REDMOND EYE CLINIC

PATIENT REGISTRATION

Name_____ Date _____
Last First MI

Address_____
Street City State Zip Code

Date of Birth_____ Last (4) of SSN_____ Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married

Email_____ Cell Phone _____ Home Phone_____

Emergency Contact/Relationship_____ Phone Number_____

Spouse Name_____ Date of Birth_____ Phone Number_____

Primary Care Physician_____ Date of last visit_____

Place of Employment_____ How did you hear about us?_____

REQUIRED INSURANCE INFORMATION

PLEASE GIVE YOUR INSURANCE CARDS TO RECEPTIONIST TO COPY

Name of Insured_____ Last 4 digits of SSN XXX-XX- _____
(if different from above) Last First MI

Medical/ ID Insurance_____ Vision Insurance_____

PERSONAL MEDICAL HISTORY

Do you currently have any problems with the following systems? **If yes, please explain** ☐ No known medical conditions

- ☐ Constitution (cancer, rapid weight loss or gain, fatigue) _____
- ☐ Ear, Nose and Throat (hearing loss, sinus problems) _____
- ☐ Neurologic (headaches, stroke, MS) _____
- ☐ Psychiatric (depression, anxiety, ADHD) _____
- ☐ Cardiovascular (high blood pressure, heart disease) _____
- ☐ Respiratory (asthma, sleep apnea) _____
- ☐ Gastrointestinal (Crohn's, colitis, ulcer) _____
- ☐ Genitourinary (kidney disease, prostate disease, pregnant) _____
- ☐ Muscular/Skeletal (arthritis, fibromyalgia) _____
- ☐ Skin (rosacea, shingles, rashes) _____
- ☐ Endocrine (diabetes, thyroid disease) _____
- ☐ Blood/Lymph (anemia, high cholesterol) _____
- ☐ Allergies/Immune (seasonal allergies, autoimmune disease) _____
- ☐ Other _____

Medications: ☐ None

_____
_____

Allergies to Medications: ☐ None

_____
_____

Do you drink alcohol? ☐ No ☐ Yes If yes, how much _____

Do you smoke tobacco? ☐ No ☐ Yes If yes, how much _____

Height _____ Weight _____ ☐ Decline

Are you currently pregnant/nursing? ☐ No ☐ Yes

PERSONAL OCULAR HISTORY

Do you currently or have you ever had any of the following? ☐ No known ocular conditions

- ☐ Dry eyes
- ☐ Itchy eyes
- ☐ Strabismus
- ☐ Amblyopia (lazy eye)
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular degeneration
- ☐ Keratoconus
- ☐ Retinal detachment
- ☐ Eye injuries
- ☐ Eye surgeries
- ☐ Other: _____

Date of last eye exam_____ Do you wear: ☐ Glasses ☐ Contacts ☐ None

Are you interested in: ☐ Glasses ☐ Contacts ☐ Vision Correction Surgery (LASIK/PRK)

Primary Reason for Visit today (if not stated above): _____

FAMILY HISTORY

Has anyone in your family ever had any of the following conditions? If so, who? ☐ None

- ☐ Cancer_____
- ☐ Diabetes _____
- ☐ Hypertension _____
- ☐ Thyroid Disease _____
- ☐ Other _____
- ☐ Cataracts _____
- ☐ Macular Degeneration _____
- ☐ Glaucoma _____
- ☐ Keratoconus _____
- ☐ Other: _____

Vision vs. Medical Insurance Plans
Vision benefit plans such as VSP are not medical insurance. They pay for an annual eye wellness exam and a prescription for glasses and/or contact lenses. They usually provide patients with a hardware benefit and allowances. They DO NOT cover any medical eye problems.

Medical insurance covers anything that happens to your body including your eyes. i.e.: diabetic eye exams, eye allergies, scratched cornea, dry eyes, infections, and chronic eye diseases such as macular degeneration, cataracts and glaucoma.

Authorization/Responsibility Agreement
I understand that my portion is to be paid at the time services are rendered. The undersigned will be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees in addition to the account balance due, as well as any compound accrued interest at the rate of twelve (12%) percent per annum. There will be a service charge on all returned checks. I understand that screening tests may not be covered by my insurance and that I will be responsible to pay in full for these tests. Professional services are not refundable and all product sales are final. Any returns that are approved may be subject to a restocking fee. I authorize payment from my insurance to be paid directly to Redmond Eye Clinic. I understand that billing any out of network insurance will be my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed. I authorize the use of this form on all insurance submissions and the release of all information to my insurance companies. I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies. I permit a copy of this authorization to be used in place of the original.

Authorization to Release Medical Information
I authorize the release of medical information regarding myself/my dependent and my current condition to my referring, consulting, or treating physician.

Acknowledgement of Notice of Privacy Practices
According to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you may request a copy of your medical record in writing. We will not disclose your records to others unless given your written consent or legal authorities authorize or compel us to do so. Our full Notice of Privacy Practices describes how your health information may be used or disclosed and is available upon request at our front desk. I acknowledge that I have had the chance to review and agree to the terms and conditions of the Notice of Privacy Practices and upon request I may have a copy.

Traditional dilation of the eyes
Routine dilation of the eyes is considered standard of care for comprehensive eye examinations. Many people may need their pupils dilated to rule out any eye disease that may cause the loss of their sight. As part of your exam today, your doctor may request that your eyes be dilated. There is no additional cost for the dilation. The drops that are used to dilate your pupils require about 20 minutes to take effect and will keep your pupils dilated for 3-5 hours. The dilation may cause your near vision to be temporarily blurry and your eyes will be sensitive to light, possibly making driving home and continuing your day's activities more challenging.

In this office, patients reserve the right to refuse any test or diagnostic procedure, despite our recommendations. I understand the risks of refusing these procedures and that without them the health of the eyes cannot be completely evaluated. Initial here _____

- ☐ YES I consent to dilation today if recommended by my doctor
- ☐ NO I decline dilation today and assume all risks and complications that arise and will not hold Redmond Eye Clinic responsible for any consequences secondary to my decision.

Contact Lens Evaluation Fees
Contact lenses are a medical device regulated by the Food and Drug Administration and require a valid prescription by an optometric physician. Evaluating your eyes for contact lens use is considered an additional service that is often not covered as part of a routine eye exam. Therefore, there may be an additional fee if you choose to be evaluated for contact lenses. This fee **starts at $90** and increases based on contact lens style.

- ☐ YES I accept the responsibility of the Contact Lens Evaluation fee.
- ☐ NO I decline the Contact Lens Evaluation acknowledging that I will not be given a prescription for contact lenses today.

Co-Payments - By law, we must collect your carrier designated co-pay at the time of service. Please be prepared to pay your co-pay at each visit.
Cancellation Policy - We understand that situations arise in which you must cancel your appointment. Please allow 24 hours cancellation notification to avoid a **$50.00** charge.
Self-Pay - Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.
Secondary Insurance - In most cases, we will only bill your ***primary insurance***. We will provide you with the necessary paperwork so that you may bill your secondary insurance.
Account Balances - You are responsible for timely payment of your account. We reserve the right to reschedule or deny any future appointments on delinquent accounts.

By signing below, I confirm that I have read and understand all of the above.

_____ _____
(Responsible Party Signature) (Date)

REDMOND EYE CLINIC is committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about insurance, our fees, or your financial responsibility.

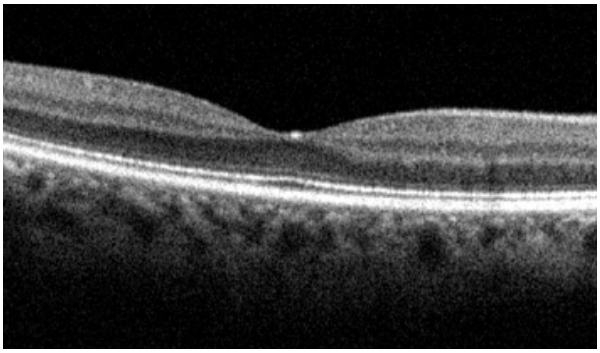
REDMOND EYE CLINIC

Advanced Wellness Screening Options

Our doctors recommend the following two screening tests prior to your eye exam

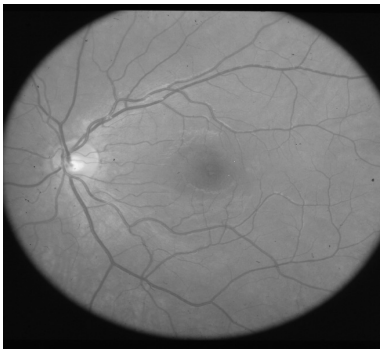
In order to provide the most comprehensive view of all layers of the eye, our doctors recommend the following state-of-the-art advanced imaging technology. Both of these tests provide the most thorough view of the eye and surrounding tissues. This provides the best opportunity to detect ocular diseases and conditions. Although dilation is not needed to perform either of these tests, the doctor may still wish to dilate your eyes as part of your exam – they will discuss this with you. Early detection and treatment of disease might save your sight!

Heidelberg Spectralis OCT Screening Scan



- 3D cross-sectional scan of the retina
- Detailed layer-by-layer view of the retina
- Images stored for comparison over time

Eidon Retinal Screening Photo



- External view of the retina from above
- Images can be magnified to 60x
- Images stored for comparison over time

Both of these instruments assist in early detection and screening for:

Macular degeneration	Medication side effects	Vitreous detachments
Glaucoma	High blood pressure damage	Optic nerve disease
Retinal detachments	Macular edema	Nevus (freckles)
Diabetic changes	Retinal scars	Melanoma and other cancers

These tests are not covered by insurance: ***Screening fees are due at the time of service***

- ☐ **Yes, I want both retinal photography and OCT screening exams for $75.**
- ☐ Yes, I only want a retinal photography screening exam for $40.
- ☐ Yes, I only want an OCT screening exam for $40.
- ☐ No, I elect to decline retinal photography and OCT screening exams.

_____ _____

Patient Signature Date

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