and agree to the above outlined financial policy of *The Eyecare Center*. I agree that I am ultimately responsible for any charges incurred at *The Eyecare Center*.

Patient/Responsible Party: _____ **Date**: _____

HIPAA Notice of Privacy Practices:

***Please review the attached policy carefully*!** This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please sign below to confirm that you have received or had the opportunity to review the Notice of Privacy Practices.

Patient/Responsible Party: _____ **Date**: _____

A Personal Representative has all of the same rights of access to information as the patient. Until I have withdrawn my authorization in writing, the following people are authorized to access my medication information as my personal representative(s).

_____	_____
Name Relationship	Name Relationship
_____	_____
Name Relationship	Name Relationship

Patient/Responsible Party: _____ **Date**: _____