BEAR EYE CARE
WELCOME TO OUR PRACTICE

PATIENT INFORMATION (Please print)

Patient's name _____ Sex M_____ F_____
Date of Birth _____ Age ____ Social Security _____
Marital Status (circle one) Single Married Widowed
Address: Street_____ Apt./Lot #_____
City _____ State_____ Zip Code_____
Home Phone _____ Cell/Work Phone _____

Patient's Employer _____ Occupation_____
Employer's Address _____ City _____

Spouse/Parent/Guardian _____ DOB_____SS#_____

Spouse/Parent/Guardian Employer _____ Work Phone_____

Family Physician _____ Phone _____

Nearest Relative/Emergency Contact
Name _____
Relationship _____
Address _____
Phone _____

Person Responsible for Bill (if not patient)
Name_____
Address _____
Phone _____ Relationship_____
DOB _____ SSN#_____

ATTENTION: **Please be aware that some medical insurances and Medicare do not cover routine eye exams (this is, glasses or contact lens check). If you believe your insurance does cover routine eye exams, please let the front desk know BEFORE you are called to the back so that we may verify your insurance.**

Insurance Must Be Presented At Time of Service

It is your responsibility to pay copay and deductible amount, or any other balance not paid by your insurance company. I hereby authorize Bear Eye Care/Dr.Rimmer to furnish information to my insurance company concerning my visit and I hereby assign to the doctor all payments for medical services and devises rendered to myself and for my dependents. I understand that I am responsible for any amount not covered by my insurance. I also understand that I am responsible for court costs and attorney fees incurred in the collection process.

If your insurance has not paid within 30 days, the balance will become the patient's responsibility.

Date: _____ Signature: _____

PLEASE NOTE: We require payment at time of service. Please indicate how you wish to pay: Cash, Check, CC.
There will be a $40.00 fee for all returned checks.

Patient Name: _____ **Date:** _____

Date Of Birth: _____

Eye History

Have you experienced, or been treated for any of the following? PLEASE ANSWER ALL

Cataracts	**Yes**	**No**
Crossed Eye	**Yes**	**No**
Eye Injuries _____		
Eye Surgery _____		
Glaucoma	**Yes**	**No**
LASIK or RK	**Yes**	**No**
Lazy Eye	**Yes**	**No**
Macular Degeneration	**Yes**	**No**
Retinal Detachment	**Yes**	**No**
Other Eye Diseases _____		

Family Medical History

Has a family member experienced or been treated for any of the following?

Blindness	**Family Member** _____
Cancer	**Family Member** _____
Cataracts	**Family Member** _____
Diabetes	**Family Member** _____
Glaucoma	**Family Member** _____
High Blood Pressure	**Family Member** _____
Macular Degeneration	**Family Member** _____

Current Medications

(prescription and over-the-counter and dosage)

_____

_____

_____

_____

_____

Primary Care Doctor: _____

Medication Drug Allergies

_____

_____

Height _____ **Weight** _____

Are you pregnant or nursing? _____

Medical History

Patient Name: _____

Date of Birth: _____ **Today's Date:** _____

Please circle Yes or No on each item.

Allergic/Immunologic

Yes / No Drug allergy

Yes / No Environmental allergy

Yes / No Rheumatoid arthritis

Yes / No Lupus

Yes / No Cancer

Yes / No Aids/HIV

Endocrine

Yes / No Diabetes - Non insulin dependent

Yes / No Diabetes - Insulin dependent

Yes / No Thyroid dysfunction

Integumentary

Yes / No Eczema

Yes / No Rosacea

Yes / No Psoriasis

Ear, Nose, Mouth & Throat

Yes / No Sinus congestion

Yes / No Post nasal drip

Yes / No Chronic cough

Gastrointestinal

Yes / No Chron's

Yes / No Colitis

Yes / No Ulcer

Yes / No Digestive

Neurological

Yes / No Multiple sclerosis

Yes / No Epilepsy/Seizures

Yes / No Alzheimers

Yes / No Parkinsons

Other not Listed: _____

_____

_____

Musculoskeletal

Yes / No Fibromyalgia

Yes / No Muscular dystrophy

Yes / No Osteoarthitis

Yes / No Ankylosing spondylitis

Cardiovascular

Yes / No High Cholesterol

Yes / No Heart Disease

Yes / No Hypertension

Yes / No Stroke

Yes / No Vascular disease

Hematologic/Lymphatic

Yes / No Blood disorder

Yes / No Anemia

Yes / No Large volume blood loss

Yes / No Leukemia

Genitourinary

Yes / No STD, viral herpetic, chlamydia

Yes / No Kidney disease

Constitutional

Yes / No Developmental disability

Yes / No Weight loss/weight gain

Yes / No Fever

Psychiatric

Yes / No Depression

Yes / No Panic disorder

Yes / No Schizophrenia

Respiratory

Smoking status:

___ Never, ___ Former, ___ Current

Yes / No Asthma

Yes / No Chronic Bronchitis

Yes / No Emphysema

BEAR EYE CARE

Patent Acknowledgement Regarding:

Precautions Following Dilation

- It may be necessary to dilate you eyes during the course of your eye examination or treatment. Dilation results in sensitivity to light and an inability to see well at close range or distance for a few hours.
- We provide free disposable sunglasses
- Patients should wear sunglasses, be cautious walking and going up and down stairs. We recommend avoiding driving or operating dangerous machinery immediately afterwards. We recommend that someone accompany you to drive you home or that you will wait until your eyes return to normal so that you can drive safely.

Dangers of Dilation

- There is a very small chance, less the 0.1%, that dilation your eyes can result in elevation in eye pressure (acute glaucoma). If this occurs, it is usually treatable.
- You may refuse to have your eyes dilated, but this will markedly reduce the thoroughness of your exam.

Refraction Service and Fee

- A refraction is the process of determining your best corrected vision and if there is a need for corrective eyeglasses. It is an essential part of an eye examination and is necessary to write a prescription for glasses, or if you are planning to have cataract surgery.
- A refraction is NOT a covered service by Medicare or most MEDICAL insurance plans. These plans consider a refraction a “vision” service not a “medical” service.
- Our office fee for a refraction is $32.00

I have read and understand the above information. I accept full financial responsibility for the cost of a refraction and understand payment is due at time of service. I understand that any copayment, coinsurance, or deductible I may have are separate from and not included in the refraction charge.

Dr. Rimmer may need to instill drops to examine your eyes. These drops may cause some sensitivity to light and blurred vision.
I DO __ **I DO NOT** ___ give permission for diagnostic drops to be used in my eyes. **(NON dilating)**

I DO__ **I DO NOT** __ give permission to have **DILATING** drops used in my eyes.

Notice of Privacy Practices Acknowledgment

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____ _____

Patient’s Name (printed) Date

_____

Patient’s Signature (Legally responsible Adult for Minor)

BEAR EYE CARE FINANCIAL POLICY

Patient Name _____

We are committed to meeting your healthcare needs. Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this in a cost effective manner, we ask that you adhere to the following guidelines.

1. You are ultimately responsible for payment of charges for services you receive from our office. Any check payment dishonored by your bank will result in a $40.00 return check charge being added to your account.

2. Please provide us with your current address, telephone number, and insurance information. It is very important that we have current information on you as we may need to contact you in case we need to mail you test results or other information. Although we realize it is inconvenient, please be prepared to update your information frequently.

3. It is your responsibility to contact your insurance carrier to confirm that we participate in your plan. If our doctor is not currently on your plan, you will be responsible for payment in full.

4. Your copay is due at EVERY visit and will be collected prior to you being brought back to the examination area. There are no exceptions to this policy. Please direct any questions regarding this policy directly to your insurance company. Please be prepared to pay for these services at the time they are rendered. If there are additional charges such as material copays, deductibles, or other services, these will be collected upon checkout. We appreciate your help in keeping our costs low by avoiding unnecessary billing charges. We can NOT bill for refractions and copays which are due at the time of service.

5. Every insurance plan is different. We attempt to interpret your plan's coverage to the best of our ability. We may or may not interpret it correctly. Your insurance carrier has the final judgment. If we calculate wrong we will refund any overages paid, or you will be responsible for any shortage.

6. We would greatly appreciate if you could give 24 hour notice if you are unable to keep your appointment. This allows us to offer this time to another patient who needs to be seen, if you do not give 24 hour notice, a charge of $25 will be applied to your account.

7. Orders placed for glasses/lenses, if cancelled within 8 hours of placing the order, will incur a 40% restocking fee. Cancellations of glasses/lenses ordered after 8 hours will result in NO REFUND. Glasses/lenses are custom ordered to your exact prescription.

8. Contact lens orders must be paid in full at time of order. No contact lenses can be returned if box has been opened, altered or tampered. Box must be in exact condition as when new. Contact lens boxes may be returned within 48 hours, less a $6.00 return charge per box if the above criteria is met.

9. All medical records release requests must be in writing. As per HIPAA guidelines, your records will be released within 30 days. There is a charge for copying your records in accordance with Georgia state law. If you need them sooner than 30 days, there may be an additional charge of $25. We will make every attempt to release records quickly but can not release them immediately. We do not release records on a walk-up basis as our first responsibility is to take care of patients being seen today. Similarly, there is a charge for any forms or dictated letters you request. Forms take at lease 2 weeks to process and will not be available immediately.

10. In the event the balance on your account becomes 60 days delinquent after insurance payments, your account may be sent to our collection agency. You would be responsible for the collation fees incurred.

11. Life is full of changes. Please be prepared to show us your insurance card AT EVERY VISIT so we can be prepared for possible changes in your coverage.

12. Ultimately, you are responsible for your medical bills in our office, and we can not interfere in payment problems or disputes between you and your insurance company. If no payment is received from your insurance company within 30 days, the amount becomes your responsibility and you may seek reimbursement from your insurance company after you have paid us.

13. If you have any questions or concerns about any of these policies, please direct them to Greg and not to the front desk.

Patient Signature _____ Date _____

BEAR EYE CARE

PATIENT FORM

Date: _____

Last Eye Exam

Do you Currently Wear Glasses?

Do you Currently Wear Contacts?

Reason for Today's Visit

I WANT TO BE FITTED WITH CONTACTS AT AN ADDITIONAL CHARGE?YES/NO

INSURANCE INFORMATION

Vision Insurance

Vision Insurance Member Name

Vision Insurance Member ID#

Vision Insurance Member Date of Birth

Primary Medical Insurance

Primary Member Name

Insurance ID#

Insurance Policy # / Group ID #

Primary Member Date of Birth

Primary Member Social Security Number

Primary Member Employer

Your Relationship to Primary Member *self / spouse / child / other (please explain)*