

**WELCOME TO OPTOM~EYES - PLEASE PRINT LEGIBLY AND COMPLETE ALL ITEMS**

Patient's Name \_\_\_\_\_  
*Legal Last First MI Name patient prefers to be called*

Name of guarantor (required if patient is a minor) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
*Please circle: Patient / Mother / Father / Guardian Patient / Mother / Father / Guardian*

e-mail \_\_\_\_\_

What's the best way to contact you? *Please circle* H/W/C Phone; Email; Text Preferred Language: English/Spanish

With whom (if anyone) may we discuss your personal information? \_\_\_\_\_

Patient's Race: American Indian or Alaska native/Asian/Black or African American/Hispanic/Native Hawaiian or other Pacific Islander/White

Patient's Ethnicity: Hispanic or Latino/Native Hawaiian or other Pacific Islander/None of the previous

Patient's Sex: M/F Patient's Marital Status (circle one): Single/Married/Divorced/Other

Patient's Date of Birth \_\_\_\_\_ Patient's Social Security Number \_\_\_\_\_

Patient's Employer/School \_\_\_\_\_ Patient's Occupation \_\_\_\_\_

Employment Status: Employed full time/Student full time/Not a student

Name of primary care physician (PCP) \_\_\_\_\_ PCP phone \_\_\_\_\_

How did you hear about OPTOM~EYES? \_\_\_\_\_ Date of Last Eye Exam \_\_\_\_\_  
Where? \_\_\_\_\_

Have you been seen before at OPTOM~EYES? Yes / No When? \_\_\_\_\_

**PATIENT'S QUESTIONNAIRE:** Do you wear contact lenses? Yes / No Are you interested in contact lenses? Yes / No

**DILATION CONSENT:** The use of dilating drops is the standard for the most thorough eye examination; it is the only way of providing a complete ocular health assessment. You may experience increased light sensitivity and some difficulty seeing up close, although there is generally little effect on distance vision. These effects can last anywhere from 2 to 5 hours. There is no additional fee for dilation.

**CHECK ONE, PLEASE:** I accept dilation \_\_\_\_\_ I decline dilation \_\_\_\_\_ I'd like to reschedule dilation \_\_\_\_\_

**CONTACT LENS SERVICES:** The initial fitting fee (additional to the routine exam fee) covers follow-up visits during the trial period (up to a month) - additional appointments will be billed as routine office visits.

**RETINAL IMAGE/OCT AUTHORIZATION (Please review attached information sheets prior to completing this part):**

Dr. Rabins recommends retinal/OCT screenings for all of his patients and we will perform these diagnostic tests at an additional cost to the comprehensive eye exam being performed today. Please select one of the following boxes:

I'D LIKE TO have my/my dependent's retinal health evaluated with retinal imaging/optical coherence tomography. I understand that I will be billed \$40 separately for this packaged service.

I DECLINE retinal imaging/optical coherence tomography. I understand that I/my dependent will still receive a thorough eye examination with ordinary slit lamp and indirect biomicroscope observation.

Signature of Patient or Parent/Guardian \_\_\_\_\_

Today's Date \_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES**

**NOTICE OF PRIVACY PRACTICES:** I acknowledge having had opportunity to review the OPTOM~EYES Notice of Privacy Practices and understand I may keep a copy for my personal files if desired.

**SIGNATURE** \_\_\_\_\_

Check here if you do not have insurance.

**VISION INSURANCE POLICY INFORMATION – please notify receptionist if you have more than one policy**

Primary Insurance \_\_\_\_\_ ID / Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

**IF POLICY HOLDER IS NOT THE PATIENT:**

Policy holder \_\_\_\_\_ Soc. Sec.# \_\_\_\_\_  
Last First Initial (may be necessary for insurance claim filing)

Relationship to Patient: \_\_\_\_\_ Policy holder's date of birth: \_\_\_\_\_

Address \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_

**MEDICAL INSURANCE POLICY INFORMATION – please notify receptionist if you have additional coverage**

Insurance Company: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Insurance ID / Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

**IF POLICY HOLDER IS NOT THE PATIENT:**

Policy holder \_\_\_\_\_ Soc. Sec.# \_\_\_\_\_  
Last First Initial (may be necessary for insurance claim filing)

Relationship to Patient: \_\_\_\_\_ Policy holder's date of birth: \_\_\_\_\_

Address \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_

FOR MEDICARE PATIENTS ONLY: Have you met your out-patient deductible for this year?  Yes  No  
Do you have a Medicare supplemental policy?  Yes  No If yes, name of insurance company: \_\_\_\_\_

**FINANCIAL RESPONSIBILITY**

Note: As a courtesy to our patients, OPTOM~EYES will file insurance claims for **contracted insurance companies**; however all copayments are due when services are rendered. Any additional charges (such as for deductibles or non-covered charges) will be billed to the policy holder. We do not file out-of-network claims, but will assist in filing such claims upon request. Payment from these companies will be directly to the policy holder and may be at a reduced rate. If you have any questions, please speak to the receptionist before your exam.

**For contracted insurances:** I, the undersigned, certify that I (or my dependent) have insurance coverage as indicated above and assign directly to my provider all insurance benefits otherwise payable to me for services rendered. I also understand that any non-covered charges (such as refraction) will be billed at OPTOM~EYES' usual and customary rates, and that I am responsible for all deductibles. I hereby authorize OPTOM~EYES to release all information necessary to secure the payment of benefits, and authorize the use of this signature on all insurance submissions.

**FOR ALL:** I understand that I am ultimately responsible for all charges accumulated. In addition, I understand that if this account becomes delinquent, it may be forwarded to an outside collection agency without notice. If this happens, I will be responsible for all costs of collection, including interest (18% per annum, on the unpaid balance), legal fees, and collection agency costs. Returned checks will be assessed a \$50 service charge.

SIGNATURE \_\_\_\_\_ PRINTED NAME \_\_\_\_\_