PATIENT DEMOGRAPHIC FORM - OPHTHALMOLOGY/OPTOMETRY

Patient Name:_____ Date of Birth:_____

Gender: Male _____ Female _____

Address:_____ City, State, Zip:_____

Home #:_____ Work #: _____

Mobile #:_____ Email:_____

Primary Care Physician: _____

Pharmacy Name & Address: _____

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 OUR 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 _____

COASTAL SKIN & EYE INSTITUTE
SKIN & EYE CARE FOR ACTIVE LIFESTYLES

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 _____

COASTAL SKIN & EYE INSTITUTE
SKIN & EYE CARE FOR ACTIVE LIFESTYLES

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? _____

Patient Name _____ DOB _____

COASTAL SKIN & EYE INSTITUTE
SKIN & EYE CARE FOR ACTIVE LIFESTYLES

REFRACTION BILLING CONSENT - OPHTHALMOLOGY

A **refraction** is the process by which we evaluate your current vision and determine what type of correction is needed to improve your vision, where possible. This can include a change in your distance prescription, reading prescription or sometimes the need for prism to correct double vision. **It is a separate service from evaluating the health of your eyes and thus is not covered by most medical insurances.** If you have noticed a decrease in your vision, worsening double vision, or if you would just like to see if your vision has changed, then a refraction is necessary to determine the appropriate solution. Unless there are ongoing changes, patients typically only need this service every 1-2 years.

Please be advised that most MEDICAL INSURANCES will not cover the refraction. The refraction is the portion of the exam that the doctor must perform in order to get your glasses prescription. If no vision insurance is available, the patient will pay out of pocket for the refraction. **The fee for a refraction is $75**. Additionally, **contact lens prescriptions differ from glasses and need special testing and fitting.** If you desire a contact lens fitting we will have you see our optometrist.

Please note that Coastal Skin & Eye Institute will allow for a one-time prescription recheck at no charge within 90 days of your examination date. Recheck visits after 90 days will be charged a $75 refraction fee.

Please select *ONE* option below:

____ **I WANT THE REFRACTION SERVICE TODAY -** I understand I will receive the refraction today and if insurance does not cover this service I am responsible for the $75 fee.
____ **I DECLINE THE REFRACTION SERVICE TODAY -** I understand that without the refraction, my eye provider today may not be able to fully assess the health and function of my eyes.

Patient Name: _____

Patient Signature: _____ Date: _____

COASTAL SKIN & EYE INSTITUTE
SKIN & EYE CARE FOR ACTIVE LIFESTYLES

CONTACT LENS ANNUAL CONSENT FORM

CONTACT LENS FITTINGS ARE NOW EXCLUSIVELY SCHEDULED WITH OUR OPTOMETRIST

PLEASE READ AND SIGN BELOW IF YOU WOULD LIKE A NEW CONTACT LENS PRESCRIPTION AND SCHEDULE YOUR APPOINTMENT WITH DR. VICTORIA VUONG.

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 Patient $150, Established Patient $100
- Refraction - $75.00
- 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.

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: _____

Patient Name _____ DOB _____

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: _____