ADVANCED EYE MEDICAL GROUP, Inc.

Faris Ghosheh, M.D. Sarah Ahmed, M.D. Noor Amra, M.D.

Patient Registration

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

All information will be confidential.

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** _____

How did you hear about us _____

Referring Physician_____ **Phone** _____

Preferred Contact Method ___ **HOME** ___ **CELL** ___ **WORK** ___**EMAIL**

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: _____

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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: _____

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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. 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 request a prescription for glasses or contact lenses. Our office fee for refraction is $58 for glasses and $125 for contact lenses. This is collected at the time of service.

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 or necessary. I agree to pay the doctor's fee in full should I receive these services.

Signature of Responsible Party: _____ Date: _____

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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

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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
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL / CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, **KIDNEY**, **BLADDER** (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
FEMALES Are you pregnant? Nursing?			
MUSCLES, **BONES, JOINTS** (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (bleeding, cholesterolemia, anemia,problems related to blood transfusion, etc.)			
ALLERGIC / IMMUNOLOGIC (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*** _____