COBB EYE CENTER

MEDICAL INFORMATION REVIEW

NAME: _____ DATE OF BIRTH: _____ DATE: _____
Occupation: _____

Primary Care Physician: _____ Endocrinologist: _____
Rheumatologist: _____ Cardiologist: _____

Past Medical History:

Do you have or have previously been treated for (if so, please describe):

Y/N Cataract _____
Y/N Glaucoma _____
Y/N Macular Degeneration _____
Y/N Eye Injury _____
Y/N Dry Eye _____

Y/N Cornea Disease _____
Y/N Retinal Tear/Detachment _____
Y/N Diabetic Eye Disease _____
Y/N Crossed Eyes/Lazy Eye _____
Y/N Other_____

Y/N Diabetes: _____ years
Controlled by Diet/Pills/Insulin (circle)
Y/N High Blood Pressure: _____
Y/N Heart Attack/Heart Disease: _____
Y/N Kidney Disease/Dialysis: _____
Y/N Thyroid Disease:_____
Y/N Stroke: _____
Y/N Cancer: _____

Y/N HIV/AIDS: _____
Y/N Abnormal bleeding: _____
Y/N Arthritis: _____
Y/N High Cholesterol: _____
Y/N Lung Disease: _____
Y/N Are you pregnant/breastfeeding? Due Date: ___
Y/N Other: _____
_____

Y/N Eye Surgeries (Please list with dates, doctor)
_____
_____

Y/N Other Surgeries (Please list with dates, doctor)
_____
_____

Y/N Eye Medications (Prescription and over the counter, include dosage and frequency)
_____
_____

Y/N Other Medications (Prescription and over the counter, include dosage and frequency)
(If you have a list to provide please give it to the front office staff)
_____
_____
_____

Y/N Are you allergic to any medications? If yes, please list:
_____

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Name: _____ Date: _____

Has anyone in your family had any of the following? If yes, please list relationship.

Y/N Cataract_____
Y/N Glaucoma _____
Y/N Macular Degeneration _____
Y/N Corneal Disease _____
Y/N Retinal Tear/Detachment _____
Y/N Crossed Eyes/Lazy Eye _____
Y/N Diabetes _____
Y/N Other _____

Patient Health History

Social History

Y/N Smoker
Former, Every day, Never (Circle)
Y/N Alcohol
Former, Every day, Social, Never (Circle)
Y/N Driving
Y/N Fall Risk
If yes, please list last fall date _____

Review of Systems

Are you currently experiencing any problems:	Yes	No	Details
Allergy/Immunology *Autoimmune, Itching, Rash, Redness, Sjogren's Disease, Other*			
Cardiovascular *Chest pain, Shortness of breath, CHF, Palpitations, Other*			
Constitutional *Fever, Fatigue, Chills, Loss of Appetite, Night Sweats, Other*			
Endocrine *Excessive urination, Dry skin, Insomnia, Other*			
Gastrointestinal *Nausea, Diarrhea, Trouble swallowing, Jaundice, GERD, Other*			
Genitourinary *Dialysis, Genital sores or ulcers, Kidney failure, Incontinence, Other*			
Hematology/Oncology *Easy bruising, Hepatitis, HIV, Anemia, Blood thinners, Frequent or easy bleeding, Other*			
HENT (Ear, Nose, Throat) *Hearing loss, Has a cold, Hearing aids, Other*			
Integumentary (Skin) *Changes in mole, Bruises, Growths, Psoriasis, Rosacea, Rash, Other*			
Musculoskeletal *Joint pain, Difficulty laying flat, Swelling, Bone fracture, Other*			
Neurologic *Scalp tenderness, Dizziness, Tremor, Seizures/Fainting, Parkinson's, Speech problems, Alzheimer's, Dementia, Developmental delayed, Migraine, MS, Other*			
Psychiatric *ADHD, Bipolar, Loss of memory, Anxiety, Confusion, Other*			
Respiratory *Cough, Bronchitis, Use of oxygen, Sleep apnea, Other*			

COBB EYE CENTER

Mr/Mrs/Ms/Miss/Dr _____ _____ _____
First Name MI Last Name

_____
Address (Apt#) City, State Zip Code

Social Security # : _____ How did you hear about us? _____

Date of Birth : _____/_____/_____ Marital Status : _____ Sex: M/F

Home #: _____ Work #: _____ Cell #: _____

Email : _____ Primary Language: _____

Race: _____ Ethnicity: African-American / Asian / Caucasian / Hispanic / Other _____

Emergency Contact Information

Name: _____ Relationship: _____ Phone: _____

****Please Complete the following information if patient is a minor****

Mother/Father's Name: _____ Work #: _____Cell #: _____

Pharmacy Information

Pharmacy Name: _____ Location: _____

Phone Number: _____

Medical Insurance Information

Insurance Company: _____ Subscriber's Name: _____

Subscriber's SSN: _____ Subscriber's Date of Birth: _____

Subscriber's Employer: _____ Relationship to Subscriber: _____

Signature: _____ Date _____/_____/_____

Financial Agreement and Policies

Financial Policy/Insurance Submissions

Payment in full is required at the time of service for all non-insured patients and insured patients with past due balances, deductible amounts that have not been met, and any other coverage that could not be verified at the time of service. As the patient, you are required to pay the co-pay/coinsurance at the time of service. Claims are billed to the insurance carrier as a courtesy; however, you are responsible for payment of all charges incurred. Please be advised that there are some clinical and surgical procedures that your insurance will not cover. Therefore, by signing this document, you agree to be held financially responsible for services rendered on or before the time of surgical or clinical service. All balances not paid by the insurance carrier within 90 days of the date of service will be your responsibility. We will be happy to refund you for any payments made by you after your insurance company has paid in full for covered services.

_____ INITIAL – I have read and agree to the above statement.

Insurance Changes

If there are any changes to your insurance information, please notify our office immediately. Cobb Eye Center will not be responsible for timely filing if we do not receive the correct insurance information prior to or at the time of the visit. It is mandatory to notify your provider of any other insurance carrier who is responsible for payment.

_____ INITIAL – I have read and agree to the above statement.

Returned Checks

All checks returned for insufficient funds, closed accounts or for any other reason will be subject to a $35.00 service charge. All further payments must be made either by credit card, money order or cash.

_____ INITIAL – I have read and agree to the above statement.

Deductibles/Coinsurance/Co-payments

Deductibles, coinsurance and co-payments will be collected at the time services are rendered. These are required by your insurance company and agreed upon by you when you accept their insurance. We also must contract with insurance companies, agreeing to collect co-payments, coinsurance and deductibles, in order to participate with their plans.

_____ INITIAL – I have read and agree to the above statement.

Collection Policy

Once a charge becomes a patient's responsibility, any balance not paid after 90 days will be turned over to an outside collection agency. Balances will also be turned over to patient responsibility if insurance is unable to process claims due to missing or incomplete information not provided by policy holder to their insurance company.

_____ INITIAL – I have read and agree to the above statement.

Surgical Predetermination Process

Predetermination takes place prior to surgery and requires that a letter of medical necessity, any photographs and/or testing be sent to your insurance company for review and possible approval. This process can take four to six weeks, and if surgery is approved, there is no guarantee of payment. Should you wish to proceed with an unapproved surgical procedure, you will be asked to sign the waiver in lieu of insurance claim filing, and we will ask for payment in full. Cobb Eye Center will not refund any private pay monies collected on an unapproved surgery. You may wish to file the claim on your own and agree to accept what your insurance company PAYS YOU after the surgery has taken place.

_____ INITIAL – I have read and agree to the above statement.

No Show or Cancellation Fee

Patients who fail to show for their scheduled appointment or did not notify the office within 24 hours of their scheduled appointment time, shall be subject to a "No Show/Cancellation fee of $40.00.

Patients who fail to show for their scheduled surgery appointment and did not notify the office within a week of their scheduled surgery appointment time, shall be subject to a "No Show/Cancellation" fee of $100.00. If surgery is cancelled by the physician as a medical necessity, then the patient is not subject to this charge. Insurance authorization denials are also an exemption of the fees.

In the event of an actual emergency and prior notice could not be given, consideration will be given, and a one-time exception may be granted.

_____ INITIAL – I have read and agree to the above statement.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. We would be willing to discuss reasonable payment plans. If you have any questions about the above information, please do not hesitate to ask us.

I hereby assign all medical and/or surgical benefits, to include major medical benefits that I am entitled, including Medicare, private insurance and any other health plan to Cobb Eye Center. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges, whether or not these charges are paid by my medical insurance. I hereby authorize Cobb Eye Center to release any and all information necessary to secure payment.

Signed: _____ Date: _____

Please Print Name:_____

Witnessed by staff member: _____ Date:_____

COBB EYE CENTER

Your health information is private and confidential. Should you wish your health information shared and/or released to ***family members or friends*** who may be assisting in your care, **please provide us with their names and relationship to you below**:

Name	**Relationship**
_____	_____
_____	_____
_____	_____

ACKNOWLEDGEMENT: I have been informed of the 2019 updated Cobb Eye Center HIPPA Notice of Privacy Practice document which is available for review.

COMMERCIAL INSURANCE OR VISION PLANS:

_____ Please Initial

I authorize the release of any medical Information necessary to process the claim and request payment of benefits either to myself or the party who accepts assignment.

_____ Please Initial

I authorize payment of medical benefits to undersigned physician or supplier for service.

MEDICARE PATIENTS ONLY: ONE TIME MEDICARE AUTHORIZATION:

I AUTHORIZE ANY HOLDER OF MY MEDICAL OR OTHER INFORMATION ABOUT ME TO BE RELEASED TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIER OF ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT. REGULATIONS PERTAINING TO MEDICARE ASSIGNMENT OF BENEFITS APPLY.

I acknowledged by signing below that I have read and agree to the policies listed above

_____ _____

Patient or Legally Authorized Signature **Date**

COBB EYE CENTER

REFRACTION

A refraction is the part of an eye examination to determine the prescription for glasses.

Most insurance plans DO NOT PAY for this portion of an eye examination. We do not include this procedure in our routine examination charge.

If you have a refraction done, there will be a $40.00 fee at the time of service, in addition to any co-payment or other non-covered fees.

You may elect not to have the refraction done; however, we will not be able to provide you with a glasses prescription.

_____ **Initial**; I **desire** a refraction during today's examination and accept the $40.00 fee.

_____ **Initial**; I **decline** the refraction during today's examination.

IMPORTANT INFORMATION REGARDING CONTACT LENS PRESCRIPTIONS

The prescription which may be given to you following your examination is for **glasses only**. This prescription will aid in the evaluation required for fitting contact lenses, **which must be done separately**.

An evaluation for measurements and diagnostic fitting for contact lenses can de done in our optical department or by another qualified optician of your choice. If you choose our optical department, they will discuss vision benefits, fitting fees and any other fees at that time.

IMPORTANT INFORMATION FOR ALL VSP AND EYEMED INSURED PATIENTS

If you have medical insurance and a VSP/EyeMed vision plan you may only choose one coverage for today's examination.

If you choose to use medical insurance only you will have a co-payment plus a $40.00 refraction fee.

If you choose to use your VSP/EyeMed coverage you will pay the co-payment only. The refraction is a covered benefit at no additional charge.

**If you choose to use your VSP/EyeMed coverage today and the physician finds a medical diagnosis you may be asked to return for a "medical" visit.

****Please inform our front office staff which insurance coverage you would like to use for today's appointment.**

I acknowledged by signing below that I have read and agree to the policies listed above.

_____ _____

Patient or Legally Authorized Signature Date

COBB EYE CENTER

CREDIT CARD AUTHORIZATION

How it works

The Intuit Customer Profile Management module securely stores your data off-site, eliminating the need to re-key or store your account data on paper or in our computer systems. It's simple, safe and secure.

Protection of Cardholder Data and Customer Data

Intuit has implemented various measures, including appropriate administrative, technical and physical safeguards, designed to ensure the security and confidentiality of Cardholder Data and Customer Data, protect against anticipated threats or hazards to the security or integrity of such information, and protect against unauthorized access to or use of such information. Such measures may include, among others, encryption, physical access security and other appropriate technologies. Intuit continually reviews and enhances its security systems, as necessary. Intuit is subject to the detailed rules and regulations of the various credit and debit card organizations and networks (i.e. VISA, MasterCard, American Express, NYCE, Star, etc.), relating to the security and safeguarding of Cardholder Data, including, but not limited to, the Payment Card Industry Data Security Standards ("PCI"), VISA Inc.'s Cardholder Information Security Program ("CISP") and MasterCard International's Site Data Protection Program ("SDP"). Intuit endeavors to comply with all such rules at all times. Pursuant to such rules and regulations, Intuit is required to undergo periodic third-party assessments and periodic network scans to ensure that, among other things, Intuit has installed and maintains a firewall configuration to protect data; does not use vendor-supplied defaults for system passwords and other security parameters; protects stored data; encrypts transmission of Cardholder Data and sensitive information across public networks; uses and regularly updates anti-virus software; develops and maintains secure systems and applications; restricts access to data to those with a business need-to-know; tracks and monitors all access to network resources and Cardholder Data; regularly tests security systems and processes; assigns a unique ID to each person with computer access; restricts physical access to Cardholder Data; and maintains a policy that addresses information security.

Authorization

By signing below, I authorize Cobb Eye Center to collect my credit card data for storage and future use. I understand that the data will be stored only by the affiliated third-party, secure, PCI compliant credit card vendor, Intuit and that the information will not be stored by Cobb Eye Center at any time.

In the event that I am owed a refund, I authorize Cobb Eye Center to apply the refund to the credit card on file.

Patient Name (printed): _____

Signature: _____ Date: _____