Patient Information

Today's date ___________________ I am a: New Patient / Former Patient

Patient ______________________________ ____________________________ ________ Male / Female
Last Name First Name MI Sex

Address ______________________________ ______________________________ _______ __________
Street Number City CA Zip Code

Home Phone (___) _________________ Cell Phone (__) ________________ Work Phone (___) _____________

Date of Birth _______________ SS# __________________ Email address _____________________________

Marital Status: Single Married Divorced Widowed Spouse's name ____________________________

Emergency contact name ____________________ Relationship _________________ Phone __________________

Employer _______________ Occupation __________________ Address ___________________________________

Referred by ____________________________________ Family doctor ____________________________________

Optometrist _____________________________ Previous Ophthalmologist __________________________________

Responsible Party Information - __ Check here and omit this section if the patient is the responsible party.

Name ___________________________ Relationship to patient _______________ Phone _____________________

Address __________________________________ Phone __________________ SS# _______________________

Employer ______________________________ Address ____

Work Phone ___________________________ Date of Birth __________________ DL # ______________________

Insurance Information - Please note: Health insurance does not cover eye exams unless you have a medical diagnosis or you have a VISION plan included with your health plan.

***** <u>PLEASE OMIT THIS SECTION IF WE ARE COPYING YOUR INSURANCE CARD.</u>*****

Vision Plan _____________________________ Subscriber name ____

ID # _________________________ Subscriber Birthdate ____

Primary Insurance _______________________________________ Subscriber's name ________________________

Claims address ____ Phone # ____________________________________

Subscriber ID # ______________________ Group # ____________________ Birthdate _________________________

Secondary Insurance ____________________________________ Subscriber's name _________________________

Claims address ____ Phone # ____________________________________

Subscriber ID # ______________________ Group # ____________________ Birthdate _________________________

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PATIENT HISTORY QUESTIONNAIRE

Last Name ______________________ First Name __________________________ MI________

Date of last eye exam ________________________ Dilated Yes/No

Today's Date ___________________________ Referred by ________________________________

MEDICAL INFORMATION

What is your general health? __________________________________

Do you have problems with any of these systems (**please circle yes or no**)

Gastrointestinal	Yes/No	Nervous	Yes/No	Endocrine (glands)	Yes/No
Ears/Nose/Throat	Yes/No	Urinary	Yes/No	Blood/lymph	Yes/No
Cardiovascular	Yes/No	Muscles/Bones	Yes/No	Allergic/Immunologic	Yes/No
Respiratory	Yes/No	Integumentary	Yes/No	Headaches	Yes/No
High blood pressure	Yes/No	Eyes	Yes/No	Mental	Yes/No

Please Explain ____

Diabetes Yes/No Type________________________________ Date of diagnosis _____________________

Allergies to Medications? Yes/No Which________________ Reactions? _________________________

Other health problems ____

Current Medication(s) ____

Have you had any operations? Yes/No Kind? _______________________________ When_____________

Name of Family Doctor___________________________

Date of last visit ________________________________ Date of last tetanus shot____________________

Family History

High Blood Pressure Yes/No Relation_____________ Macular Degeneration Yes/No Relation__________

Diabetes Yes/No Relation_____________ Retinal Detachment Yes/No Relation__________

Glaucoma Yes/No Relation____________ Cataracts Yes/No Relation__________

Personal Eye Information

Do you have any eye conditions or problems? Yes/No What Kind? _________________________________

Have you had any eye operations? Yes/No Type_________________________ Date___________________

Have you had any eye injury? Yes/No Kind_________________________ Date___________________

Do you have glaucoma? Yes/No Cataracts Yes/No Dry eyes Yes/No

Macular Degeneration? Yes/No Retinal Detachment Yes/No Blurred vision? Yes/No

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Signature on File, Assignment of Benefits, Financial Agreement

____
Name (print)

1. **MEDICARE:** I request that payment of authorized Medicare benefits to be on my behalf of Clarity Eye Group for services furnished to me. 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 payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Clarity Eye Group accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non covered services. Coinsurance and deductible are based upon the charge of the Medicare Carrier.

2. **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Clarity Eye Group if possible or otherwise to me.

3. **RELEASE OF INFORMATION:** Clarity Eye Group may disclose all or any part of my medical record and/or financial ledger to any person or corporation (1) which is or may be liable or under contract to Clarity Eye Group for reimbursement for services rendered and (2) any health care provider for continued patient care. Clarity Eye Group also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, education medical research, for the collection of statistical data or pursuant to State or Federal Law , status or regulation. A copy of this authorization may be used in place of the original.

4. **OTHER INSURANCE:** I understand that Clarity Eye Group maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. The doctors have no contract expressed or implied with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Clarity Eye Group.

5. **NON- COVERED SERVICES:** I understand that Clarity Eye Group contracts with health care services plans (i.e. HMO'S, PPO'S) related only to items and services which are “covered” by the health care service plans. Accordingly to the undersigned accepts full financial responsibility for all items and services include which are determined by the health care service plans not to be covered. Examples of non-covered services include which are determined by the health care services not specified as being covered in the patient's contract with a health care service plan or in or in the benefit summery the health care service furnishers to the patients and treatments or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Clarity Eye Group to obtain necessary health care service plan authorizations.

6. **FINANCIAL AGREEMENT:** I agree that in return for the service provided to the patient by Clarity Eye Group, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to the doctor for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient or any other party liable to the patient is hereby assigned to Clarity Eye Group. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Clarity Eye Group. However, it is understood that the undersigned and/or the patient responsible for the payment of my bill.

____ _______________
Beneficiary Signature or Authorized Party Date

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NOTICE OF PRIVACY PRACTICES
Acknowledgement of Receipt

By signing this form, you acknowledge receipt of the ***Notice of Privacy Practices*** *of Clarity Eye Group.*

Our ***Notice of Privacy Practices*** *provides information about how we may use and disclose your protected health information.* ***We encourage you to read it in full.***

Our ***Notice of Privacy Practices*** *is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting Privacy Officer (714)842-0651.*

Name (Please print) ___________________________________

Signature: _____________________________ *Date*__________
(Parent, patient, conservator, guardian)

____

FOR OFFICE USE

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reason why the acknowledgement was not obtained:

Signature of provider representative: ______________________________ Date____________

( ) Individual refused to sign

( ) Communication barriers prohibited obtaining the acknowledgement

( ) An emergency situation prevented us from obtaining acknowledgement

( ) Other (Please Specify) ______________________________________

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Patient Financial Responsibilities

In order to simplify your check-in and check-out procedure we ask that you come to your appointment prepared with the following:

Please bring your insurance cards with you for us to copy for you file.

Be aware if your insurance plan provides medical coverage or vision coverage including glasses and contact lenses. Most medical plans do not cover refractions, which is the most important measurement of your vision. If you do not have a vision plan, you are responsible to pay for the refraction.

Be prepared to pay your co-payment or your portion of services and materials that are not covered by your insurance.

If you do not have insurance or you have not met your yearly deductible, you are responsible to pay for services in full.

Prior insurance authorization is not a guaranty of payment for services or materials. This is per your insurance company.

We cannot verify insurance coverage for all patients, therefore if for any reason your insurance does not pay for your services or materials, you will be responsible for payment.

I have read and agreed to the above Patient Financial Responsibilities.

Patient or guardian signature ______________________Date_________

Thank You

Clarity Eye Group

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Comprehensive Eye Exam

A comprehensive or complete eye exam consists of two parts.

Part 1

The first part of your eye exam is what the insurance companies refer to as the **"Medical"** part of your exam. This is checking your eyes for cataracts, glaucoma and other eye diseases.

Part 2

The second part of your exam is what insurance companies refer to as the **"Vision"** part of your exam. This is determining the best possible vision for you both with glasses and without. The best and most important indication of how your eyes are working is a measurement of your best possible vision. Without this part of the exam we cannot clearly determine if any deterioration in your vision is due to eye disease or needing a change in your corrective lenses.

If you have **"Medical"** insurance and do not have a **"Vision"** plan we are contracted with, you will be responsible to pay for the Vision part of your exam today which is $40.00 plus your co-pay for your **"Medical"** insurance.

I understand and agree that regardless of my insurance status, I am responsible for the "Vision" part of my exam today. I understand that the billing department will file the fee with my insurance and if payment is received it will be refunded to me.

____ _______________________

Patient or Responsible Party Signature Date

Thank you,
Clarity Eye Group