PATIENT REGISTRATION FORM

First Name: _____ Middle Initial: _____ Last Name: _____

Birth Date: _____ Gender: ☐ Male ☐Female Marital Status: _____

SSN: _____ Driver's License: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

E-Mail Address: _____

Occupation: _____

Employer: _____

Employer Phone Number: _____

Referring Physician: _____ Primary Care Physician: _____

Pharmacy: _____ Town/State: _____ Phone: _____

How did you find us? _____

Emergency Contact: _____Relationship: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance Company and Policy number: _____

Secondary Insurance Company and Policy number: _____

Who is responsible for the policy (primary holder)? _____

Date of Birth for Primary holder: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Surgical Eye Care, LTD, t/a Siepser Laser Eye Care or insurance company to release any information required to process my claims.

_____ _____

Signature of Patient or Guardian Date

Medical History Questionnaire

Patient Name: _____

Please answer the following questions to the best of your ability. Give dates, a brief description and which eye was involved to any yes answer.

Reason for visit: _____

Ocular History

Have you ever had any eye disease, surgery or injury? No ☐ Yes ☐

If yes, please describe including dates and the name of the doctor who treated you.

Date	Doctor	Description

Have you ever worn glasses or contact lenses? No ☐ Yes ☐

How old is your prescription? _____

Have you ever been told you have amblyopia or "lazy eye"? No ☐ Yes ☐

Medical History

Have you ever had major surgery or been hospitalized for any reason? No ☐ Yes ☐

If yes, please describe: _____

Have you ever had any complications from anesthesia? No ☐ Yes ☐

If yes, please describe: _____

Family History:

Blindness	No ☐	Yes ☐	Diabetes	No ☐	Yes ☐
Cataract	No ☐	Yes ☐	Heart Attacks	No ☐	Yes ☐
Glaucoma	No ☐	Yes ☐	High Blood Pressure	No ☐	Yes ☐
Macular Degeneration	No ☐	Yes ☐	Thyroid Disease	No ☐	Yes ☐
Strabismus (Lazy Eye)	No ☐	Yes ☐			

If yes to any of the above, please explain relationship to patient: _____

The above medical information that I proved is true and accurate to the best of my knowledge.

_____ _____

Signature of Patient or Guardian Date

Vision History

Does your vision make it difficult for you to?	Read?	No	☐	Yes	☐
	Write?	No	☐	Yes	☐
	Drive?	No	☐	Yes	☐
	Cook?	No	☐	Yes	☐
	Sew?	No	☐	Yes	☐
	Watch TV?	No	☐	Yes	☐
	Work?	No	☐	Yes	☐
Do you:	Smoke?	No	☐	Yes	☐
	Chew tobacco?	No	☐	Yes	☐
	Drink alcohol?	No	☐	Yes	☐
	Use illegal drugs?	No	☐	Yes	☐
Do you have any **DRUG** allergies?		No	☐	Yes	☐

If yes, please list the name of the drug or describe allergy_____

_____

What kind of reactions have you experienced? _____

_____

Medications

Please list **all medication(s)** including eye drops, which you are currently taking. List the amount or strength of the medication(s) and how frequently you take the medication(s).

Name of Medication	Amount Taken	Times Taken per Day	Which Eye?

Review of Systems

Do you have any issue in the following areas? If yes, please explain.

Skin	No ☐	Yes ☐	_____	
Head (Headaches)	No ☐	Yes ☐	_____	
Ears, Nose, Throat and Mouth	No ☐	Yes ☐	_____	
Lungs/Breathing (TB)	No ☐	Yes ☐	_____	
Heart (High Blood Pressure)	No ☐	Yes ☐	_____	
Stomach/Intestines	No ☐	Yes ☐	_____	
Genitals, Kidney, Bladder	No ☐	Yes ☐	_____	
Bones, Joints, Muscles	No ☐	Yes ☐	_____	
Neurologic System	No ☐	Yes ☐	_____	
Lymph Nodes/Swelling	No ☐	Yes ☐	_____	
Blood (HIV Positive, Hepatitis)	No ☐	Yes ☐	_____	
Allergic, Immunologic	No ☐	Yes ☐	_____	
Endocrine (Diabetes, Thyroid)	No ☐	Yes ☐	_____	
Psychiatric	No ☐	Yes ☐	_____	
Other	No ☐	Yes ☐	_____	

The above medical information that I proved is true and accurate to the best of my knowledge.

_____ _____

Signature of Patient or Guardian Date

SIEPSER LASER EYECARE FINANCIAL POLICY

Our practice participates in many Medical and Vision insurance plans. If your plan does not cover services provided by our physicians, or our providers are out of network, payment in full is expected at the time of your visit. We accept cash, checks, VISA, MasterCard, Discover and American Express.

Please be sure to provide us with your most current insurance card(s) at each visit. We cannot properly file your insurance claim if we do not have accurate insurance information in your account. If you do not have your insurance card with you at the time of service we will be happy to see you but payment in full will be due at the time of service. You must bring your insurance card to us in order for the claim to be filed. Once payment has been received from your insurance company, we will gladly refund the patient payment less any applicable co-pays or deductible. We must emphasize that your insurance coverage is a contract between you and your insurance company. We are a specialty practice. We realize temporary financial difficulty may affect the timely payment of your account. It is your responsibility to contact us promptly for assistance in the management of your account. Remember we are here to help. ***Patient balances are due with 30 days of the date of service and insurance reimbursement.***

Currently all the insurance plans we are contracted with require that we provide the patient's full name, date of birth, social security number, and complete home address. If you feel uncomfortable providing us with that information, we will provide you with a bill so you can file your own claim with your insurance plan. If you choose to file the claim yourself, payment in full will be due at the time of service.

Office Visits: Eye Examinations have two portions, the medical eye exam, and the refraction. The refraction is the measurement taken to determine if there is a need for glasses and if so, dispense your glasses prescription. Refractions may be done for routine eye exams or medical exams. **Medical insurance plans, including Medicare, do not pay for refractions. To update your glasses prescription, you will be asked to pay for the refraction at the time of your visit. This $60 fee is additional to any co-pay or deductible.**

If you currently wear, or wish to start wearing contacts, there is separate charge for the contact lens fitting which, please ask for a copy of our contact lens policy.

****Patient Signature: _____ (I understand by signing this that if I choose to have a refraction during a medical visit I am responsible for a $60 refraction fee).****

Vision Insurance: Vision insurance, like dental insurance, is provided by a third-party company and is not the same as your medical insurance. If you have vision insurance an authorization is required for us to bill your exam, we need to know the subscriber's information and insurance details prior to your examination. **Failure to provide this information 24 hours before your appointment will result in rescheduling your appointment or payment in full at the time of service.**

Many insurance plans require a referral/authorization for specialist office visits. You will need to obtain this referral/authorization from your primary care physician **prior** to being seen in our office. If a referral is not in place prior to your appointment **you will be asked to reschedule or payment in full will be required at the time of service.**

Surgery: If you are having surgery, we will assist in getting pre-certification or prior approval for your procedure. Please keep in mind that most insurance plans have deductibles, copayments, or both, associated with surgery, and you will be responsible for payment of these fees at the time of service. We suggest that your review your insurance plan prior to visiting our office, so you will be familiar with your insurance plan guidelines and requirements. Please be prepared to pay patient responsibility at the time of service.

Billing and Credit: ***Statements will be mailed monthly and are due for payment with 30 days. Monthly statements will follow until the account is paid in full.*** If you have any questions, please feel free to discuss them with our Insurance/Billing Department by calling 800-413-7764. ***If you have not paid your bill, or have not set up payment within 90 days, we will ask for assistance from our collection agency.***

PROFESSIONAL COURTESY POLICY AND CODE CHANGE REQUESTS*:* We greatly value our privilege to provide medical care to all our patients. In accordance with state and federal regulations, it is potentially unlawful to accept "insurance only", to waive copays, and/or to alter codes that accurately depict medical services rendered. For these reasons, the practice of making "professional courtesy" adjustments is strictly prohibited at all Siepser Laser EyeCare Practices, as is the practice to alter codes that accurately depict the services rendered.

CONSENT FOR TREATMENT

The undersigned Patient /Guardian has received a copy of our financial policy and hereby authorizes the physicians of Siepser Laser EyeCare, and the employees', to perform any treatment or procedures they may deem necessary for the Patient's treatment.

_____ _____

Signature of Patient or Guardian Date

I hereby authorize the staff of Siepser Laser EyeCare to release information to insurance carriers, appropriate physicians and/or Workers' Compensation departments, as required, concerning my illness and treatments and authorize all payments made to Siepser Laser EyeCare. I understand that if I did not get prior authorization as required by my insurance, that I will assume all financial responsibility for such charges associated with my visit.

- I am aware of Siepser Laser Eye Care Office Financial Policy
- I am aware of Siepser Laser Eye Care Office Refraction Policy

_____ _____

Signature of Patient or Guardian Date

_____ _____

Printed Name of Patient Date

ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Siepser Laser Eyecare's Notice of Privacy Practices.

Name (please print): _____
Signature: _____
Date: _____

Addendum

In recognition of the integral role that family and friends play in a patient's health care, the HIPAA Privacy Rule allows these routine – and often critical – communications between health care providers and these persons. Where a patient is present and has the capacity to make health care decisions, health care providers may communicate with a patient's family members, friends, or other persons the patient has involved in his or her health care or payment for care, so long as the patient does not object. See 45 CFR 164.510(b). The provider may ask the patient's permission to share relevant information with family members or others, may tell the patient he or she plans to discuss the information and give them an opportunity to agree or object, or may infer from the circumstances, using professional judgment, that the patient does not object. A common example of the latter would be situations in which a family member or friend is invited by the patient and present in the treatment room with the patient and the provider when a disclosure is made.

Where a patient is not present or is incapacitated, a health care provider may share the patient's information with family, friends, or others involved in the patient's care or payment for care, as long as the health care provider determines, based on professional judgment, that doing so is in the best interests of the patient. Note that, when someone other than a friend or family member is involved, the health care provider must be reasonably sure that the patient asked the person to be involved in his or her care or payment for care.

In all cases, disclosures to family members, friends, or other persons involved in the patient's care or payment for care are to be limited to only the protected health information directly relevant to the person's involvement in the patient's care or payment for care.

In the space provided below please list the names and contact information individuals who have permission to be noticed regarding your health care information.

1. _____
2. _____
3. _____

I have received the above addendum copy of Siepser Laser Eyecare's Notice of Privacy Practices

_____ _____
Signature of Patient or Guardian Date

_____ _____
Printed Name of Patient Date