

### Patient Registration

*Thank you for choosing our office! In order to serve you properly, we need the following information.*

All information will be confidential. **PLEASE PRINT**

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Sex M F Status S M W D

Home Address \_\_\_\_\_ Email Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ SSN \_\_\_\_\_

Phone (H) \_\_\_\_\_ Phone (C) \_\_\_\_\_ Phone (W) \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Patient Employer \_\_\_\_\_ Work Address \_\_\_\_\_

Spouse's Name \_\_\_\_\_ DOB \_\_\_\_\_ Employer \_\_\_\_\_

How did you hear about us \_\_\_\_\_

Referring Physician \_\_\_\_\_ Phone \_\_\_\_\_

Preferred Contact Method  HOME  CELL  WORK  EMAIL  WRITTEN

Race \_\_\_\_\_ Preferred Language \_\_\_\_\_ Ethnicity \_\_\_\_\_

**DECLINE TO ANSWER**

**Parent / Guardian / Responsible Party (if Minor)**

Name \_\_\_\_\_ SSN \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_

Phone (H) \_\_\_\_\_ Phone (C) \_\_\_\_\_ Phone (W) \_\_\_\_\_

Employer \_\_\_\_\_

**Medical Insurance Information**

Is this Worker's Comp  Yes  No If yes, Date of Accident \_\_\_\_\_ Employer Notified:  Yes  No

**Primary Insurance** \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_ Policy # \_\_\_\_\_

Policy Holder DOB \_\_\_\_\_ Relationship to Policy Holder \_\_\_\_\_

**Secondary Insurance** \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_ Policy # \_\_\_\_\_

Policy Holder DOB \_\_\_\_\_ Relationship to Policy Holder \_\_\_\_\_

**\*\*PLEASE NOTE!** Medical Examinations and Treatment are not covered by ROUTINE Vision Plan Insurance.

**The above information is true and correct to the best of my knowledge.**

Signature of Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

ADVANCED EYE MEDICAL GROUP, Inc.

R.K. Ghosheh, M.D.

Omar Ozgur M.D.

Faris R. Ghosheh, M.D.

**Office and Financial Policies**

We would like to thank you for choosing Advanced Eye Medical Group for your medical eye needs. To keep you informed of our current office and financial policies, we ask that you read and sign our financial acknowledgement prior to any treatment.

For the purpose of evaluation, your pupils may be dilated. This may result in blurred vision, making driving difficult. Please ask for assistance if your vision is markedly affected.

On an annual basis, we will request that you update your demographic information by filling out a new registration form. At each visit, we will inquire about your insurance and ask to see your insurance cards. Please note that we cannot file insurance for your services unless we have a card that is correct and current. Although this is often regarded as an inconvenience to you, we have found that it is now a necessity due to frequent changes in carriers and necessary information.

**Financial Assignment and Agreements**

**Medicare**

Name of Beneficiary: \_\_\_\_\_

Health Insurance Claim #: \_\_\_\_\_

I request that payment of authorized health insurance benefits, including Medicare and Medigap, be made either to me or on my behalf to Dr. \_\_\_\_\_ for services furnished to me by this provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits payable for related services.

Signature of Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

**Commercial Insurance**

I hereby authorize direct payment of surgical/medical benefits to Dr. \_\_\_\_\_ for services rendered by him/her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance, including co-pays, deductibles, and refractions. I hereby authorize Dr. \_\_\_\_\_ to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefits.

Signature of Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

## **Refraction Fee Policy**

### **What is a refraction?**

Refraction is a test done to determine the refractive error of your eyes, or the need for corrective glasses and/or contact lenses.

### **When do I have to pay for a refraction?**

Refraction (CPT code 92015) is a **non-covered** service by Medicare. As a result, your healthcare provider is required by CMS (the department to the federal government that controls Medicare) to charge for this service. Most other insurance plans follow Medicare's rules. All these plans consider refraction a "vision" service not a "medical" service.

### **How much do I have to pay?**

You will only be charged a refraction fee if you receive a prescription for glasses or contact lenses. Our office fee for refraction is \$35. This is collected at the time of service in addition to any co-payment your plan may require. Should your plan pay us for the refraction, we will refund you accordingly.

### **Suggestions When Filling Your Prescription**

Since refraction (measuring for an eyeglass and/or contact lens prescription) is an inexact art in which errors may arise at any step, including from the patient, the doctor, and the optician making the eyeglasses, we suggest the following:

1. Fill your prescription at an establishment that agrees to make at least one adjustment (including changes that we make in the prescription if you are having trouble with new glasses) at no charge to you.
2. Purchase only one pair of new glasses with the new prescription, so that if any changes are made subsequently, only one pair of glasses need be adjusted. Once you are sure you are happy with the new prescription, proceed with making additional pairs as needed.
3. Please address any legibility issues regarding the written prescription with the prescribing doctor prior to filling the prescription.
4. Change as few parameters -- lens size and shape, lens company/brand (especially with progressive add spectacles) -- as possible with your new glasses to minimize the risk of being uncomfortable with newly prescribed glasses.

### **What if my glasses or contact lenses don't fit well?**

Our physicians will re-evaluate you at no charge within 60 days of your initial refraction to change your prescription if necessary. However, our office does not pay for revision of glasses in which good faith efforts were made in measuring and writing the prescription

### **Advance Notice regarding Insurance Reimbursement and Beneficiary Agreement**

I have been informed that refraction (the measurement of one's eyeglass prescription and the determination of the best visual sharpness) is usually not considered by insurance companies, health maintenance organizations, and Medicare to be medically reasonable of necessary. Knowing this, I have instructed the doctor to proceed with the services. If insurance decides to reduce or even deny the fee or services, I agree to pay the doctor's fee in full.

Signature of Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

# Authorization for Release of Information

**Patient Information:**

Name of Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

**Advanced Eye Medical Group** is authorized to release protected health information pertaining to the above named patient to the entities below.

**I have received a copy of the Notice of Privacy Practices for the above named practice.**

**Signature**

**Date**

**Entity to Receive Information.** (Initial each that is subject to this authorization)

\_\_\_\_\_ Leave information voice mail/answering machine. \_\_\_\_\_ Give information to spouse/parents.

\_\_\_\_\_ Leave information with the following persons \_\_\_\_\_ Give information to patient.

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

**Description of information to be released** (Initial each that is appropriate)

\_\_\_\_\_ Financial information on billing \_\_\_\_\_ All information

\_\_\_\_\_ Medical information, including results from any tests or x-rays.

\_\_\_\_\_ Other information as described: \_\_\_\_\_

**Rights of the Patient**

I understand that I have the right to revoke this authorization at any time by sending a written notification. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document. I can do this by written notification to:

I understand that my treatment will not be conditioned on signing this authorization.

I understand that I have the right to refuse to sign this authorization.

\_\_\_\_\_ Date \_\_\_\_\_

Signature of Patient or Personal Representative

Print or Type Name of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation)

Reason for Non Signature on back

**ADVANCED EYE MEDICAL GROUP, Inc.**

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**MEDICAL HISTORY QUESTIONNAIRE**

**Name** \_\_\_\_\_

**Date** \_\_\_\_\_

Date of **Birth** \_\_\_\_\_ Date of **last eye exam** \_\_\_\_\_  
 List any **medications** you currently take (Rx and over-the-counter): \_\_\_\_\_  
 \_\_\_\_\_  
 Do you have **allergies** to any medications? **YES NO**  
 If YES, list the medications: \_\_\_\_\_  
 List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or **injuries** (concussion, etc.):  
 \_\_\_\_\_  
 List any **surgeries** you have had (cataract, appendectomy): \_\_\_\_\_

Do you **currently** have any problems in the following areas? If YES, please provide additional information.

	YES	NO	Details
<b>EYES</b> (poor vision, eye pain, tearing, redness, etc.)			
<b>GENERAL / CONSTITUTIONAL</b> (fever, heat stroke, weight loss, weight gain, unusually tired)			
<b>EARS, NOSE, THROAT</b> (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)			
<b>CARDIOVASCULAR</b> (high BP, racing pulse, etc.)			
<b>RESPIRATORY</b> (congestion, wheezing, short of breath, etc.)			
<b>GASTROINTESTINAL</b> (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
<b>GENITAL, KIDNEY, BLADDER</b> (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
<b>FEMALES</b> Are you pregnant? Nursing?			
<b>MUSCLES, BONES, JOINTS</b> (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
<b>SKIN</b> (pimples, warts, growths, rash, etc.)			
<b>NEUROLOGICAL</b> (numbness, headache, seizures, paralysis, etc.)			
<b>PSYCHIATRIC</b> (anxiety, depression, insomnia)			
<b>ENDOCRINE</b> (diabetes, hypothyroid, etc.)			
<b>BLOOD / LYMPH</b> (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
<b>ALLERGIC / IMMUNOLOGIC</b> (sneezing, swelling, redness, itching, hives, lupus, etc.)			

**FAMILY HISTORY** (Mother, Father, Grandparent, Sibling)

Has any member of your family had these diseases (circle all that apply) ? **YES NO UNKNOWN**  
**Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis**  
 Other heritable disease: \_\_\_\_\_

**SOCIAL HISTORY**

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)?.....**YES NO**  
 Have you ever had a blood transfusion?.....**YES NO**  
 Do you drink alcohol?..... **YES NO** If YES, how much? \_\_\_\_\_  
 Do you smoke?..... **YES NO** If YES, how much? \_\_\_\_\_ How many years? \_\_\_\_\_

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

**Physician's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_