Patient Registration

Patient Name___________________________________ Today's Date____________________

Home Address____

City______________________________ State____________________ Zip Code____________

Home Phone ____________________________Cell Phone______________________________

Date of Birth ______________________Gender: M F Marital Status: Single Married

Emai____

Race _______________________________ Preferred Language_________________________

Person to notify in case of emergency____

Phone number (s)________________________________Relationship_____________________

Primary Insurance Company____

ID#____Group#______________________

Secondary Insurance Company____

ID#____Group#______________________

I certify that I (or my dependent) have insurance coverage as stated above and agree to have insurance payments made directly to Central Vermont Eye Care to be applied to my account for services rendered. **<u>I understand that I am financially responsible for all charges incurred in the event that my insurance denies payment.</u>** I am aware there may be additional collection and/or attorney's fees if my account is referred for collection. For patients covered by Medicare the patient will be responsible for 20% of the Medicare allowable charges plus any deductibles, coinsurance and uncovered charges that apply.

_________________________________ ____________________________

Signature of Patient/Parent/Guardian Date

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Printed Name

AUTHORIZATION FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION:

I authorize my physician and/or administrative and clinical staff of Central Vermont Eye Care to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices.

Name and relationship of person(s) who you wish to allow access: (e.g., your spouse, son, daughter, friend).

Name of Person or Entity	Relationship

____________________________________	_______________________________
Signature	Date

NOTICE OF FINANCIAL AND PRIVACY POLICIES

At Central Vermont Eye Care, we are committed to providing you with the highest level of service and quality care. If you have medical insurance, we will help you receive your maximum allowable benefits. To this end, we ask for your assistance and acknowledgment of our financial policy. Ultimately, any and all financial liability rests with you - the patient.

Our office participates with most major health insurance plans**.** *We do not, however, participate with any vision plan (VSP, Davis Vision, EyeMed, etc.).* Your visit will be covered by your medical insurance if you are here for management of a **medical condition** (i.e., cataract, diabetes, dry eyes). Most medical insurances do not cover the cost for refraction (the prescription-finding portion of the exam). You may be asked to pay the $50 refraction fee at the time of your visit. For more information regarding refractions, please see our policy at the front desk.

If your visit today is for routine eye care (i.e., update in glasses or contacts) for a **"non-medical" condition** (near-sightedness, far-sightedness, etc.), it is unlikely that your medical insurance will cover the cost of the exam. For this reason, we are offering you the option of paying the same amount that our non-insured patients do at the time of their visit: $159, self-pay. If you elect this option, you will be asked to pay at the time of your visit.

It is the patient's or guardian's responsibility to:

- be familiar with the benefits and obligations of your plan, including copays, co-insurance and deductibles.
- bring all current insurance cards to all visits.
- provide our office with up to date contact information.
- be prepared to pay your co-pay at each visit.

Available for viewing at the front desk is a notice of privacy practices as mandated by the Health Insurance Portability and Accountability Act of 1996, otherwise known as HIPPA. This notice describes how medical information about you may be used and disclosed, how you can get access to it, and lists your rights under this law.

I understand the above statements regarding the financial policy and privacy practices used by Central Vermont Eye Care.

____ ________________
Signature of Patient or Guardian Date

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Printed Name

Name:____________________ **Primary Care Physician**:____________________

Date of Birth:____________________ **Preferred Pharmacy**:____________________

Past Eye Problems

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Prior Eye Surgery

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Eye Medications

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Past Medical History

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Family History

Condition		*family member*
Cataracts	**Y/N**	________
Glaucoma	**Y/N**	________
Macular Degeneration	**Y/N**	________
Crossed/Lazy Eye	**Y/N**	________
Retinal Detachment	**Y/N**	________
Diabetes	**Y/N**	________

Other Medications

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Past Surgical History

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Social History

Do you consume alcohol? **Y/N**

Do you use recreation drugs? **Y/N**

If **YES**, please Specify: ____________

Do you currently smoke cigarettes? **Y/N**

If **NO**, did you previously smoke? **Y/N**

If so, when did you quit? ____________

Allergies

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Review of Systems: Please circle all that apply

Cardiovascular
chest pain
irregular heart beat
shortness of breath

HEENT
dizziness
hearing loss
hoarseness
ringing in ears
sore throat

Musculoskeletal
back pain
joint pain
muscle aches
stiffness
swelling

Respiratory
cough
trouble breathing
wheezing

Blood Pressure
good BP control
borderline BP control
poor BP control
unknown BP control

Constitutional
fatigue
fever
night sweats
weakness
weight loss

Hematologic
bleeding
bruising
tender nodes

Neurologic
balance problems
headaches
numbness
tingling

Skin
hair loss
rash
skin lesions

Diabetic Control
good DM control
borderline DM control
poor DM control
unknown DM control

Genitourinary
genital discharge
genital lesions
painful urination
urgency

Metabolic
cold intolerance
excessive hunger
excessive thirst
frequent urination
heat intolerance

Psychiatric
anxiety
depression
insomnia
irritability
nervousness

Allergy
itching
hives
chronic runny nose
seasonal allergies

Pregnancy
first trimester
second trimester
third trimester
nursing

Other Problems: Specify Below