Welcome to Long Family Eye Care!

Please take a few moments to fill out this patient information sheet. It will allow us to get to know you better and assist in billing procedures and filing your insurance. All information is strictly confidential.

Thank you and we hope you enjoy your visit with us today!

Patient Name:_____ **Nickname**:_____ **Today's date**_____

Address:_____

City_____ **State**_____ **Zip**_____

Email_____

Phone (please check preferred number):

☐ (home)_____ ☐ (cell) _____

Sex: Male/Female **Date of Birth**_____/_____/_____ **Age**:_____ **Social Security#**_____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Domestic Partner

Employment Status: ☐ Full time ☐ Part time ☐ Student ☐ Not Employed

Employer _____Job Title_____

Please list the names of immediate family members who are patients here:

_____

Financially Responsible Party (if different from above)

Name_____SS#_____Relationship to Patient_____

Primary Eye Care Insurance_____ ID#_____Group#_____

Secondary Insurance_____ ID#_____ Group#_____

Patient Eye History

Date of last exam_____ **by whom?** _____

Do you wear Contacts? Yes ☐ **No** ☐ **Contact lens type:** Rigid Gas Perm/Soft **Brand** _____

Wear schedule: daily/ biweekly/ monthly

Do you wear glasses? Yes ☐ **No** ☐ If so, mark all things that apply:

☐ Full-time and/or ☐ Distance ☐ Reading ☐ Computer ☐ Other:_____

Do you…. ☐ use a computer? ☐ have RX sunglasses? ☐ have colored contacts?

☐ want information on Laser Vision Correction surgery? ☐ have an interest in the latest contacts?

Have you had or been treated for… ☐ cataracts ☐ glaucoma ☐ corneal abrasion ☐ eye infection

☐ eye injury ☐ lazy eye ☐ macular degeneration ☐ retinal detachment ☐ diabetic eye problems

☐ dry eye drops/treatment _____

Have you experienced…. ☐ Blurred vision ☐ itchiness ☐ tearing ☐ floaters ☐ flashes of light ☐ sun sensitivity ☐ trouble seeing at night ☐ uncomfortable glasses

☐ dry eye If so, what drops/self-treatment _____

_____

Family History

Is there a family history of any of the following? Please list family member and age of onset.

Blindness _____
Glaucoma_____
Cataracts_____
Macular Degeneration_____
Retinal Detachment_____
Other_____

Crossed/Lazy Eye_____
Diabetes_____
Cancer _____
Heart Disease _____
High Blood Pressure _____

Patient Medical History

Medical Doctor_____ **Last Physical** _____ **City/State**_____

Medications (including eye drops, vitamins, non-prescription)

_____
_____
_____
_____

Allergies to Medications? Y/N _____

Do you…Use cigarettes/tobacco? Y/N Alcohol? Y/N Other substance(s)? Y/N

Are you currently being treated for the following? ☐ Allergies ☐ Asthma ☐ Arthritis ☐ Cancer

☐ Cholesterol ☐ Diabetes ☐ Heart Disease ☐ High blood pressure ☐ Kidney Disease

☐ Anxiety/Depression ☐ Thyroid Disease ☐ Auto Immune Disease (please specify)_____

☐ Other_____

If you have been diagnosed but not currently being treated for one of the above please list below with date of diagnosis:

_____

All Patients must sign below

Consent, Assignment and Release: By my signature below, I authorize Long Family Eye Care, PC to release any information needed to determine my Medicare, Medigap/Supplement, or other insurance benefits to the Social Security Administration, Health Care financing Administration, or any other insurance agent. Payment of authorized benefits will be made on behalf of Long Family Eye Care, PC. My signature on this form acknowledges that I have read and understand the above, and it will also serve as my "***signature on file***".

_____ _____

Signature Date

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have either received a copy of or been advised regarding Long Family Eye Care's Notice of Privacy Practices.

Date _____ Patient name_____

Signature _____

Authorization to Discuss Your Information with Family or Caregivers

To comply with the HIPAA Federal Privacy Regulations, we must receive your written permission to discuss your case with anyone. By authorizing this, we will be able to, without requiring your presence, discuss your case, answer questions, leave detailed messages, and contact, in the event of an emergency, the person(s) listed below. If you would like us to answer questions or discuss your case with anyone other than yourself, you must include them below.

1 Name_____

Relationship_____

Phone_____

2 Name_____

Relationship_____

Phone_____

Your Signature_____

Long Family Eye Care, P.C.

Agreement to Pay for Services

In consideration of Long Family Eye Care, P.C. providing services and supplies to me or the patient designated below, I agree to the following payment terms regarding all services and supplies obtained by me or the below designated patients.

1. I agree to pay for all services at the time they are provided unless Long Family Eye Care, P.C has agreed to bill my insurance company.
2. If supplies or materials are ordered for me, I agree to pay one half (1/2) down when the order is placed and the remaining balance when the supplies or materials are received.
3. I understand Long Family Eye Care, P.C. will charge a $25.00 returned check fee for any checks written and returned for non-sufficient funds or stop payment. I agree to pay this fee as well as collection and attorney fees incurred in collecting the dishonored check as specified below in this agreement.
4. If Long Family Eye Care, P.C. has agreed to bill my insurance company, I agree to provide them with a copy of my insurance card and all necessary information.
5. After my insurance company has been billed, I agree to be responsible for and pay all outstanding amounts including those claims denied by my insurance company or any co-pay amounts or uninsured amounts remaining due after payment by my insurance company to Long Family Eye Care, P.C.
6. All outstanding amounts will be due and payable within thirty (30) days of the service or within thirty (30) days after written notice from my insurance company that the claim has been denied or only partially paid. After these thirty (30) days has expired, all account balances will be past due.
7. All past due account balances will accrue interest at the rate of eighteen percent (18%) per year.
8. I understand that all past due account balances over one hundred twenty (120) days or any dishonored checks will be turned over to an attorney or collection agency for collection. I will be responsible for attorney fees, court costs and any collection agency fees incurred in collecting the debt, as well as any and all pre-judgment and post-judgments accrued interest.

I hereby authorize payment to be made directly to Long Family Eye Care, P.C. for any services, supplies, or materials provided for my benefit or the below designated person's benefit that I may be entitled to from any insurance carrier. This agreement will remain in effect until revoked by me in writing. I also authorize said assignee to release all information acquired in the course of examination or treatment necessary to secure payment for services.

I have read, understood and agree to the terms of this Agreement to Pay for Service.

Patient: _____

Signature of responsible party_____ Date:_____