CHILDREN'S EYE
SPECIALISTS

Today's Date: _____

Patient Name: _____ **DOB:** _____

PATIENT INFORMATION
(please print)

Name: _____ also known as: _____

Date of Birth: _____ SS# _____ ☐ M ☐ F

Address: _____

_____

Home: (____)_____ Cell: (____)_____

Work: (____)_____ Other: (____)_____

Email: _____

Referring Doctor: _____ Practice: _____

INSURANCE

Primary Insurance:

Name: _____ Policy #: _____

Policy Owner: _____ Relationship to patient: _____

Date of Birth: _____ SS# _____

Secondary Insurance:

Name: _____ Policy #: _____

Policy Owner: _____ Relationship to patient: _____

Date of Birth: _____ SS# _____

FOR PATIENTS UNDER 18 YEARS OF AGE:

Father's name: _____

[ ] Address/phone same as patient

Address: _____

Phone: (____)_____ [ ] Home [ ] Cell [ ] Work

Mother's name: _____

[ ] Address/phone same as patient

Address: _____

Phone: (____)_____ [ ] Home [ ] Cell [ ] Work

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FINANCIAL RESPONSIBILITY AND WAIVER/RELEASE

Insurance

I understand that it is the patient/parent responsibility to supply Children's Eye Specialists, LLC with any current insurance information and/or any referral authorization forms that may be necessary for my insurance claim.

I authorize Children's Eye Specialists, LLC to receive all payments for medical services rendered to myself or dependents. These authorizations will remain on file for all future treatment. If this account results in collection agency involvement, the undersigned guarantor agrees to pay all legally allowed interest and associated fees.

I AM AWARE THAT I AM RESPONSIBLE FOR ANY UNPAID/OVERDUE BALANCES.

I understand that most insurance carriers do NOT pay for all health care costs. Carriers only pay for covered benefits. Some items and services are not covered benefits and carriers will not pay for them. If I receive a service that is not a covered benefit, I will be financially responsible for payment. I also understand that I am responsible for all insurance deductables, co-insurance, co-pays and any non-covered services at the time services are rendered.

Initial here _____

Medical vs Vision Insurance

Medical insurance DOES NOT cover any vision-related services (refraction or routine exams). Vision plans do not cover any medical testing, consultation or treatment. I understand that Children's Eye Specialists, LLC only bills through medical insurance and not vision policies.

Refractions are required to establish the status of your vision. Your medical insurance will not cover this service. **Our fee is $30.00 and is payable at the time of service.**

IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. WE ACCEPT CASH, CHECK AND ALL MAJOR CREDIT/DEBIT CARDS.

Initial here _____

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Surgery

If you are having surgery, we will obtain any pre-authorization, if necessary, and verify covered insurance benefits. There are three separate charges regarding surgery which includes the surgeon fee, facility fee and anesthesia. I understand that Children's Eye Specialists reserves the right to collect any due fees (co-pays, co-insurance, and deductables) for the surgeon before services are rendered unless other arrangments are made in advance. The other fees (facility and anesthsia) are separate from fees due to Children's Eye Specialists.

Initial here _____

Conclusion

Although our staff is very knowledgeable about insurance plans and policies, it is NOT our responsibility to know the details of individual plans. Your insurance is a contract between you and/or your employer and the insurance company; not with Children's Eye Specialists, LLC or the doctor. We do encourage you to speak with your insurance company BEFORE your scheduled appointment to review any specific details. We will do everything we can to be of assistance.

Initial here _____

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NOTICE OF PRIVACY PRACTICES

I have read the notice of privacy practices form and understand my rights. Any questions I may have, have been answered clearly and I understand my rights in the Notice. I authorize the release of medical information to other healthcare providers (i.e. primary care physician, hospitals, etc).

FINANCIAL RESPONSIBILITY AND WAIVER/RELEASE

I authorize all payments of services from all insurance carriers to be made out to Children's Eye Specialists, LLC. I understand the Financial Responsibility and Waiver/Release form and agree that I am responsible for paying any amount not covered by my insurance plan. I understand that I am responsible for all charges whether it is covered by insurance benefits or not.

CONSENT FOR TREATMENT

I AGREE AND GIVE CONSENT TO THE TREATING PHYSICIANS AND STAFF OF CHILDREN'S EYE SPECIALISTS. I CONSENT TO ALL TREAMENTS AND DIAGNOSTICS.

_____ _____

Printed name of patient or person acting on patient's behalf Relationship

_____ _____

Signature of patient or person acting on patient's behalf Date

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I can authorize other parties to have access to medical information that is not included in the Notice of Privacy Practices. There are other people that I will want to have access to my medical information in the case that I am not available or do not have the information they need. If there are any individuals listed below who should only have limited access to the information, I must document that next to their name. Otherwise, the individuals listed below can have full access to any of my medical information.

_____ _____
Printed name Relationship

_____ _____
Printed name Relationship

_____ _____
Printed name Relationship

_____ _____
Printed name Relationship

[ ] By checking this box, I would like NO information to be released to anyone.

_____ _____
Printed name of patient or person acting on patient's behalf Relationship

_____ _____
Signature of patient or person acting on patient's behalf Date

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PATIENT MEDICAL HISTORY INFORMATION

Pediatrician/Primary: _____ **Practice:** _____

Preferred Pharmacy: _____

Preferred Pharmacy Address: _____

Eye History:

Seen by other eye doctor: ☐ No ☐ Yes _____

History of eye disease: ☐ No ☐ Yes _____

History of patching: ☐ No ☐ Yes _____

History of eye surgery: ☐ No ☐ Yes _____

History of wearing glasses: ☐ No ☐ Yes _____

Other eye problems: ☐ No ☐ Yes _____

Medications: ☐ No ☐ Yes *If yes, please note medication and dose below:*

_____

Surgeries *(please list all surgeries and estimated dates)*

_____

Allergies: _____

Other pertinent medical history/comments:

_____

_____

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Patient Name: _____ **DOB:** _____

Patient History:

Sickle Cell	☐	Asthma	☐
Previous hospitalization	☐	Hydrocephalus	☐
Developmental delay	☐	Recent illness	☐
Genetic disorder	☐	Heart disease	☐
Learning disorder	☐	Joint problems/arthritis	☐
Seizures	☐	Psychiatric disorders	☐
Cerebral palsy	☐	Bleeding disorders	☐
Headaches	☐	Diabetes	☐
Smoking / Smoke Exposure	☐	Alcohol use	☐

Hobbies/interests: _____

Occupation: _____

For patients 18 and under:

Premature: ☐ No ☐ Yes – Gestational age: ____ wks Birth weight: _____ gms

Patient Lives with: ☐ Father ☐ Mother ☐ Siblings, how many? _____

☐ Others _____

School grade: _____ School: _____

Family History - any blood relatives have:

Blindness	☐	Childhood cataracts	☐
Amblyopia/lazy eye	☐	Childhood glaucoma	☐
Strabismus/eye misalignment	☐	Eye Cancer	☐
Nystagmus/jerking eyes	☐	Delayed development	☐
Glasses before age 6	☐	Other eye disease	☐

_____