BROOKSEYE
ASSOCIATES

PATIENT INFORMATION: Today's Date _____

Last Name_____ First Name _____ MI _____ Race_____

Date of Birth _____ Age____ Marital Status_____ Social Security #_____ M or F (circle one)

Address _____ Apt # _____

City _____ State _____ Zip _____Email _____

Home # _____ Cell # _____ Work # _____

Employer Name _____City _____ State _____ Zip _____

INSURANCE INFORMATION:

Primary Insurance Carrier _____Type of Plan: PPO / HMO / Other

Policy # _____Group # _____

Policy Holder's Last Name _____ First Name _____ MI _____

Policy Holder's DOB _____ Social # _____ M or F (circle one)

Patient's relationship to Insured (circle one) Self Spouse Child

Secondary Insurance Carrier _____ Type of Plan: PPO / HMO / Other

Policy # _____Group # _____

Policy Holder's Last Name _____First Name _____ MI ____

Policy Holder's DOB _____ Social # _____ M or F (circle one)

Patient's relationship to Insured (circle one) Self Spouse Child

EMERGENCY CONTACT:

Name _____ Relationship _____ Phone _____

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NOTICE REGARDING EYE REFRACTION

REFRACTION POLICY:

Refraction is a diagnostic test that can help determine your EYEGLASS PRESCRIPTION. It is an essential part of an eye examination, but is NOT usually a covered service by most medical insurances, including Medicare. This test is required by your insurance company as necessary documentation to evaluate for possible CATARACT SURGERY. Our office has a **$100 fee for an eyeglass prescription at the REQUEST of the patient.** If the patient chooses to request an eyeglass prescription in addition to the diagnostic refraction, the fee will be collected along with any co-pays at the time of service. You may choose to file directly with your insurance company with your receipt at check-out.

ACKNOWLEDGMENT:

I have read the above information and understand that if I choose to request an eyeglass prescription in addition to the diagnostic refraction, I understand that it is a non-covered service. I accept full financial responsibility for the cost of the prescription if I so choose to request one, and I understand that the co-pay is separate from the eyeglass prescription.

_____ _____

Patient Name (Printed) Patient or Guardian Signature

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FINANCIAL/INSURANCE POLICY

We have contracted with many insurance carriers or managed care networks to be providers on their plan. Contractually, both the provider and the patient have certain obligations under these plans. If you have medical insurance, we are anxious to help you receive your maximum benefits allowed. In order to achieve that goal, we need your assistance and your understanding of our payment policies.

- All payments for services not covered by your insurance plan, or being filed on an insurance plan are due at the time of service.
- We must have a copy of your current insurance card at the time of your visit in order to file a claim for you. If we do not have proof of valid insurance, the patient will be responsible for the full amount of services rendered.
- We will collect all co-payments/or deductibles due at the time of service.
- Your insurance is a contract between you, the employer, and the insurance company. We are not a party to that contract, and are not responsible for knowing the specific benefits of your plan.
- Verification of your benefits does not guarantee payment.
- Not all services are a covered benefit in your insurance contract. Some insurance companies select certain services they will not cover or set maximum limitations. Any services identified as such will be your responsibility and payment will be due at time of service.

We must emphasize that filing of claims is a courtesy we extend to all of our patients. All charges are your responsibility from the date services are rendered. It is understood that temporary financial problems may affect timely payment of your account. If such problems arise, please contact us promptly for assistance in the management of your account.

PLEASE ACKNOWLEDGE YOUR UNDERSTANDING AND AGREEMENT TO THESE TERMS BY SIGNING BELOW:
I hereby authorize Brooks Eye Associates, to furnish my insurance company, its representatives or any other insurance company or attorney, the customary medical information requested about me. I understand that Brooks Eye Associates will file my insurance on my behalf and I will be responsible for following up with my insurance company for timely payment of services rendered. I agree to pay in full all balances due that are not paid by the insurance company.

Signature _____ Date _____

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CONSENT FOR USE AND DISCLOSURE OF INFORMATION

I have reviewed the NOTICE OF PRIVACY PRACTICES of Brooks Eye Associates.

I also consent to the use or disclosure of my protected health information for the following purposes:

a. **TREATMENT**
It will be necessary to share protected health information with all members of the treatment team for treatment purposes. This can include employees in this office, as well as other providers.

b. **PAYMENT**
Necessary information will be shared with appropriate payer sources and their representatives for payment purposes, including but not limited to eligibility, benefit determination, and utilization review. It will also be necessary for the billing personnel, including but not limited to employees, case managers, claims representatives, third party billing services or clearinghouses to have access to protected health information to carry out their job functions.

c. **HEALTHCARE OPERATIONS**
Necessary information will be shared for the continuing operations of this office. Some examples include, but are not limited to peer review, accreditation, credentialing processes, and compliance with all federal and state laws.

I understand that my treatment may be conditioned upon my consent. This consent is given freely and I understand that I can revoke this consent at any time in writing, which will apply to disclosures and uses made subsequent to the revocation date.

d. **DISCLOSURE OF MEDICAL INFORMATION**
Please list below the names of any individuals with whom you authorize members of our office staff to discuss your medical information (example: your spouse or a parent):

_____.

_____ _____
Patient Name (Printed) Date

_____
Patient or Guardian Signature

BROOKSEYE
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Patient Refund Policy

Brooks Eye Associates strives to collect the accurate amount owed from patients for co-pays, deductibles, co-insurance and advanced technology lenses.

However, on some occasions the patient will be due a refund. In the instance of a required refund, the following policies shall apply:

- Refunds are processed for payment within 30 days of notification from the insurance provider, patient or explanation of benefits that a refund is due to the patient.
- If the patient paid for services with a debit or credit card, we will process the refund back to that specific card. We will NOT issue checks for credit or debit card refunds.
- If the payment was made with a check or cash, we will provide the refund in the form of a paper check and mail that to the patient's last known address.

I (print name) _____ have read the Brooks Eye Associates refund policy and understand how refunds are processed

_____ _____

Patient Signature **Date**

Patient Acknowledgement of Receipt of Privacy Practices

I (print name) _____acknowledge that I have received a copy of the Brooks Eye Associates Privacy Practices packet. I understand this is for informational and educational purposes only and it is a requirement of HIPAA guidelines that my physician practice provides this notice to me.

Patient Signature: _____ **Date**: _____

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Referred By: _____ **Optometrist:** _____

What is the reason for your visit today? _____

_____

History of <u>eye surgery</u>? (Circle One) Yes or No

		Right Eye	Left Eye
☐	Cataract Surgery	Dates _____	_____
☐	Cornea Surgery	Dates _____	_____
☐	Glaucoma Surgery	Dates _____	_____
☐	Refractive Surgery (LASIK, PRK)	Dates _____	_____
☐	Retinal Surgery	Dates _____	_____
☐	Strabismus (Muscle) Surgery	Dates _____	_____
☐	Vitreous Surgery	Dates _____	_____
☐	Other _____		

History of <u>eye disease</u> or problem? (Circle One) Yes or No
(Examples: Glaucoma, macular degeneration, iritis, or dry eye syndrome)

If yes, explain: _____

List current eye drops being used: _____

Do you wear contact lenses? Y or N If yes, are they soft or hard lenses? _____

Family history of eye disease? Y or N If yes, explain: _____

Allergies to Medication: _____ ☐ **NONE**

MEDICATION:	REASON FOR USE:	*FOR OFFICE USE ONLY*

<u>Major surgeries</u> within the last 10yrs: _____

Primary Care Provider _____ **Phone #** _____

Preferred Pharmacy _____ **Street or Intersection** _____

City _____ **Phone#** _____

Review of Systems

√ *Please check if applicable*

Cardiovascular	Immunologic	Gastrointestinal	Endocrine
☐ chest pain	☐ Lupus	☐ abdominal pain	☐ Diabetes(How long:_____)
☐ irregular heart beat	☐ Rheumatoid Arthritis	☐ constipation	☐ Kidney disease
☐ High blood pressure	☐ Crohn's Disease	☐ heartburn	☐ Thyroid disease
☐ Pacemaker	☐ Ulcerative Colitis	☐ Nausea/vomiting	☐ Other
☐ Congestive Heart Failure	☐ Other	☐ Hiatal Hernia	
☐ *Negative*	☐ *Negative*	☐ *Negative*	☐ *Negative*

Infectious	Hematologic/Other	Metabolic	Musculoskeletal
☐ HIV/AIDS	☐ Bleeding problems	☐ cold intolerance	☐ back pain
☐ Hepatitis	☐ Bruising easily	☐ excess hunger	☐ joint pain
☐ Other	☐ Anemia	☐ excessive thirst	☐ muscle aches
	☐ Prostate	☐ frequent urination	☐ stiffness
		☐ heat intolerance	☐ swelling
☐ *Negative*	☐ *Negative*	☐ *Negative*	☐ *Negative*

Neurological	Psychiatric	Respiratory	Skin
☐ Multiple Sclerosis (MS)	☐ anxiety	☐ cough	☐ hair loss
☐ headache	☐ depression	☐ COPD/Emphysema	☐ rash
☐ Numbness/tingling	☐ insomnia	☐ Tuberculosis (TB)	☐ skin lesions
☐ Stroke/TIA	☐ irritability	☐ Asthma	☐ Shingles
☐ Seizures	☐ nervousness		☐ Cancer _____
☐ *Negative*	☐ *Negative*	☐ *Negative*	☐ *Negative*

Social History

√ *Please check if applicable*

Smoking	Alcohol	Recreation Drugs	Occupation	Hobbies
Frequency	*Frequency*	*Frequency*		
☐ 1 – Current Everyday Smoker	☐ Never	☐ Never	☐ Business	☐ Computers
☐ 2 – Current Some Day Smoker	☐ Rarely	☐ Rarely	☐ Manual labor	☐ Music
☐ 3 – Former Smoker	☐ Occasional	☐ Occasional	☐ Office work	☐ Sewing/Crafts
☐ 4 – Never Smoked	☐ Daily	☐ Daily	☐ Retired	☐ Sports
☐ 5 – Smoker, Status Unknown	☐ Frequently	☐ Frequently	☐ Student	☐ Travel
☐ 9 – Unknown if Ever Smoked	☐ Heavy	☐ Heavy	☐ Teacher	☐ Golf
			☐ Driver/Pilot	☐ Hunting
Type of Tobacco	*Type of Alcohol*	*Type of Drug*	☐ Engineer	☐ Reading
☐ Cigarettes	☐ Beer	☐ Amphetamines		☐ Cards
☐ Cigar	☐ Liquor	☐ Cocaine		☐ Other_____
☐ Pipe	☐ Wine	☐ Intravenous drugs		
☐ Electronic Cigarettes		☐ LSD		
		☐ Marijuana		

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Lifestyle Vision Assessment

Dr. Dain Brooks, strives to provide the best quality of care and customized vision solutions for his cataract and refractive lens exchange patients. This form will assist him in helping you to choose the treatment best suited for your visual needs and lifestyle.

Name:_____ Date:_____

1) What are your favorite hobbies? _____

_____

2) If you work, what are some of your daily work-related tasks? _____

_____

3) If Dr. Brooks determines that you are an appropriate candidate for the advanced technology currently available, would you be open to hearing about an implant that could significantly reduce or possibly eliminate your need for glasses? □ **Yes** □ **No**

4) If you had to wear glasses/contact lens after surgery for one activity, for which activity would you be most willing to use glasses?

□ **Reading fine print** □ **Computers** □ **TV / Driving**

5) How would you describe your personality?

□ **Easy going** □ **In between** □ **Meticulous**

It is important to understand that some people still need to wear glasses for certain activities after surgery.