PARTNERS PACIFIC OPTOMETRY

New Patient Information

Name: _____ Sex: M F Date of Birth: _____/_____/_____

Patient Soc. Sec. #: __ __ __ - __ __ - __ __ __ __ Marital Status: □ Single □ Married □ Other: _____

Street Address: _____ City: _____ State: _____
Zip: _____ □ *I receive mail here*

Name of Guarantor/Parent if under 18: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Preferred method of contact: □ Home Phone □ Work Phone □ Cell Phone □ Email □ Text □ Postal Mail
Employment Status: □ Employed FT □ Employed PT □ Not Employed □ Retired □ Student FT □ Student PT
Email: _____ Employer: _____ Occupation: _____

Emergency Contact Name & Phone #: _____ Relationship: _____
□ Ok to discuss medical information with this person

Insurance Information

It is your responsibility to know the terms and limitation of your policies. Failure to inform us of all of your insurance information may result in a denial of benefits and payment in full being owed by you. Please provide us with all of your insurance information. Your carrier is required to respond to our claim submission within 30 days. If we receive no response from your insurance company we may ask you to contact your insurance company or remit payment yourself and seek reimbursement from your insurance company. **We are currently not providers of HMO plans; if you have an HMO plan for medical visits, you are responsible for all fees at the time of your visit. Medical insurance and vision plans are very different in their terms of service and their coverage. We are unable to determine which, if any, can be billed until after the examination is completed.** When a medical condition is present (diabetes, high blood pressure, dry eyes, red eyes, allergies, etc.) it is necessary to file the claim with your major medical carrier. Vision plans do not typically cover medical problems, just as medical insurance does not cover routine glasses and contact lens exams. **We are often unable to bill your vision plan for the glasses/contact lens portion of your exam on the same day we bill your medical insurance for management of your medical eye problem. Our office does not make these policies, they are defined by the insurance carriers themselves.** We will need copies of your insurance cards and a photo ID.

Primary Medical Insurance:

Policy Holder (PH) Information (Complete only if you are not the primary policy holder):

Carrier (circle): Medicare Aetna Anthem BC/BS Cigna United Healthcare Other: _____

ID#: _____ Group #: _____

Name of PH: _____ Date of Birth: _____ Soc. Sec. # of PH: __ __ __ - __ __ - __ __ __

Secondary Medical Insurance

Carrier (circle): Medicare Aetna Anthem BC/BS Cigna United Healthcare Other: _____

ID#: _____ Group #: _____

Name of PH: _____ Date of Birth: _____ Soc. Sec. # of PH: __ __ __ - __ __ - __ __ __

Vision Plan Information

Carrier (circle): VSP EyeMed MES Spectera Superior Other: _____

ID#: _____ Group #: _____

Name of PH: _____ Date of Birth: _____ Soc. Sec. # of PH: __ __ __ - __ __ - __ __ __

By signing below, you attest the information listed above is true and that you have read and understand the financial policies of this office listed on this form. If you are using insurance and are denied any part of your claim, you agree to pay any outstanding balance. Please provide your insurance card(s) and a valid form of picture identification with this form at check in.

Patient Signature (OR Parent/Guardian if under 18): _____ Date: _____

New Patient Health Information

Patient Eye History:

Date of Last Eye Exam: _____ By Whom? _____
Do you wear contact lenses? □ Yes □ No Are you interested in learning of new contact lens options? □ Yes □ No
Are you satisfied with the vision and comfort of your contact lens? □ Yes □ No □ N/A
Current Glasses Wearers: How old are your glasses? _____
What do you wear them for? _____
What do you like about your glasses? _____
What do you not like about your glasses? _____
Do you have your prescription sunglasses with UV protection? □ No □ Yes
Do you have your computer glasses with blue light protection? □ No □ Yes

Lifestyle Questions: *Please help our staff & doctors understand your current vision demands.*	**No**	**Yes**
Do you get eyestrain or headaches when using a computer?		
Are you required to wear safety glasses at work?		
Do you participate in shooting sports?		
Do you golf, run, or participate in outdoor activities?		
Do you participate in water sports (i.e. skiing, surfing, fishing)?		
Do you have problems with glare at night?		
Do you have problems with glare during the day?		
Do you have problems with your glasses fogging over?		
Do you have problems with cleaning your glasses?		
How many hours a day do you spend on the computer (working, studying, gaming)?		

Have YOU been diagnosed, treated, or currently experiencing any of the following ocular conditions?

□ Blurry Vision
□ Cataracts
□ Crossed eye/Eye turn
□ Lazy Eye
□ Eye infections
□ Flash of light
□ Glaucoma
□ Headaches
□ Itchiness
□ Tearing
□ Grittiness
□ Macular Degeneration
□ Retinal Detachment
□ Floaters/Spots
□ Burning
□ Corneal Abrasions
□ Double Vision
□ Eye Injury/Trauma
□ Iritis/Uveitis
□ Light Sensitivity
□ Glare/Trouble seeing at night
□ Other Eye Disorders: _____

Primary Care Physician ***Name:*** _____ ***City:*** _____

Personal Medical History: Have you had any of the following? If yes, is it current (within the last 2 months)?

Condition	No	Yes	Current?
Allergy			
Seasonal/Dust/Pollen			
Medication Allergy			
Cardiovascular			
Elevated Cholesterol			
High Blood Pressure			
Stroke			
Constitutional			
Excessive Urination			
Excessive Thrist			
Endocrine			
HYPERthyroid			
HYPOthyroid			
Diabetes (Insulin Dependent)			
Diabetes (Non- Insulin Dependent)			
Gastrointestinal			
Hepatitis			

Condition	No	Yes	Current?
Genitourinary			
Bladder/Kidney Disease			
Ear/Nose/Throat			
Hearing Impairment			
Sinus headaches			
Hematologic/Lymphatic			
Temporal Arteritis			
Immunological			
HIV/AIDS			
Lyme Disease			
Sjogren's Disease			
Herpes Simplex (Oral/Genital)			
Herpes Zoster (Shingles)			
Integumentary (Skin)			
Contact Dermatitis			
Rosacea			
Lupus			

Condition	No	Yes	Current?
Musuloskeletal			
Ankylosing Spondylitis			
Arthritis			
Myasthenia Gravis			
Marfan's Syndrome			
Neurological			
Bell's Palsy			
Seizures			
Multiple Sclerosis			
General Headaches			
Migraine Headaches			
Psychological			
ADD/ADHD			
Bipolar			
Depression			

Condition	No	Yes	Current?
Autism			
Mentally Challenged			
Dementia			
Respiratory			
Asthma			
COPD			
Emphysema			
Cancer			
Breast			
Colorectal			
Lung			
Prostate			
Skin			
Other			
List:			

Family History: *Have any of your blood relatives developed any the following **over the last year**:*

Ocular Conditions	No	Yes	Relation	Medical Condition	No	Yes	Relation
Glaucoma				Diabetes			
Macular Degeneration				High Blood Pressure			
Retinal Tear/Detachment				High Cholesterol			
Amblyopia/Lazy Eye				Thyroid			
Blindness				Cancer			
Cataracts							

Medications: Please list all your medications, including birth control, over the counter medications, vitamins & supplements:

_____

_____

_____

_____

For Women: Are You Pregnant? □ No □ Yes If Yes, How Many Months? _____
Are you breast feeding? □ No □ Yes

Social History: Do you smoke? □ No □ Yes Did You Ever Smoke? □ No □ Yes If you've quit, how long ago? _____
Do You Drink? □ No □ Yes If Yes, how many drinks/week? _____ Do You Use Any Recreational Drugs? □ No □ Yes

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The following questions are required by the Centers for Medicare and Medicaid Services (CMS) FOR ALL PATIENTS to meet the standards for meaningful use of electronic records. Racial and ethnic classifications were determined by CMS. If you have questions, please ask the staff.

Language: □ English □ Spanish □ Vietnamese □ Other: _____

Race: □ American Indian/Alaskan Native □ Asian □ Black/African American □ Hawaiian/Other Pacific Islander
□ White □ Other: _____

By signing below, you attest the provided on this form is accurate and true.

Patient (Guardian if under 18) Signature: _____

Financial Responsibility Statement & Acknowledgement of Office Policies

Financial Policy: Payment is expected at time service is rendered and before orders are placed. By signing you agree to be held liable for all expenses, costs and reasonable court, attorney and collection agency fees for any delinquent balance. Any check returned unpaid will incur a fee of $25 applicable under state law. A collection service fee will be assessed for any unpaid balances after 30 days of initial notice of balance due. A $25.00 service fee will be assessed for failure to pay your copay at the time of service. Our office may assess an administrative fee for completion of any outside paperwork, forms and chart reviews requested by you. A cancellation fee may be assessed for any appointment missed without at least 24 hours prior notice.

To our patients WITH Vision/Medical benefits: It is your responsibility to know your coverage and co-pay amounts. Please be aware, unless your insurance plan has specific benefits for contact lens fittings, you will be expected to pay that amount along with your co-pay and any other non-covered services. Any out-of-pocket expenses collected from you at the time of service are estimates only, your insurance will determine your final out of pocket costs. **We are currently not providers of HMO plans; if you have an HMO plan for medical visits, you are responsible for all fees at the time of your visit.**

In the event that your insurance company determines that you are not eligible at the time of service or makes a determination that you are eligible for a reduced level of coverage, by signing this statement you hereby agree to be financially responsible for any and all charges incurred by you and not paid by the insurance plan, and any additional collection fees necessary to collect all amounts due. Be aware that any pre-authorizations received by our office are not in any way a guarantee of payment from your insurance company. After we receive your plan sponsor's response any and all remaining balances will be due within 30 days. If we do not receive a response from your insurance company within 90 days, we will bill you for the balance due in full. Due to the time limit restrictions imposed by many insurance companies, failure to supply us with the correct insurance information may result in payment in full being owed by you.

Glasses Recheck Policy: This office will recheck any prescription one time at no cost within 60 days of the date on which the prescription was determined. If you were told at the time of the exam that your glasses will need to be altered for varying medical reasons within the 60 day period this recheck policy does not apply and you may be charged a fee. You must be able to furnish the glasses/contacts that you had filled with the aforementioned prescription if not filled through our office. A fee of $25 to confirm the parameters of a prescription pair of glasses not purchased in our office or online store may apply. Other restrictions may apply, ask an associate for details. After 60 days a fee of $45 will be incurred for any recheck. Rechecks will not be performed after 6 months from original exam date and a new exam will be necessary.

Glasses Remake Policy and Frame and Lens Warranty: This office will remake prescription glasses once within 60 days of pickup at no charge to the patient in cases of prescription change. Any remakes required beyond the initial remake can and will result in fees for the lenses and any treatments charged at 50% of our usual and customary fees. Frames purchased from our office have a 1-year manufacturer defect warranty and do not cover acts of abuse. Lenses with a scratch treatment have a 1-year warranty depending on the type of scratch treatment purchased which covers wear and tear scratches but not acts of abuse. The replacement warranty fee is $50 at time of use. Neither of our warranties for frames or lenses cover loss or theft. If you used insurance to purchase your glasses your warranty changes from our standard office warranty to your insurance company's warranty.

Pupillary Distance and Other Glasses Measurements: This office takes pupillary distance and other measurements to properly fit prescription glasses as part of the service provided for eyewear purchased from our office. Patients that do not purchase prescription eyewear through our office will be charged a $25 fee for taking these measurements in conjunction with our prescription verification service.

Refund Policy: All orders are final when placed. No refunds are given on custom made prescription items. If you are unhappy with your glasses for any reason, please bring them back to us so we may change them to meet your expectations. Any opened contact lens boxes may not be returned. Refunds will not be given on services provided.

Appointment Cancellation Policy: This office requires 24-hour notification of your appointment cancellation. Cancellations, no shows and late arrivals (15 minutes) will take away an important appointment time slot for someone who needed the appointment and drain unnecessary resources. Any cancellation within 24 hours of your appointment will incur a fee of $50.

Privacy Policy, HIPAA and Your Records: This office follows HIPAA guidelines concerning the privacy of your medical information. We will not release any of your information to anyone without your written prior authorization with the exception of other health professionals and your insurance company as outlined in HIPAA if applicable. A copy of the HIPAA guidelines is available upon request. Under California law your records will be maintained for a minimum of seven years.

By signing below, you understand the financial statement and policies of Partners Pacific Optometry listed above.

Patient Signature (OR parent/guardian if under 18): _____ Date: _____

Eye Wellness Digital Retinal Exams

Partners Pacific Optometry is pleased to offer you and your family the most highly advanced state of the art technology available in eye disease detection: the Optomap Digital Retinal Imaging & Optovue Wellness Exam.

Our Doctors are concerned about retinal diseases such as macular degeneration, glaucoma, retinal detachments, and diabetic retinopathy, all which can lead to partial loss of vision or blindness. Additionally, systemic diseases such as diabetes and high blood pressure can be detected with a retinal examination. Eye exam with retinal evaluations can help you safeguard both your eyesight and general health.

The **Optomap Digital Retinal Imaging** allows us to scan 85% of the retina to thoroughly evaluate your internal eye health with dramatically improved precision. The **Optovue Wellness Exam** is a quick and non-invasive scan of your eye that lets the doctor see the individual layers of your retina to aid in the diagnosis of sight-threatening eye disease. Early detection is crucial.

The doctor strongly recommends that ALL patients have this procedure performed every year. It is especially important for people who have:

- Family history of glaucoma, blindness, or macular degeneration
- Family history of diabetes or high blood pressure
- Headaches
- Patients over the age of 40 years old
- Diabetes
- High Blood Pressure
- High Cholesterol

With an annual Wellness Imaging, our doctors can track your eye health for concerns, perform annual comparisons, and initiate treatments sooner. Medical and Vision insurances do not pay for routine screening photos. As a result, there is a **$40.00** fee for this procedure. *(Please advise staff if you have a history of epilepsy.)*

These Retinal Images augments a dilated exam by creating a permanent documentation of the retina.

____ I am a **NEW patient** and understand retinal imaging is **mandatory**. I understand there is a $45 fee for this procedure because some medical and vision insurances do not pay for routine photos.

____ Returning patient: I choose to have the Retinal Wellness Imaging. I understand that based on the doctor's assessment of the retinal scan and examination, dilation may still be recommended. I understand there is a **$45.00** fee for this procedure because some medical and vision insurances do not pay for routine photos.**

____ Returning patient: I choose to be **dilated** today. I understand that after dilation, my vision will be slightly blurry when reading, and I might be sensitive for 3-4 hours.

*** *Some medical and vision plans cover retinal imaging. Patient is responsible for the contracted co-pay of retinal imaging at the time of the exam. Co-pays vary by insurance plans and contracts.*

Signature: _____ **Date:** _____