isight VISION CARE

www.isightvisioncare.com
t. 714 465.9978 f. 714 465.9986
18693 BROOKHURST STREET · FOUNTAIN VALLEY, CA 92708

Date: / /

PATIENT INFORMATION

LAST NAME	FIRST NAME	M.I.	OCCUPATION		
ADDRESS			SEX M - F	MARITAL STATUS M S W D	AGE
CITY, STATE	ZIP CODE		DATE OF BIRTH / /		
HOME PHONE NUMBER	CELL PHONE NUMBER		WORK PHONE NUMBER		
SOCIAL SECURITY NUMBER	DRIVER'S LICENSE NUMBER				
EMAIL ADDRESS	EMPLOYER				

EMERGENCY CONTACT

NAME	RELATIONSHIP	PHONE NUMBER
HOW DID YOU HEAR ABOUT US?		

AUTHORIZATION TO RELEASE INFORMATION, ASSIGMENTS OF BENEFITS, FINANCIAL AGREEMENT

I hereby authorize iSight Vision Care to furnish information to insurance carriers on my behalf concerning my illness, and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges not covered by my insurance benefits. A cancellation fee will be issued for no-shows and cancellations less than 24 hours in advance. A service charge will be issued for returned checks.

Patient's Signature:_____ Date: _____

Your Rights Regarding Medical Information About You:

With certain exceptions, you have the right to inspect and/or obtain a copy of your medical records via written request. Any additional copies of your records will be subject to a reasonable charge. You have the right to request an addendum or amendment to this agreement via written request.

By signing this form, you are agreeing that you have read and understand this notice.

Patient's Name: _____

Patient's Signature: _____ Date: _____

Guardian's Signature (if under 18 years old): _____ Date: _____

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PATIENT HEALTH HISTORY QUESTIONAIRE

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH
			/ /

DATE OF LAST EXAM	WERE YOUR PUPILS DILATED?	DO YOU WEAR GLASSES?	CONTACT LENSES? IF SO, WHAT TYPE?
/ /	☐ YES / ☐ NO	☐ YES / ☐ NO	☐ NO ☐ SOFT ☐ TORIC ☐ RGP

PATIENT EYE HISTORY

HAVE YOU EVER HAD ANY OF THE FOLLOWING? IF SO, PLEASE EXPLAIN BELOW.		
EYE OPERATIONS?	YES / NO	
EYE INJURIES?	YES / NO	
DRY EYES?	YES / NO	
CATARACTS?	YES / NO	
GLAUCOMA?	YES / NO	
MACULAR DEGENERATION?	YES / NO	
OTHER EYE PROBLEMS?	YES / NO	

FAMILY EYE HISTORY

HAS ANYONE IN YOUR FAMILY EVER HAD ANY OF THE FOLLOWING? IF SO, PLEASE EXPLAIN BELOW.		
HIGH BLOOD PRESSURE?	YES / NO	
DIABETES?	YES / NO	
CATARACTS?	YES / NO	
GLAUCOMA?	YES / NO	
MACULAR DEGENERATION?	YES / NO	
RETINAL DETACHMENT?	YES / NO	
OTHER EYE PROBLEMS?	YES / NO	

PATIENT MEDICAL HISTORY

HAVE YOU EVER HAD ANY OF THE FOLLOWING? IF SO, PLEASE EXPLAIN BELOW.		
IRREGULAR HEART RHYTHM?	YES / NO	
HIGH BLOOD PRESSURE?	YES / NO	
DIABETES?	YES / NO	
COPD?	YES / NO	
ASTHMA?	YES / NO	
URINARY INCONTINENCE?	YES / NO	
CANCER?	YES / NO	
ALLERGIES TO MEDICATION?	YES / NO	
ALLERGIES TO OTHER THINGS?	YES / NO	
OPERATIONS IN GENERAL?	YES / NO	

PLEASE CIRCLE

SMOKING	ALCOHOL	RECREATIONAL DRUGS
☐ NEVER SMOKED	☐ NEVER	◉ NO / ○ YES
☐ FORMER SMOKER	☐ SOCIALLY	IF YES, PLEASE LIST:
☐ SMOKES EVERYDAY	☐ 1 GLASS PER DAY	
☐ SMOKES SOME DAYS	☐ 1+GLASS PER DAY	

PLEASE LIST ANY MEDICATIONS YOU ARE TAKING

PATIENT'S SIGNATURE: _____ **DATE:** _____

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INSURANCE POLICIES

iSight Vision Care, Inc. is currently contracted to be *In-Network* with the following PPO Plans and 1 HMO plan.
Note: These plans are subject to change without notice

- AARP
- Aetna
- Blue Cross
- Blue Shield
- Cigna
- Health Net
- Humana
- Medicare
- Medi-Cal (Secondary to Medicare)
- Tricare/Triwest
- United Food Worker Union
- United Health Care
- HMO MemorialCare Medical Group

In-Network: This means that we accept and have agreed to a contracted rate assigned by the above health insurance plans for various covered services we provide in exchange for serving patients by such plans. These rates vary according to insurance policies. Some services are not considered medically necessary, including cosmetic services, and will not be covered by your insurance. If you have any questions, or are in doubt, please contact your insurance company.

Co-Pay/Co-insurance: Depending on your plan, you may or may not have a co-pay or co-insurance. Co-pays also vary between a PCP and a specialist; usually, a specialist's co-pay will be higher than a PCP. Your co-pay is a flat fee you pay at the time of service. **We will collect your co-pay before any services are rendered.** Occasionally, your plan will obligate you to pay a co-insurance, which is a certain percentage (generally, less than 20%) of allowed charges incurred which are not covered/paid by your plan, whether or not you have met your annual deductible.

Deductible: A deductible is the amount you must first pay for out of your own pocket for all medical services you receive during a given calendar year before your insurance will start covering. This is **NOT** the same as a co-pay. Sometimes, deductibles do not apply to office visits. A deductible can range anywhere from $350-$10,000, depending on your plan. Regardless of your deductible, it will be better for you to see a provider who is in-network, as this will decrease your out of pocket fees significantly. We will then submit a claim to your insurance so that you will get credit for these charges toward your remaining deductible balance. Once again, this varies between insurance policies. If you have any questions, please call your health plan to have further clarification.
Note: If you have not satisfied your annual deductible, we will collect the amount allowed by your insurance for the covered services we perform (i.e., the contracted rate). We will then submit a claim to your insurance so that you will get credit for these charges toward your remaining deductible balance.

Out-of-pocket Maximum: Your out-of-pocket maximum is not the same as your deductible. Generally, it is the total out-of-pocket limit **INCLUDING** deductible, co-pays, and co-insurances before the insurance will pay 100% of all covered services. Once again, this varies between insurance policies. If you have any questions, please call your health plan to have further clarification.
We are ***out-of-network*** for all other plans not listed. You can still be seen, but you will have to pay for all the charges incurred at the time of service with us determined by our fee schedule, **NOT** at contracted insurances rates which tends to be lower than cash market rates. We will be happy to provide you with an itemized list of coded diagnosis and charges which you can submit to your insurance to receive reimbursement for out-of-network services you have received. Please note that we do not guarantee that you will be reimbursed for the full amount of charges incurred. In fact, it varies depending on limitations and restrictions of your plan.

We understand that health insurance coverage is difficult and outright confusing to understand at times. We encourage you to ask questions. If we can be of any assistance, please ask. Once again, this is a very broad explanation of an insurance policy. However, for more specific answers to any of your questions, please call your insurance.

By signing this form, you have read and understand our policy.

Patient's Name: _____ Date: _____

Patient's Signature: _____