

**Patient information**

Patient Name: Date of Birth:

Address:

City: State: Zip: Race:

Social Security #: Sex: M F Marital Status:

Home Phone: Work Phone: Cell :

Email:

Employer Name: Occupation:

Were you referred? YES  NO By Whom:

Primary Care Physician: Phone:

Cardiologist: Phone:

Pharmacy of Choice: Phone:

**\*\* If the patient is a minor or you have power of attorney and would like the billing to be sent to a different address then above, please fill out the following information\*\*\***

Parent or Guardians Name:

Address:

City: State: Zip: Social Security #:

Home Phone: Cell Phone:

Emergency Contact

Name:

Phone: Relationship:

Primary Insurance:

Policy Holder (if other then Patient):

Policy Holder DOB: SS #:

Relationship to Patient (Circle One) SPOUSE PARENT SELF OTHER

Secondary Insurance:

Current Eye Medications:

Current Other Medications:

Allergies:

List Prior Eye Surgeries:

Surgeon: Type of Surgery: Right  Left  Both

Surgeon: Type of Surgery: Right  Left  Both

Surgeon: Type of Surgery: Right  Left  Both

Describe any other problems, illnesses, Surgeries or medicine not described in the above questions:

Past Major Surgeries:

Medical History: Please check all that applies:

* Asthma  Epilepsy  HIV positive / AIDS
* Arthritis (RA/LUPUS)  Glaucoma  Kidney Disease
* Cancer  Heart Attack  Macular Degeneration
* Chronic Bronchitis  Heart Murmur  Migraines
* Cirrhosis  Headaches  Stroke
* Clotting Disorder  Hepatitis  Thyroid Disease
* Diabetes  High Blood Pressure  Other:
* Emphysema  High Cholesterol

**Family History: Please check all that apply**

 Cancer  Heart Attack  Kidney Disease  Migraines

 Diabetes  Heart Disease  Liver Disease  Stroke

 Glaucoma  High Blood Pressure  Macular Degeneration

**Social History:**

Tobacco Use:  Current  Former  Never Type: How Often

Alcohol Use:  Current  Former  Never Type: How Often

Drug Use:  Current  Former  Never Type: How Often

**Review of Systems: Please check YES or NO if you are CURRENTLY experiencing, IF YES PLEASE EXPLAIN**

Blurry / Distorted Vision  YES  NO

Double Vision  YES  NO

Loss of Vision  YES  NO

Glare / Light Sensitivity  YES  NO

Floaters / Flashes  YES  NO

Mucus / Discharge  YES  NO

Pain or Soreness  YES  NO

Infection of Eyes or Lids  YES  NO

**Please Check Yes or No – IF YES Please Explain**

**Constitutional System**  YES  NO

(Fever, Weight loss, other)

**Ears, Nose, Mouth, Throat**  YES  NO

(Heating problems, sinus congestion)

**Cardiovascular**  YES  NO

(High Blood Pressure, Heart disease, other)

**Respiratory**   YES  NO

(Asthma, emphysema, shortness of breath, tuberculosis, lung cancer, other)

**Gastrointestinal (Stomach)**  YES  NO

(Jaundice, Hepatitis, ulcers, hiatal hernia, cancer, GI bleeding, acid reflux, other)

**Genitourinary**  YES  NO

(Genital / Kidney / Bladder)

**Integumentary**  YES  NO

(Skin disease, skin cancer, breast cancer, other)

**Musculo-Skeletal**  YES  NO

(Degenerative arthritis, Rheumatoid arthritis, lupus, other)

**Neurological**  YES  NO

(Fainting, dizziness, migraines, seizures, stroke/paralysis, other)

**Psychiatric**  YES  NO

(Depression, schizophrenia, other)

**Hematologic / Lymphatic**  YES  NO

(Anemia, sickle cell disease, bleeding disorders, leukemia, other)

**Allergic / Immunologic**  YES  NO

(Seasonal allergies, hay fever, immune problems)

**Endocrine**  YES  NO

(Diabetes, thyroid problems, hormone replacement therapy, other)

I have reviewed and confirmed the above history /Julie Foreman MD/ Date

**Refraction Policy**

One of the most important parts of your eye exam is the refraction. That is the part of the exam by which we determine the best possible acuity for your eyes, which is an essential piece of medical information that is used to assess your eyes and search for medical conditions and vision problems. It is NOT a covered service by MEDICARE and MANY OTHER INSURANCE Plans. The refraction fee is collected AT THE TIME OF SERVICE. This is an addition to any co-payment, co-insurance, or deductible your plan may require.

By signing, you are indicating that you have read the above information and understand that the refraction is a NON-COVERED service. You accept full responsibility for the cost of this service and understand it is due at the time of service. You understand that any co-payment, co-insurance or deductible that you may have is separate from and not included in the refraction fee.

\*\*Should you choose not to have a refraction done and you break or lose your glasses, we will not be able to provide you with a glasses prescription. You will be asked to schedule a return appointment and charged another office visit along with the refraction fee of $35.00.

Patients Signature:

Printed Name:

Date:

**DILATION CONSENT**

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye. Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it’s best if you make arrangements not to drive yourself.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Dr. Julie Foreman and / or HER assistants, as may be designated by her, to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

Patients Signature:

Printed Name:

Date:

**Patient Record of Disclosures**

The HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of protected health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means or contacts.

We may need to contact you to provide information about treatment plan, treatment alternatives, test results, surgical scheduling, or health care information.

What phone number would you like us to call to contact you?

May we leave a confidential message on your answering machine or voicemail?

By the following list, I hereby give the office of Dr. Julie Foreman limited permission to disclose to a family member or personal friend, or any other person identified by me, the protected health information directly related to such person’s involvement with my care or payment related to my health.

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| --- | --- | --- | --- | --- | --- | --- |
| NAME | PHONE # | RELATIONSHIP | TREATMENT | BILLING | APPTS | ALL |
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Whom do you **NOT WANT** notified of any of your health or general information?

Patients Signature:

Printed Name:

Date:

**Dr. Julie Foreman Financial Policy**

In connection with the medical services currently received from Dr. Julie Foreman (the “Practice”),the undersigned hereby agrees as follows:

**Authorization to Release Information**: Insurers and managed care companies occasionally review medical charts to ensure compliance with the company procedures. I understand that my chart may be selected for such review and that the confidentiality of this information in my chart will be preserved and I hereby consent to such review and release the physician and such insurer or managed care company for liability for any reasonable review of my chart.

**Payment Agreement**: I request that payment of authorized medical benefits be made on my Behalf to the office of Dr. Julie Foreman or any physician in their association or employ, for services furnished me by said physicians. I further understand that I will be solely responsible for any deductibles, co-insurance and/or non-covered services not payable by my insurance plan. I further understand that most insurance companies will not pay for an examination for glasses or contact lens or change of lenses and that I will be asked to pay for this service at the time the service is done. I authorize the release of medical information about me to my insurance carrier and its agents needed to determine the benefits payable for related services. In the event I am not covered by an insurance plan to which Dr. Foreman belongs to at the time of my visit, I understand that I am responsible to pay for services provided at standard clinic charge amounts.

**Medicare Signature Authorization**: Medicare DOES NOT pay for services provided if there is no medical eye disease or medical eye problem. If you are here to have your eyes examined for glasses only, you will be responsible for full payment because Medicare does not cover a standard eye exam for glasses. Medicare has made it very clear that this is NOT a covered service. If you are here for problems with your eyes (blurry vision, red eyes, swollen eyes, glaucoma, cataract, etc.) Medicare WILL cover the visit; however, they WILL NOT cover the refraction. Most Medicare supplements will also not pay. I request payment of authorized Medicare benefits be made to Dr. Julie Foreman for any services furnished to me by her office. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related service.

**No Insurance Coverage**: I understand that should I not have insurance coverage, I am fully responsible for payment of services provided by the office of Dr. Julie Foreman to me and/or my dependents, AT THE TIME SERVICES ARE RENDERED, unless other financial arrangements have been made with the practice PRIOR to being seen by my physician.

**Financial Agreement**: I understand that the office of Dr. Julie Foreman will file a claim on my behalf for the services rendered at the time of service and I authorize her office to receive payment from my insurance company. Should it be determined that my insurance is not valid when my insurance company receives and processes the claim. I understand that I will be fully responsible for all charges incurred on the date of service.

**Cancellation / Late Arrival and “NO SHOW” Fee Policy**: We reserve the right to charge a fee of $20 for all missed appointments (NO SHOWS) and appointments which are not cancelled with a 24- hour advanced notice. This fee is not covered by insurance and MUST be paid prior to your next appointment being scheduled. Multiple “NO SHOWS” in any 12 month period may result in termination from our practice. I understand that Dr. Foreman’s office has scheduled a time for my appointment and if I arrive more then 15 minutes after my scheduled time, the practice has the right to reschedule my appointment to the next available date.

Notice of Privace Policies: I have read and been offered a copy of the Notice of Privacy Practices located in the main lobby.

Patient Signature:

Printed Name:

Date: