PATIENT FINANCIAL RESPONSIBILITY

Recognizing the need for patients to understand what is expected regarding payment of vision services, we have established our financial policy. Some of these items are required by law. It is our goal to remain sensitive to our patients' needs while providing quality care, and we encourage you to contact our office if a problem should arise regarding your account.

1. **All co-pays and co-insurance required by your insurance company must be paid at the time services are rendered.** We accept cash, Care Credit, Visa, MasterCard, and Discover. Our office **DOES NOT ACCEPT CHECKS, OR AMERICAN EXPRESS.** As with all professional services, there are NO REFUNDS.
2. **It is the patient's responsibility to be aware of the contract benefits of his/her insurance carrier or any co-payment or deductible obligation.** If your insurance requires referrals for full benefits to be paid, it is your responsibility to verify that the referrals are in place prior to your visit.
3. **Our office will file both primary and secondary insurance claims for medical services rendered.** Claims for a third insurance contract will not be filed unless required by our contract with the carrier. We cannot file claims correctly without accurate information from you. **Proof of insurance must be presented at each visit.**
4. **If you do not have insurance,** payment in full is expected at the time of service unless financial arrangements have been made in advance with our billing department. As an alternative we accept Care Credit and can assist with the application process.
5. Professional fee is for the initial contact lens evaluation and measurement. For first time wearers, a class will be given on proper management of contact lenses, and 1 follow up visit 1 week from the initial exam. Any follow up care and visits after 30 days of initial exam is the responsibility of the patient and is NOT covered by the initial fees. The Patient will be assessed a refitting fee. Any medical issue, contact lens related or not, is not included in the follow up care.
6. **You will receive a statement from our office within 45 days of your insurance company's response.** If you are dissatisfied with their payment, *Please contact your insurance carrier*. Payment of the patient's portion of the balance is due upon receipt of the statement.
7. **We are participating providers for Medicare.** This means that we must accept Medicare's allowed charge for the services rendered. Medicare will pay 80% of the approved amount. **The patient is responsible for the remaining 20%, plus any out-of-pocket deductible**. We will write off the difference between what we charge and what Medicare approves. If you have secondary insurance we will submit the claim for the remaining balance after Medicare has paid. **Please remember that although we accept assignment for Medicare, the patient, by law, is responsible for any portion of the approved amount not paid by Medicare or a secondary insurance company.**

If you have any question, please speak with our staff or call us at 972-509-8555.

Patient's Signature (Authorized Representative/Guardian) **Date**

____ __/__/____

PATIENT INFORMATION AND MEDICAL HISTORY FORM Date: ____________

Name: ____ Birthdate: ____/____/______ Age: ___ Sex: M___ F ___
Last First MI

SS#: ____________________ Driver's license #: _________________ Last eye exam: ________ Last physical exam: ________

Address: ____City: _______________ State: _______ Zip: ____________

Home phone: ________________ Day time phone: __________________ Employer: ___________________________________

Referred by: ________________________________ Primary Care/Family Physician: ___________________________________

Insurance information: Please present your insurance card(s) to us so that we may make a copy to complete your records.

Insurance plan: ______________________________ Policy #: _____________________________ Group #: _________________

Subscriber Name: ____________________________ Subscriber's Birthdate: _____________ Relationship to patient: _________

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above plan and assign directly to Jenny Fan, O.D. or William Fan, O.D. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I'm financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

By signing this statement, I understand that my vision and/or health insurance coverage is a contract between myself and my insurance company. Although Dr. Fan and staff have made every effort to verify my benefits before my appointment, no guarantee can be made that the information received is accurate since incorrect information may be provided by my insurance company from time to time. I understand that it is ultimately my responsibility as the patient to understand my vision and/or health insurance coverage as well as handle any charges my plan does not cover.

Patient/Guardian Signature: _______________________________ Date:____________________________

Notices of Privacy Practices

I acknowledge that I have read and understand Notice of Privacy Practices as implemented my Jenny Fan, O.D. and William Fan, O.D. I am aware that I may request a copy of the agreement for my person records.

Patient/Guardian Signature: _______________________________ Date: ____________________________

Medical & Eye History:

What is the reason for your visit today? ____

____

Do your eyes itch? No___ Yes___ Are your eyes dry? No___ Yes___

Do you have difficulty when seeing far? __________ or doing near work? __________ Describe: _________________________

Have you ever had eye injury? No___ Yes___ Describe: ____

Have you ever had an eye surgery? No___ Yes___ Describe: ____

Do you wear glasses? No___ Yes___ If yes, how old is the present glasses? ___________________________________

Do you wear contact lenses? No___ Yes___ If yes, how old is your present pair of lenses? _______________________

Type of contact lenses: Rigid___ Soft___ Brand of lens: ____

How often do you replace your lenses? Every ___ weeks or ___months or ___years

Do you sleep in your contact lenses? No___ Yes___ If yes, how many nights at a time? _____

Are you allergic to any medications? No___ Yes___ Please list: ____

List any medications you take (including birth control, aspirin, over the counter medications): ___________________________

____

Please continue to next page

List all major illnesses, injuries and surgeries, including eye conditions (crossed eyes, lazy eye, glaucoma, cataracts) (with dates):____

____

____

Are you pregnant or nursing? No___ Yes___ If you are pregnant, when is the due date? _____________

Family history:

		Relationship			Relationship
Cataracts	No___ Yes___	__________	Retinal detachment	No___ Yes___	__________
Glaucoma	No___ Yes___	__________	Heart disease	No___ Yes___	__________
Diabetes	No___ Yes___	__________	Eye disorders	No___ Yes___	__________
High blood pressure	No___ Yes___	__________	Cancer	No___ Yes___	__________
Macular degeneration	No___ Yes___	__________	Other (please state)	____________	__________
Blindness	No___ Yes___	__________			

Social History:

Current occupation: __________________________ Hobbies: ____

Do you drink alcohol: No___ Yes___ If yes, how often: _____________________________

Do you use tobacco products: No___ Yes___ If yes, amount: ________________________

Review of systems Do you currently, or have you ever had any problems in the following areas?

Constitutional

Fever	No___ Yes___
Weight gain/loss	No___ Yes___

Integumentary (Skin)

Skin disorder	No___ Yes___

Eyes

Loss of vision	No___ Yes___
Blurred vision	No___ Yes___
Distorted vision/Halos	No___ Yes___
Loss of side vision	No___ Yes___
Dryness	No___ Yes___
Itching	No___ Yes___
Pain	No___ Yes___
Double vision	No___ Yes___
Discharge	No___ Yes___
Flashing lights	No___ Yes___
Spots in eyes	No___ Yes___
Other (please state)	____________

Ears, nose, mouth, throat

Sinus congestion	No___ Yes___
Chronic cough	No___ Yes___
Hearing loss	No___ Yes___

Cardiovascular/Vascular

Heart conditions	No___ Yes___
Hypertension	No___ Yes___
High Cholesterol	No___ Yes___
Stroke	No___ Yes___

Endocrine

Diabetes	No___ Yes___
Thyroid	No___ Yes___

Respiratory

Asthma	No___ Yes___
Chronic bronchitis	No___ Yes___
Emphysema	No___ Yes___

Gastrointestinal

Stomach/intestines	No___ Yes___
Liver problem	No___ Yes___

Genitourinary

Kidney/ kidney stones	No___ Yes___
Bladder/ other	No___ Yes___

Hemotologic/lymphatic

Anemia	No___ Yes___
Blood disease	No___ Yes___
Lymph nodes	No___ Yes___

Musculoskeletal

Joint/Muscle pain	No___ Yes___
Rheumatoid arthritis	No___ Yes___

Neurological

Headache/migraine	No___ Yes___
Weakness/tingling	No___ Yes___
Seizures	No___ Yes___
Mentally Challenged	No___ Yes___

Allergic /Immunologic

Allergies/ Hay fever	No___ Yes___
Cancer	No___ Yes___
HIV positive	No___ Yes___

Psychiatric No___ Yes___