



## PATIENT DEMOGRAPHIC FORM - OPTOMETRY

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Gender: Male \_\_\_\_\_ Female \_\_\_\_\_  
Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
Home #: \_\_\_\_\_ Work #: \_\_\_\_\_  
Mobile #: \_\_\_\_\_ Email: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Pharmacy Name & Address: \_\_\_\_\_

How did you hear about us?

☐

Facebook/Instagram

☐

Direct referral from MD

☐

Website

☐

Word of Mouth

☐

Google

☐

Other. Please specify \_\_\_\_\_

May we text you for:

\_\_\_ Health and Appointment notifications

\_\_\_ Discounts/Specials/Promos

Emergency Contact Name / Phone #: \_\_\_\_\_

Relationship to Emergency Contact: \_\_\_\_\_

I authorize Coastal Skin & Eye Institute, to submit a medical claim to my medical insurance carrier or its intermediaries for all covered services or products provided by the practice. I understand that I am responsible for any deductible, coinsurance, copayment or non-covered services. I understand that it is the policy of the practice to collect at the time of service. I understand that the practice is able to refer my account to collections if I do not make payment. I understand that it is my responsibility to update my insurance file whenever I change insurance carriers. I understand that failing to provide current information will make me immediately responsible for balances otherwise paid by my medical carrier. I understand that if I join an HMO, I will inform the practice prior to scheduling any case, such that the staff can identify my eligibility for care with this practice. I have completed the above information and certify that it is true and correct to the best of my knowledge. I will notify the office of any changes in my health status or the above information.

Signature of Patient or Legal Representative: \_\_\_\_\_

Date: \_\_\_\_\_

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_



## INSURANCE INFORMATION

**IF YOU HAVE ALREADY PROVIDED YOUR INSURANCE CARDS TO THE FRONT DESK, YOU MAY SKIP THIS SECTION.**

### Primary Insurance

PRIMARY INSURANCE COMPANY NAME	
SUBSCRIBER'S NAME IF DIFFERENT FROM PATIENT	
SUBSCRIBER'S ID NUMBER	
GROUP NUMBER	SUBSCRIBER'S BIRTHDATE
Self Spouse Father Mother Partner Other	
PLEASE INDICATE RELATIONSHIP TO PATIENT	

### Secondary Insurance

SECONDARY INSURANCE COMPANY NAME	
SUBSCRIBER'S NAME IF DIFFERENT FROM PATIENT	
SUBSCRIBER'S ID NUMBER	
GROUP NUMBER	SUBSCRIBER'S BIRTHDATE
Self Spouse Father Mother Partner Other	
PLEASE INDICATE RELATIONSHIP TO PATIENT	

If using a vision plan, please complete the following:

Name of vision insurance:		
Subscriber's name:	Group no:	Policy no:

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_



## MEDICAL HISTORY

Past Medical History *(please circle all that apply):*

Anxiety	Depression	Leukemia
Arthritis	Diabetes	Lung Cancer
Artificial Joints	End Stage Renal Disease	Lymphoma
Asthma	GERD (Acid Reflux)	Pacemaker
Atrial Fibrillation	Hearing Loss	Prostate Cancer
Benign Prostate Hyperplasia	Hepatitis	Radiation Treatment
Bone Marrow Transplant	Hypertension	Seizures
Breast Cancer	HIV / AIDS	Stroke
Colon Cancer	Hypercholesterolemia	Valve Replacement
COPD (Emphysema)	Hyperthyroidism	
Coronary Artery Disease	Hypothyroidism	

☐ Autoimmune conditions: \_\_\_\_\_

☐ Other: \_\_\_\_\_ ☐ None

Past Surgical History:

Type of surgery:	Approximate date:

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_



## MEDICAL HISTORY (Continued)

Past Ocular History *(please circle all that apply)*:

Amblyopia	Dry Eye	Glaucoma (Right, Left)
Cataract (Right, Left)	Blepharitis	RK
Corneal Dystrophy	Macular Degeneration	
Diabetic Retinopathy	Retinal Detachment (Right, Left)	
Double Vision	LASIK or PRK (Right, Left)	

☐ Other: \_\_\_\_\_

Medications and Supplements: *(please fill in or attach separate list)*

Medication name	Dosage

Drug Allergies:

Medication name	Reaction

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_



## MEDICAL HISTORY (Continued)

Cigarette Smoking: Yes ☐ No ☐ Former ☐ Current every day smoker: Yes ☐ No ☐

Number of packs per day: \_\_\_\_\_ Date started smoking: \_\_\_\_\_ Date quit: \_\_\_\_\_

Do you drink alcohol? Yes ☐ No ☐ If yes, how many drinks per week? \_\_\_\_\_

## FAMILY MEDICAL HISTORY

Family History:

	Mother/ Father	Grandmother/Father	Sibling
Hypertension			
Diabetes			
Cataracts			
Lupus			
Arthritis			
Glaucoma			
Macular Degeneration			
Other Eye Diseases			

Do you have a family history of Melanoma? Yes ☐ No ☐

If yes, which relatives? \_\_\_\_\_



## EYE REFRACTIONS AND MEDICAL INSURANCE

### PAYMENT FOR REFRACTIONS

One of the most important parts of an eye exam is checking a refraction. A refraction is the part of the exam by which we determine whether your vision can be helped in any way with a new glasses prescription. You may remember this test as “Which is better, 1 or 2?” We do not know if your glasses or contact prescription has changed unless we check it.

### **CHECKING A REFRACTION IS NOT A COVERED SERVICE BY MEDICARE AND MOST OTHER INSURANCE PLANS**

Please see the CMS publication “Your Medicare Benefits” if you have any questions about this. These plans consider refraction a “vision” service not a “medical” service. Our office fee for refraction is \$75, and unless your plan automatically covers the refraction charge, this fee is collected at the time of service in addition to any co-payment your plan may require.

If you have VISION INSURANCE in addition to medical insurance, we can use your vision insurance benefits to cover the refraction. You may combine the benefits of both insurance plans. Vision insurance rarely covers imaging/testing to diagnose eye disease or monitor its progress. If you require these advanced services, their charges will be applied to your medical insurance plan, and any deductibles or coinsurance requirements of your medical insurance plan will apply.

We have made an attempt to contact your carrier(s) prior to the arrival for your appointment to maximize your benefit coverage and to determine your financial responsibilities. **Please understand that whatever we report to you is only an estimate.** We are not your insurance carrier and can only discuss your coverage and benefits from the information they report to us.

### **Please select ONE option below:**

☐ **I DO NOT HAVE VISION INSURANCE** - I have read the above information and understand that the refraction is a non-covered service through medical insurance. I accept full financial responsibility for the cost of this service (\$75.00) and understand it is due at time of service. I understand that any co-payment, coinsurance or deductible I may have are separate from and not included in the refraction fee.

☐ **I DECLINE THE REFRACTION SERVICE TODAY.** I understand that without the refraction, Dr. Vuong may not be able to fully assess the health and function of my eyes.

☐ **I HAVE VISION INSURANCE** and want to use my VISION INSURANCE benefits for my refraction service today. I have provided the office with an up-to-date VISION INSURANCE card and understand that it is my responsibility to make sure my benefits are active.

Signature of Patient or Legal Representative: \_\_\_\_\_

Date: \_\_\_\_\_



## CONTACT LENS ANNUAL CONSENT FORM

**CONTACT LENS FITTINGS ARE NOW EXCLUSIVELY SCHEDULED WITH OUR OPTOMETRIST, DR. VICTORIA VUONG. DR. MICHELLE CROSBY AND DR. NEETA VARSHNEY ARE NO LONGER ACCEPTING CONTACT LENS FITTING APPOINTMENTS AT THIS TIME.**

### **PLEASE READ AND SIGN IF YOU WOULD LIKE A NEW CONTACT LENS PRESCRIPTION**

Contact lenses are a medical device that are fitted to wear on top of the cornea. Before we can give you a new prescription, we are required to check the health of your eye and the contact lens fit. This is regardless of whether you are experiencing any change in vision.

All corneal evaluations for contact lenses will include 90 days of follow up care. After 90 days, a charge of \$75 will be applied for any additional visits. Once finalized by the doctor, a contact lens prescription will be given with an expiration date of one year from the original date of service.

### **CONTACT LENS FITTING:**

The contact lens portion of your exam is not covered by your medical insurance. If you have supplemental vision insurance, we will review your benefits and inform you of your applicable copays, including the fitting fee for contacts. This contact lens fitting fee covers the cost of the additional testing required to establish and update your contact lens prescription, the contact lens trials we may provide you, and other applicable costs.

### **Contact lens exam fees without insurance are as follows:**

- Office Visit - New Patients \$150, Established Patients \$100.00
- Refraction - \$75
- Contact Lens Fitting - \$150
- Specialty Hard Lens - \$250

**Contact lens trials: As a part of the contact lens fitting process, we may provide you with trial lenses. The purpose of these trials is to find the best fitting, clearest vision, healthiest, and most comfortable lenses for your eyes. After wearing the trial lenses, you are responsible for communicating with us in a reasonable amount of time so we can either change lens options or finalize your contact lens prescription. We set that time frame at three weeks from your receipt of the trials. If we haven't heard back from you within that period of time and you want to make any changes to your contact prescription, a \$75 RE-FITTING FEE WILL BE CHARGED FOR ADDITIONAL TIME with the doctor and/or trial lenses.**

### **Dispensing and Cancellations**

Contact lenses are a medical device and therefore are non-refundable and cannot be returned. Orders may be cancelled or changed with no penalty if cancelled on the same day before close of business. Contacts must be picked up within 30 days after notification that the order is ready to be dispensed. Contacts not picked up within this timeframe will void any warranties and return policies. The order will be considered a cancelled order and no refunds or credits will be issued.

Patient Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## FINANCIAL POLICY

At Coastal Skin & Eye Institute we are committed to your treatment being a successful experience. Please help us maintain accurate records by filling out forms legibly, and inform us if any changes need to be updated on our account (for example: address, telephone number, medical insurance, etc.)

### CO-PAYMENTS

Co-payments are due at the time you receive care or services. The co-payment amount is determined by your specific insurance plan. Coastal Skin & Eye Institute has no control over this cost. If you will not be able to pay the copayment at the time you receive care or services, you will need to call ahead to see if you will be able to keep your appointment. You as the patient/client are responsible for all or part of the charges not covered by your insurance, based on your coverage and insurance plan. Again, these amounts are not determined by Coastal Skin & Eye Institute but by your individual insurance plan.

### INSURANCE AND INSURANCE COLLECTION

If you are unable to present an insurance card at the time of service, or if you are covered by an insurance company with which we are not contracted, we require that you pay for services at the time of service.

### KNOW YOUR PLAN BENEFITS – NON COVERED SERVICES ARE YOUR RESPONSIBILITY

Each and every insurance company, including Medicare has different plans, each with different benefits. Because your health insurance is an arrangement between you and your insurer, you should understand what services are covered under your specific plan. Your insurer can assist you with any questions you have relative to your own benefits.

### CARE OR SERVICES NOT COVERED BY YOUR INSURANCE PLAN

Coastal Skin & Eye Institute will send a medical claim to your insurance company based on the insurance information that you have provided to the practice. Please note that not every service may be covered by every insurance plan. Some or all of the care or services you receive might not be covered by your insurance, or may be denied by your insurance plan. Even if we have an established contract with your insurance carrier, you may still have some financial obligation based on your individual plan. If this is the case, and your insurance denies payment or holds you responsible for part of the payment, you will be responsible for the cost determined by your insurance policy. We advise that you ask your insurance company to approve services in advance if there is any question about coverage. If you receive a service that is not covered, you will be responsible for payment in full.

I have read and agree with the **Financial Policy**. I understand the terms and conditions outlined herein as confirmed by my signature below.

Patient Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_





## CHANNEL OF COMMUNICATION REQUEST

You have the right to request how we communicate with you. We may communicate with you by phone, text, email, or US Mail including use of automated communication devices. I hereby request the use of the following communication channels for information related to my personal health, treatment, or payment for treatment. This request supersedes any prior request for confidential communications I have made. This permission is valid for one year from the date signed. You may revoke your authorization to receive further calls or messages at any time. The revocation does not have to be in writing. The ability to receive treatment from CSEI is not contingent upon your communication choices Please circle all that apply and indicate with options(s) you prefer:

Preferred Contact Method (Check all that apply): ☐ Phone ☐ Email ☐ Text

Primary Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Alternate Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

\_\_\_\_\_ DO NOT leave messages on my voicemail

\_\_\_\_\_ OKAY TO leave messages on my voicemail

If you are unavailable, Coastal Skin & Eye Institute has permission to speak with: \_\_\_\_\_

### NOTICE OF PRIVACY PRACTICES AS REQUIRED BY THE PRIVACY REGULATION CREATED BECAUSE OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPPA)

I understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

A basis for planning my care and treatment

A means of communication among many health professionals who contribute to my care

A source of information for applying my diagnosis and surgical information to my bill

A means by which a third-party payer can verify that services billed were actually provided

And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand that I have the right to review a Notice of Information Practices that gives a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation, will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions that the organization has already taken action in reliance thereon. The Privacy Rule gives the right to access an individual's health records to a personal representative of the individual. If you would like a representative to have access to your health records, please indicate so below.

#### PATIENTS MUST SIGN HERE EVEN IF THEY DO NOT WISH TO GIVE ACCESS TO ANY REPRESENTATIVES

Name of Representative: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature of Patient: \_\_\_\_\_

Date: \_\_\_\_\_