



**NEW PATIENT
HEALTH AND EYE QUESTIONNAIRE**

____/____/____
DATE

NAME _____ OCCUPATION _____
LAST FIRST INITIAL

REASON FOR APPOINTMENT: COMPLETE EYE HEALTH EXAM DIABETIC EYE EXAM
 INJURY/ER OTHER _____

EYE HISTORY

1. Do you wear glasses? Yes No
2. Do you wear contact lenses? Yes No
3. Do you have problems reading? Yes No
4. Are you currently experiencing any eye symptoms? Please check all boxes that apply:
 Eye pain Blurry vision Eye lid crusting Flashes of light Halos
 Discharge Light sensitivity Double vision Decreased vision Floaters
 Lazy eye Crossed Eyes Other

5. Have you ever had an eye injury? Yes No If yes, please describe:

6. Have you ever had eye surgery or laser? Yes No If yes, please describe:

SURGICAL HISTORY (Please list the operation and year, example; tonsils 1991) None

REVIEW OF SYSTEMS If you have any medical conditions in any of the following, please check the appropriate box.

If yes, please describe:

- | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Y | N | Y | N | Y | N |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Eyes | | Stomach | | Blood | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Ears, Nose, Throat | | Skin | | Immune system | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart | | Muscles, Joints | | Hormones | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lung | | Brain | | Psychiatric | |

PAST MEDICAL HISTORY (Please check the box(s) that apply)

- Diabetes
 Heart Disease
 Arthritis
 Stroke
 Cancer
 Thyroid Disease
 High Blood Pressure
 None
 Other _____

FAMILY MEDICAL HISTORY Please list medical conditions and relationship (example: uncle - diabetes)

- Diabetes _____
 Heart Disease _____
 Arthritis _____
 Stroke _____
 Cancer _____
 Thyroid Disease _____
 High Blood Pressure _____
 None
 Other _____

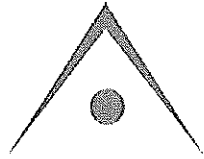
SOCIAL HISTORY

- Alcohol Yes No
 Recreational Drugs Yes No
 Tobacco Yes No

ALLERGIES TO MEDICATIONS Yes None (if yes, please list the medication(s) below)

MEDICATIONS Yes None (if yes, please list all current medications. Please include any eye medications)

_____	MG	_____	TIMES DAILY	_____	MG	_____	TIMES DAILY
_____	MG	_____	TIMES DAILY	_____	MG	_____	TIMES DAILY
_____	MG	_____	TIMES DAILY	_____	MG	_____	TIMES DAILY
_____	MG	_____	TIMES DAILY	_____	MG	_____	TIMES DAILY
_____	MG	_____	TIMES DAILY	_____	MG	_____	TIMES DAILY



Reed Vision Associates, PC

To Our Vision Exam Patients

If you are here for a typical vision exam your doctor will perform a comprehensive ophthalmic assessment. The health of your eyes will be thoroughly reviewed. In addition, your sight will be corrected, if needed, to ascertain your best corrected visual acuity. This may result in a prescription for glasses or contact lenses or both should the need be determined by your doctor.

If your doctor finds that you have no eye disease or abnormality of any kind and you only require a correction of your sight with glasses or contact lenses, we are obligated to bill your vision carrier for the visit.

If a medical condition is discovered; however, we are obligated to bill your medical insurer, since vision plans will not pay for visits related to diseases of the eye.

Our recommendation is for patients have vision exams on a yearly basis. It is your responsibility to know how frequently your vision plan allows examinations.

If you have a medical condition (glaucoma, diabetic retinopathy, etc.), exams are typically allowed more frequently.

Without insurance information, the visit is the patient's financial responsibility.

I have read and understand the information above:

Signed: _____ Date: _____

Staff Initials: _____



Reed Vision Associates, PC **Financial Policy**

We recognize the need for patients to understand what is expected of them and what they may expect regarding financial arrangements for medical care. It is our hope that our patients will understand that many of these credit and collection policies are required by state and federal laws and to assure the financial resources necessary to provide quality medical care to the community. The existence of a formal financial policy does not circumvent our sensitivity to the needs of our patients. We encourage contact with our billing office if a problem regarding your account should arise. Our financial policy is as follows, is applicable to all patients and effective immediately.

1. It is the patient's responsibility to know what are **covered or non-covered services** under their health insurance policy. Many procedures, while excellent relative to a patient's overall care, are considered preventive and are not covered by some insurance plans. Examples of these services are routine annual eye exams, customized tints, Blepharoplasty, etc. Check with your insurer to see if these services are covered prior to scheduling any test or procedure.
2. Likewise, it is the patient's responsibility to know if a **referral and/or authorization** are required from their insurance carrier for full benefits to be paid for our services and to *make certain whatever is required has been requested from their insurer. The patient* will be financially responsible for any charges incurred and subsequently denied by their insurer in the absence of an appropriate referral and/or authorization.
3. **All co-payments are due and payable at the time of service**, in accordance with state and federal legal requirements for collecting patient responsibility amounts.
4. **If you do not have insurance**, payment in full is expected at the time of service unless financial arrangements have been made in advance with our billing department.
5. **When purchasing eyeglasses or contact lenses**, payment in full is required when placing your order. The patient is responsible for all applicable state sales taxes on eyeglasses and contact lenses.
6. **If you are a contact lens wearer** or planning to become one, contact lens examinations are separate from an eye exam. Some insurance does not cover the contact lens exam.
7. **Eyeglass lenses** are custom made for your prescription. For this reason they are not refundable.
8. **Insurance claims for both medical services** will be submitted to your primary and secondary insurer. Claims for **Optical Services** will be submitted to your primary insurer. It is the patient's responsibility to provide our office with up-to-date and accurate insurance information. If our information is inaccurate and we are unable to file a claim, you will be billed privately for those charges. Ultimately, the patient is responsible for payment of any services provided to them or their covered dependents.
9. *Once the insurer has paid the claim*, **any deductibles, co-payment amounts or non-covered services** will become the responsibility of the patient. Prompt payment is expected once a statement has been received (within 30 days). If that is not possible, please contact our billing office.



10. We are **"participating providers"** with most major insurance plans, including Medicare. "Participation" means we will accept what the insurer approves as payment in full, exclusive of any patient responsibility amounts, such as copay amounts, deductible amounts or non-covered services. For instance, Medicare will pay 80% of the approved amount. The patient is responsible for the remaining 20%, plus any out-of-pocket deductible. We are required by state and federal laws to collect the patient responsibility amounts for both federally funded programs and private insurers.
11. We are happy to provide treatment for **work related injuries** (Workers' Compensation) to our patients. Any charges incurred are ultimately the responsibility of the patient, unless we have been provided with a viable claim number, allowed diagnoses and date & history of injury.
12. We are happy to provide treatment for injuries related to **auto accidents** for our established patients; however, the payment for these services will not be contingent upon a settlement from the accident insurer. It is the patient's responsibility to make arrangements for payment of services rendered to them as the result of injuries sustained in an auto accident. Compensation to the patient for the payments they have made for our medical services can be directly negotiated between the accident insurer and the patient.
13. Payment of services rendered to **children of divorced or separated parents** rests with the parent who seeks treatment. Any court ordered financial arrangements must be between the individuals involved, without including our office.
14. It is the responsibility of those patients who receive benefits from any **state sponsored welfare program** to provide us with a current copy of their card. Failure to provide verification of current benefits will result in the patient being financially responsible for any services provided to them as well as any non-covered services.
15. All patients may receive **monthly statements** from our office, even if their insurers are still processing the claim for our services. These statements are informational, until such time as there is an amount listed in the "Patient Balance" column. Any amount so listed is due and payable upon receipt of the statement. If you are dissatisfied with your insurer's payment, please contact your insurance carrier.
16. Any **account delinquent** for a period of 90 days will be referred to an outside collection agency for collection action and may result in the termination of patient care from the practice. The patient will be responsible for all collection fees.
17. There will be a \$45.00 **overdraft charge** for all checks returned by your bank.

It is our hope that you will find this information helpful. If you have questions, please speak with our billing staff at (734) 243-5300 X2926.

 PATIENT'S SIGNATURE (OR AUTHORIZED REPRESENTATIVE/GUARDIAN)

 PATIENT'S DATE OF BIRTH

 DATE

 WITNESS' SIGNATURE

 DATE



REED VISION ASSOCIATES PATIENT INFORMATION SHEETS

PATIENT #: _____

AGE: _____ TODAY'S DATE: ____/____/____

NAME: _____
LAST FIRST INITIAL

ADDRESS: _____
STREET Apt #
CITY STATE ZIP CODE

PHONE # (____) _____ (____) _____
HOME / EVENING BUSINESS / DAY

DATE OF BIRTH ____/____/____ SOCIAL SECURITY # ____ -- ____ -- ____

EMAIL _____ CELL PHONE _____

MARITAL STATUS SINGLE MARRIED DIVORCED WIDOW(ER) SEX: MALE FEMALE

EMPLOYER: _____
COMPANY NAME STREET CITY STATE ZIP

SPOUSE/PARENT: _____
LAST FIRST INITIAL DATE OF BIRTH ____/____/____

RELATIONSHIP TO MINOR: _____ SIGNATURE _____

EMPLOYER SOCIAL SECURITY (____) PHONE # _____

(EMPLOYER'S ADDRESS) STREET CITY STATE ZIP

EMERGENCY CONTACT PERSON: _____
NAME/RELATIONSHIP PHONE # _____

PRIMARY CARE PHYSICIAN: _____
(FAMILY DOCTOR/ GENERAL PRACTITIONER) NAME PHONE # _____

HOW DID YOU HEAR ABOUT US? _____

INSURANCE INFORMATION

Vision Insurance: _____

Primary Insurance: _____ Subscriber: _____ DOB ____/____/____

Policy # _____ Subscriber's relationship to patient: _____

Secondary Insurance: _____ Subscriber: _____ DOB ____/____/____

Policy # _____ Subscriber's relationship to patient: _____

I authorize the release of any medical information needed to process all claims and I authorize the release of payment for medical benefits to my physician.

Patient or Parent Signature: _____ DATE: ____/____/____

I accept that I am fully responsible for any co-pays, deductibles or items not covered by my insurance. I am also aware that I may be charged a collection fee of \$25.00 if I do not pay Reed Vision for these charges in a timely matter.

Patient or Parent Signature: _____ DATE: ____/____/____

REED VISION ASSOCIATES PATIENT INFORMATION SHEETS

MEDICARE SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

BENEFICIARY NAME (PRINT)

I request that payment of authorized Medicare benefits be made on my behalf to
Reed Vision Associates, P.C., for services furnished to me by **Reed Vision Associates**.

I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) and its agents any information needed to determine these benefits or the 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.

Reed Vision Associates accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

MEDICARE SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

BENEFICIARY SIGNATURE OR AUTHORIZED PARTY

DATE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Reed Vision Associates, P.C., reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the Notice of Privacy Practices for
REED VISION ASSOCIATES, P.C.

PATIENT NAME (PRINT OR TYPE)

PATIENT SIGNATURE

____/____/____
DATE

SIGNATURE OF PATIENT REPRESENTATIVE
(REQUIRED IF THE PATIENT IS A MINOR OR AN ADULT WHO IS UNABLE TO SIGN THIS FORM)

____/____/____
DATE

RELATIONSHIP OF PATIENT REPRESENTATIVE TO PATIENT

**DOCUMENTATION OF ATTEMPT TO OBTAIN
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

ATTEMPT TO OBTAIN ACKNOWLEDGEMENT

An attempt was made to obtain an acknowledgement of receipt of the Notice of Privacy Practices on _____. The acknowledgement was not obtained because:

- The patient was undergoing emergency treatment
- The patient declined to sign the acknowledgement
- Other _____

PATIENT SIGNATURE

____/____/____
DATE

STAFF SIGNATURE

____/____/____
DATE