Mack Eye Center
Welcome To Our Office

Welcome to Mack Eye Center. Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. If you have any questions, please do not hesitate to ask.

Today's Date: _____

First Name: _____ MI: _____ Last Name: _____ Preferred Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Social Security #: _____/_____/_____ Date of Birth: _____/_____/_____ Sex: _____ Primary Language: _____

Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____ Email: _____

Emergency Contact: _____ Relationship: _____ Emergency Phone: _____-_____-_____

Primary Insurance Information

Insurance Co: _____ Identification #: _____ Group#: _____

Name of Insured: _____ Insured Birth Date: _____ Relationship to Insured: _____

Secondary Insurance Information

Insurance Co: _____ Identification #: _____ Group#: _____

Name of Insured: _____ Insured Birth Date: _____ Relationship to Insured: _____

Patient History and Information

Primary Care Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Referring Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Reason for today's visit: _____ last eye exam: _____

Medications

_____

_____

_____

Allergies

_____

_____

_____

Medical History Questionnaire

Disease	Self (Yes or No)	Family member (Yes or No)	Which family member(s)
Amblyopia (Lazy Eye)			
Blindness			
Cancer			
Color Blindness			
Diabetes			
Glaucoma			
High Blood Pressure/Stroke			
Macular Degeneration			
Neurological Disease			
Retinal Disease			
Strabismus (Crossed Eyes)			
Thyroid			

Social History

Do you smoke?	Yes or No	Occasional	½ pack day	1 pack day	1+ pack
Do you drink?	Yes or No	Occasional	1 per day	2-3 per day	4+ day
Do you use Illegal drugs?	Yes or No				

We wish to thank you for completing this form. This will help us in better serving your needs. I acknowledge that the above information is true.

Patient Signature or Legal Guardian: _____ Date: _____

Consent for Release of Confidential Information

Mack Eye Center respects the privacy of every patient and does it best to protect such information. We will however release medical information to another physician when it is necessary for the treatment of our patients. Please know that only pertinent information will be released to ensure that your privacy is maintained.

There are also times when your insurance carrier requires additional health information I order to process payment for claims. In the instances, only the relevant information will be provided to them. Again, we do our best to protect your health information.

I understand that Mack Eye Center has the right to release my health information for the above reasons. I also know that they will protect my information to the best of their ability.

This consent is valid the entire length of my relationship with the Mack Eye Center. Should I feel it is necessary to revoke this notice, I understand it must be done in writing to my physician's office.

Patient Signature or Legal Guardian: _____ Date: _____

More detailed information is available upon request.

FINANCIAL AGREEMENT

Mack Eye Center's goal is to provide and maintain a good physician-patient relationship. Advising you of our office policy in advance allows for improved communication and enables us to achieve our common goal. Please read this policy carefully and if you have any questions, do not hesitate to ask our staff. Thank you in advance.

- It is your responsibility to understand your health insurance plan benefits regarding all services.
- According to your insurance plan, you are responsible for any and **ALL** co-payments, deductibles and co-insurances **(due at the time of service)**.
- If our physicians are out of network or you do not have insurance, payment is due in full, at the time of service.
- Patient balances are billed immediately upon receipt of your insurance company's explanation of benefits. Your payment is due within 30 days upon receipt.
- Accounts with balances over 60 days past due will be turned over to a collection agency. If your account is in collections, there will be an additional 50% fee charged to your balance.
- If our account is in bad debt or assigned to a collection agency, NO future routine appointments will be scheduled until the balance is paid in full.
- In an effort to serve you better, we require a 24-hour notice for canceling appointments, otherwise a $100 fee will be charged. This NO SHOW charge is NOT reimbursable by your insurance company. You will be billed directly. If a 3rd no show or cancellation/reschedule with no 24 hour notice should occur the patient may be dismissed from Mack Eye Center. Patients arriving more than 15 minutes after their appointment time may be asked to reschedule.
- A $30 fee will be charged for any returned checks, due to insufficient funds.
- A refraction (a test used to measure the refractive error of your eyes) is typically not covered by medical insurance. It is your responsibility to understand your insurance coverage and that you will be held responsible for the $55 charge, even when it is necessary for your treatment to have this test. If you would like to opt out of this test, please let the technician know at the beginning of your exam.
- If you have any forms for the physician to fill out, such as FMLA, Disability, etc. there is a $25 fee for completion of these forms. Payment is due when forms are delivered. There is a one-week turnaround time for these types of forms. Please note: this form must be signed for treatment and visits at Mack Eye Center.

DISMISSAL OF PATIENTS FOR FINANCIAL REASONS

Patients can be dismissed from the practice for a number of reasons, including the following financial situations:

1. Collection Agency Turnover will result in a dismissal from the practice if a patient fails to pay his or her balance within the 30day turnover.
2. Expedited dismissal occurs when a patient is not honoring his or her financial responsibilities. All patients should be given at least 30 days' notice before being dismissed from the practice unless instructed otherwise by the physician.

I _____ have read and understand this financial agreement.

Patient name:_____ Signature: _____

Relationship to patient: _____ Date: _____

Routine Eye Exams, Medical Eye Exams and Refractions

Regular eye examinations are important to maintain your vision for your lifetime. It is important that you be aware of your insurance benefits and how they apply to your visit, so you will know how billing will be handled. **Ultimately, it is your responsibility to know what your own medical or vision plan covers.** We hope this information will help you to understand how your visit is submitted to your insurance for today's visit and future visits with Mack Eye Center. Benefits may vary based upon the reason for your visit. Your description of your eye condition will help us to determine whether your visit to the clinic is defined as "Routine" or "Medical". Your symptoms and eye examination will determine how your visit is coded and billed to your insurance.

Routine Eye Examinations – A "routine eye exam" takes place when you come for an eye exam without any medical eye problems and there are no symptoms except for visual changes. This type of exam can be corrected with glasses or contact lenses.

Medical Eye Examinations – Your visit will be coded as a "medical eye examination" whenever you are being evaluated/treated for a medical condition, such as dry eye or cataracts. These things often aren't determined until the Doctor sees you.

Vision Service Signature Plan (VSP) and other vision plans, such as Eyemed – if you have a vision plan, we need to be aware of this coverage prior to your exam. Vision insurance only covers routine eye exams. If you determine that you have vision coverage after your exam has been completed, we will not bill them, but will happily provide you with the financial documentation needed for independent filing.

What is a Refraction?

A refraction is a vision test that determines your best corrected visual acuity with eyeglasses. This is a measurement that the doctor or technician takes with an instrument called a phoropter. It holds corrected lenses in front of your eyes. You may hear the doctor/technician ask you, "which is better... lens one or lens two?" This test is not covered by Medical insurance, even if it is medically necessary. The charge for this service is **$55.00**. This is a routine charge for all Medical and Surgical Ophthalmologists' offices. If you wish to forego this test, please inform us **BEFORE** we begin doing any testing.

I understand the difference between routine and medical eye examinations. I understand that depending on the type of exam I have, it may go to either my Medical or my Vision insurance (if you have a vision plan). I understand that fees will may apply and I will be responsible for what is not covered by insurance.

Patient Signature:_____ **Date**_____