FORRESTER EYE ASSOCIATES

3320 NORTH MAIN STREET ANDERSON, SC 29621
PHONE 864 642 1889
FAX 864 224 1768
WWW.FORRESTEREYE.COM

PATIENT PAPERWORK

_____ _____ _____/_____/_____

PATIENT'S LAST NAME **PATIENT'S FIRST NAME** **PATIENT'S DATE OF BIRTH**

PATIENT'S GENDER: **SOCIAL SECURITY #** **STREET ADDRESS:**_____

☐ MALE **APT./UNIT:**_____ **CITY:**_____

☐ FEMALE _____-_____-_____ **STATE:**_____ **ZIP:** _____

MAY WE TEXT YOU REGARDING YOUR APPOINTMENTS?

☐ YES _____ _____

☐ NO **HOME PHONE** **CELL PHONE**

_____ _____ _____

EMPLOYER OR SCHOOL **OCCUPATION OR GRADE IN SCHOOL** **EMAIL**

PARENT OR GUARDIAN INFORMATION

_____ _____ _____/_____/_____

PARENT OR GUARDIAN'S LAST NAME **PARENT OR GUARDIAN'S FIRST NAME** **DATE OF BIRTH**

RELATION TO PATIENT:_____

❒ **ADDRESS and PHONE IS THE SAME AS THE PATIENT**

GENDER: **SOCIAL SECURITY #** **STREET ADDRESS:**_____

☐ MALE **APT./UNIT:**_____ **CITY:**_____

☐ FEMALE _____-_____-_____ **STATE:**_____ **ZIP:** _____

HOME PHONE:_____ **CELL PHONE:** _____

FINANCIAL INFORMATION

WHO IS RESPONSIBLE FOR THIS ACCOUNT:

❒ Myself ❒ Parent or Guardian (must be checked if patient is under 18)

NAME:_____

ARE YOU A SELF PAY PATIENT? ❒ YES ❒ NO

INSURANCE INFORMATION

☐ PRIMARY MEMBER OF MEDICAL AND VISION INSURANCE FOR THIS VISIT IS ME.

☐ THE PRIMARY MEMBER OF MEDICAL AND VISION INSURANCE USED FOR THIS VISIT IS THE SAME AS THE PARENT AND GUARDIAN INFORMATION ALREADY PROVIDED.

_____ _____ _____/_____/_____

PRIMARY MEMBER'S LAST NAME **PRIMARY MEMBER'S FIRST NAME** **DATE OF BIRTH**

RELATION TO PATIENT:_____ **PRIMARY MEMBER'S**

PATIENT'S GENDER: **SOCIAL SECURITY #** **STREET ADDRESS:** _____

☐ MALE **APT./UNIT:**_____ **CITY:**_____

☐ FEMALE _____-_____-_____ **STATE:**_____ **ZIP:** _____

_____ _____ _____ _____ _____

MEDICAL INSURANCE CARRIER **MEDICAL INSURANCE ID #** **PLAN NAME** **GROUP #** **PHONE NUMBER**

_____ _____ _____ _____ _____

VISION INSURANCE CARRIER **VISION INSURANCE ID #** **PLAN NAME** **GROUP #** **PHONE NUMBER**

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WHAT IS THE REASON FOR TODAY'S EXAM?

- ☐ Eye Exam for Medical Conditions such as corneal disorders, diabetes, cataracts, glaucoma, dry eye, etc.
- ☐ Basic Exam for an eyeglass prescription
- ☐ Current Wearer - Contact lens and Eye Exam
- ☐ New Wearer - Contact lens and Eye exam
- ☐ Medical Visit due to illness or injury ** List symptoms and duration:_____
- ☐ Purchase Contacts with outside Prescription

_____ _____ _____

DATE OF LAST EXAM **AGE OF CURRENT GLASSES** **BRAND OF CONTACT LENSES, AND SOLUTION USED**

PERSONAL HISTORY

PLEASE SELECT ANY EYE CONDITIONS YOU HAVE NOW OR HAVE BEEN DIAGNOSED IN THE PAST WITH BELOW, PLEASE CHECK ALL THAT APPLY:

- ☐ NONE ☐ Dry eye ☐ Cataracts ☐ Glaucoma
- ☐ Retinal disease ☐ Macular degeneration ☐ Strabismus ☐ Iritis/Uveitis Floaters
- ☐ Flashes of light ☐ Double Vision ☐ Previous eye injury ☐ Previous eye surgery

PLEASE LIST ANY EYE INJURY OR SURGERY AND WHEN: _____ _____

MEDICATIONS

- ☐ **I WILL PROVIDE A LIST TO SCAN INTO MY FILE TODAY.**
- ☐ **I DO NOT TAKE MEDICATION.**

	Medication	Dose/Frequency	Reason for Use
1			
2			
3			
4			
5			

PLEASE LIST ANY ALLERGIES TO MEDICATION HERE:

_____

FAMILY HISTORY

PLEASE SELECT CONDITIONS ON YOUR MOTHER'S SIDE OF THE FAMILY BELOW.

- ☐ NONE ☐ Macular degeneration ☐ Cataracts ☐ Glaucoma
- ☐ RETINAL DISEASE ☐ Diabetic

PLEASE SELECT CONDITIONS ON YOUR FATHER'S SIDE OF THE FAMILY BELOW.

- ☐ NONE ☐ Macular degeneration ☐ Cataracts ☐ Glaucoma
- ☐ RETINAL DISEASE ☐ Diabetic

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SOCIAL HISTORY

PLEASE CHECK ALL THAT APPLY:

☐ NONE ☐ Smoker ☐ Former smoker ☐ Alcohol ☐ Recreational user

MEDICAL HEALTH HISTORY

_____ _____

PRIMARY MEDICAL DOCTOR'S NAME **PRIMARY MEDICAL DOCTOR'S PHONE NUMBER**

PLEASE CHECK ALL THAT APPLY:

ALLERGIES/IMMUNE:

☐ NONE ☐ Seasonal ☐ Medical ☐ Environmental ☐ Lupus ☐ Sjogren's Syndrome

CARDIOVASCULAR:

☐ NONE ☐ High blood pressure ☐ Heart disease ☐ Congestive heart failure

HEMATOLOGIC/LYMPH:

☐ NONE ☐ Cholesterol ☐ Anemia

EAR/NOSE/THROAT::

☐ NONE ☐ Hearing loss ☐ Sinus conditions ☐ Vertigo ☐ Dry mouth

ENDOCRINE:

☐ NONE ☐ Thyroid dysfunction ☐ Diabetes I ☐ Diabetes II

☐ **PLEASE LIST LAST A1C AND DATE TESTED: _____**

INTEGUMENTARY:

☐ NONE ☐ Eczema ☐ Rosacea ☐ Psoriasis ☐ Shingles

MUSCULAR/SKELETON:

☐ NONE ☐ Arthritis ☐ Fibromyalgia ☐ Muscular dystrophy

NEUROLOGICAL:

☐ NONE ☐ Multiple sclerosis ☐ Epilepsy ☐ Migraines ☐ Stroke

PREGNANT/NURSING:

☐ NONE ☐ Nursing ☐ Pregnant

☐ **HOW MANY WEEKS ALONG IF PREGNANT: _____**

PSYCHIATRIC:

☐ NONE ☐ Depression ☐ Anxiety ☐ ADHD

RESPIRATORY:

☐ NONE ☐ Emphysema ☐ COPD ☐ Sleep apnea ☐ Asthma

OTHER CONDITIONS NOT LISTED ABOVE:

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FINANCIAL POLICIES

EYEGLASS PRESCRIPTIONS are guaranteed 60 days from the exam date. Any changes to the prescription occurring after 60 days from the date of the exam will incur an office visit fee of **$30.00.**

You will be provided two copies of your eyeglass prescription at the end of your exam.

CONTACT LENS PATIENTS POLICIES First-time contact lens wearers **must** complete the staff-led contact lens training before the release of trial lenses. All contact lens prescriptions require follow-up care before the release of the prescription. You are responsible for following through with your follow-up appointment. Your contact lens exam fee includes two follow-up care for the following 45 days of the initial exam. Any **changes made after the 45 -day period** will incur an office visit fee of **$35.00.** Any changes made after 3 months will require another exam and fitting.

You will be provided two copies of your contact lens prescription once Dr. Forrester releases you for continued wear.

FORMS OF PAYMENT: Cash, major credit card, or Care Credit

CO-PAYS & DEDUCTIBLES: All Medicare, Medicaid, and other health plan co-pays, deductibles, and shared costs are payable on the date of service; otherwise, a fee of $20 will be added to your bill as a fee for late payment. We verify your benefits to the best of our ability. However, it is ultimately your responsibility to know your coverage.

MEDICARE: We accept assignments and will file all Medicare claims. **At the time of service, you are responsible for 20% of the Medicare allowable fee, plus the deductible and any service charge not covered by Medicare.** Medicare will only pay for services that it determines to be "reasonable and necessary" under Section 1862(a)(I) of the Medicare law. If Medicare denies payment, you agree to be personally and fully responsible for all costs by signing. You also agree that payment of authorized Medicare/Medigap benefits is made payable to Forrester Eye Associates for services rendered by that physician/supplier. Your signature will also authorize any holder of medical information about you to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. A current copy of the Medicare card is required before treatment, or the patient will be rescheduled when the card can be provided.

MEDICAID: A current copy of the Medicaid card is required before treatment, or the patient will be rescheduled.

PRIVATE INS & MANAGED CARE: If you participate in a plan that we accept, we will be happy to file your insurance claims. Otherwise, payment in full is your responsibility. Please note that you are ultimately responsible for payment if your private insurance company denies payment.

SELF-PAY: Payment is expected at check-out for all services rendered. You may call our office for an estimate of our fees. If you are unprepared to cover your exam, we recommend exploring Care Credit or rescheduling your appointment.

NON-COVERED SERVICES: Several non-covered services are essential for the doctor to evaluate and treat you during your eye exam properly. They include refraction, retinal photography, contact lenses, contact fitting fees, etc. Medicare and most insurance plans do not cover these fees, payable upon check-out. You may choose to defer these or any services.

SERVICE CHARGES: **Our office only accepts checks through the mail to resolve any balance owed**. We no longer accept checks in the office for services rendered for appointments. Any check returned to our office for non-payment will generate an additional processing fee. We can assist you with setting up a payment plan to pay any outstanding balance. If your account is sent to a collection agency, you will incur an administrative fee for that effort, including any court costs.

DRIVERS FORMS: We will be happy to complete a Drivers' Form for you for a $15.00 fee.

OTHER FORMS: A nominal fee per form will be charged for any additional insurance forms or dictated letters from our doctor. Documents will be ready in 2- 3 business days.

No-Show Charge Due to the negative impact of missed appointments on our staff, doctors, and other patients, a fee of $25.00 will be charged for a no-show or missed appointment if you have not provided us with at least 24 hours.

I have read and agree to all the above-stated office policies by signing below.

PRINTED NAME:_____

SIGNATURE: _____ **DATE:** _____

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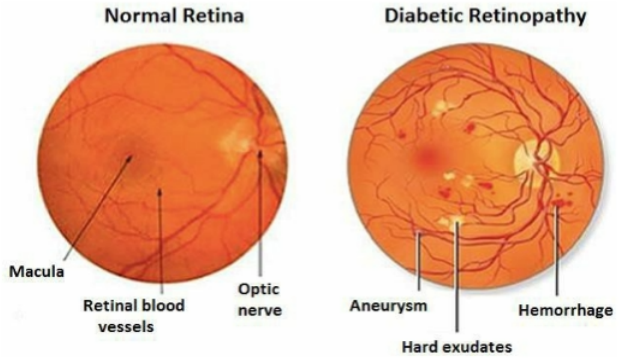
RETINAL IMAGING, VISUAL FIELD SCREENING, AND DILATION CONSENT

RETINAL IMAGING

As part of your eye exam, we recommend a special diagnostic procedure called Retinal Photography. In this procedure, a Retinal Camera is used to photograph the back of the eye (the retina). This is not an X-ray or an ultrasound; nothing will touch your eye, it is simply a highly magnified photograph. Also, with Retinal Photography you may not need to be dilated.



This permanent digital record is very valuable in assessing the health of your eyes presently and in monitoring the health of your eyes over the years. We can observe the retina, optic nerve, macula, blood vessels, and arteries of the eyes. It will also serve as an initial reference point to compare any changes as we monitor your health in subsequent years.

Your doctor strongly believes retinal photos are important to your comprehensive eye exam. Retinal photos also allow you to see your eye's appearance - just as the doctor sees it.

The fee for this additional part of your eye exam is **$38,** which will be charged every year that photos are taken. Depending on your diagnosis, if there is a medical issue such as diabetes, glaucoma, etc., this procedure may be covered under your medical insurance. Retinal Photography is not covered under most vision plans such as VSP, EyeMed, or Davis Vision. This office will advise you of your coverage.

❒ **Yes, I want to have retinal photos taken of my eye.**

❒ **No, I do not wish to have retinal photos taken**

VISUAL FIELD

A critical part of comprehensive eye care is the visual field. We highly recommend this test, which gives a computerized examination of your side (peripheral) vision. Many diseases revealed by a visual field are undetectable in an eye examination and may only be diagnosed with a visual field. Some diseases that a visual field may detect are GLAUCOMA, RETINAL DISEASE, BRAIN TUMORS, and many other disorders relating to the eye and brain.

The fee for this test is $19.00. Most insurance will cover this cost.

❒ **Yes, I give consent to have a visual field.**

❒ **No, I decline to have a visual field performed. I understand that this test helps in the detection of many diseases which can cause permanent and irreversible vision loss. I also decline this important part of my eye examination and release all doctors, personnel, and businesses associated with this facility from any liability related to the failure to detect and treat any condition in which the diagnosis would have been aided by this test.**

DILATATION

❒ **No, I decline to have my eyes dilated, UNLESS IT IS NECESSARY. I understand this is an important part of my eye examination and release all doctors, personnel, and businesses associated with this facility from any liability related to the failure to detect and treat any condition in which the diagnosis would have been aided by this test.**

❒ **Yes, I give consent to have my eyes dilated. While dilated, we do not guarantee what you can or cannot do (INCLUDING DRIVING). So please do not ask if you can drive because everyone is affected differently. There are two main effects from pupil dilation. The first effect for about 2 hours is decreased distance and near vision; the second is increased sensitivity to light for about 6 hours.**

SIGNATURE: _____ **DATE:** _____

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

Our full HIPAA Privacy Policies are located on our website at forrestereye.com, and a hard copy will be provided for you by request.

The notice contains a patient's rights section describing your rights under the law. You ascertain by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change; if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but we shall honor this agreement if we do. The HIPAA (Health Insurance Portability and Accountability Act of 1996) allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as the law allows.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time, and all full disclosures will cease.
- The practice may condition receipt of treatment upon the execution of this consent.

May we phone, email, or text you to confirm appointments?	YES	NO
May we leave a detailed message on your home answering machine or cell phone?	YES	NO
May we discuss your medical condition with a family member?	YES	NO

If YES, please name the members allowed:

_____

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____