Welcome

Many insurers, including Medicare are mandating this or similar forms. We appreciate your cooperation!

Last Name _____ First Name _____ MI _____ Age _____ Birthdate _____

Who may we thank for referring you? _____

Personal Physician Name: _____ Physician Number: (___) _____

Do you have any medication allergies? Y N

Please list. _____

Are you taking any medications? Y N

Please list. _____

Have you had any serious eye disease, injuries, or surgeries? (Glaucoma, Cataract, etc.) Y N

Family History

Glaucoma? Y N

Macular Degeneration? Y N

Other (list) Y N

Do you smoke? Y N

Medical Problems not listed below:

Have you ever had any of the following diseases or medical problems?

Abnormal Bleeding	Y	N	Fainting Spells	Y	N	Sinus Problems	Y	N
Alcohol/Drug Abuse	Y	N	Frequent Headaches	Y	N	Stroke	Y	N
Alzheimers/Dementia	Y	N	Hay Fever	Y	N	Thyroid Problems	Y	N
Anemia	Y	N	Heart Attack (date____)	Y	N	Tuberculosis	Y	N
Arthritis	Y	N	Heart Murmur	Y	N	Ulcers	Y	N
Artificial Joints/Valves	Y	N	Heart Surgery (date____)	Y	N			
Arrhythmia	Y	N	Hepatitis	Y	N			
Asthma	Y	N	Herpes/Fever Blisters	Y	N			
Auto Immune Disease	Y	N	High Blood Pressure	Y	N			
Blood Transfusion	Y	N	HIV/AIDS	Y	N			
Cancer/Chemotherapy	Y	N	Kidney Problems	Y	N			
Colitis	Y	N	Liver Disease	Y	N			
Congential Heart Defect	Y	N	Low Blood Pressure	Y	N			
COPD	Y	N	Mitral Valve Prolapse	Y	N			
Defibrillator	Y	N	Pacemaker	Y	N			
Depression	Y	N	Psychiatric Issues	Y	N			
Diabetes	Y	N	Radiation Treatment	Y	N			
Difficulty Breathing	Y	N	Seizures	Y	N			
Elevated Cholesterol	Y	N	Shingles	Y	N			
Epilepsy	Y	N	Sickle Cell Disease	Y	N			

I attest the information I have given is correct to the best of my knowledge. I also understand this information is held in the strictest confidence and that it is my responsibility to notify this office of any changes.

_____

Patient Signature Date

Reviewed and Updated:

Patient Initials: _____ Date _____

Patient Initials: _____ Date _____

Patient Initials: _____ Date _____

Patient Initials: _____ Date _____

Patient Initials: _____ Date _____

PATIENT REGISTRATION – Des Peres Eye Center

Patient Name _____ Today's Date _____
Last First Middle

Home Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

E-mail address _____ Marital Status Single Married Divorced Widowed

Social Security Number _____ Date of Birth _____ Age _____ Gender M F

Employer/Parent's Employer _____ Occupation _____

Work Address _____ Work Phone _____

City _____ State _____ Zip Code _____

Spouse name (Parent name if minor) _____ Spouse/Parent Work Phone _____

Person to notify in case of emergency (other than spouse) _____

Phone number (s) _____ Relationship _____

Your Pharmacy Name, Address & Phone: _____

VISION Insurance: _____ **ID#:** _____ **Subscriber Name:** _____ **DOB:** _____

Primary Medical Insurance Company		
ID#	Group #	Effective Date
Subscriber Name		**Relationship to Patient**
Social Security Number	Date of Birth	Employer

Secondary Medical Insurance Company		
ID#	Group #	Effective Date
Subscriber Name		**Relationship to Patient**
Social Security Number	Date of Birth	Employer

I certify that all above information is true and accurate, and I authorize the release of any medical or other information necessary to file and process my insurance claims. I understand all medical information provided will be kept strictly confidential and will only be released to me or at the request of my insurance company.

_____ _____

Patient's signature **Today's date**

DES PERES EYE CENTER FINANCIAL POLICY

Updated January 1st, 2023

Our office participates with most major insurance plans. We provide **MEDICAL, SURGICAL and VISION** ophthalmologic care to our patients.

If you have a managed care plan that requires a referral to see a specialist, you must obtain a referral in order for your visit in our office to be covered under your medical insurance. If you do not have the valid referral and still wish to be seen, you will be asked to pay for the visit prior to your examination.

A refractive examination is not a covered service by most medical insurance companies, including Medicare. When you receive a refraction, you will be charged $50 which is payable at the time of visit. This also applies to the Contact Lens Check that is charged yearly to contact lens wearers.

BILLING**As Medical Doctors, we will bill your office visit to your Medical Insurance unless specified by the patient as ROUTINE ONLY with authorized Vision Insurance to apply.**

It is the patient's/parent's/guardian's responsibility to:

- Provide our office with accurate insurance information, including co-pays, co-insurance and deductibles.
- **You will be responsible for your office visit and any charges resulting from that visit if your insurance is inactive on your date of service or Des Peres Eye Center is out of network for your insurance plan.**
- Bring any required PCP referrals, if no referral is on file you will be responsible for the office visit charge.
- Provide our office with current information including address, phone number and employer.
- In accordance with your insurance contract, you must be prepared to pay your co-pay at each visit. If you do not make your co-payment at the time of the visit, you will be charged an additional **$5 billing fee**. We accept cash, checks and all major credit cards for services.

We appreciate prompt payment in full for any outstanding balance. If your account is turned over to our collection agency, you agree to pay any fees imposed by the collection agency in order to collect the overdue amount. Any check payments that do not clear the bank will be subjected to a **$25.00** returned check fee.

There will be a **$35.00** charge if you fail to show for any scheduled appointment. Any patient, who does not show up for a scheduled surgery, will be charged a cancellation fee of **$250.00**. Legitimate emergencies will be taken into consideration.

I agree to permit Des Peres Eye Center and their business associates to contact me, and all other responsible parties on my account, on our cell phone or other mobile devices concerning any and all aspects of my account.

I have read and understand the Des Peres Eye Center financial policy updated 01/01/2023.

_____ _____

Signature of patient/guardian/parent Date

It is Des Peres Eye Center's ongoing mission to give our patients the finest care possible. We apologize for any inconvenience these changes cause. If you have questions regarding the new fee structure, please call us.

Sincerely, Drs. David Brigham, Eric Chiu, Ethan Crider and Kirk Morey

BILLING INFORMATION FOR TODAY'S VISIT

VISION insurance is intended to provide you with a baseline eye evaluation. It will only cover what is considered a **ROUTINE** eye exam one time a year. Insurance companies define a "routine" or "annual" vision examination as an office visit for the purpose of checking vision, screening for disease, and/or updating eyeglass or contact lens prescriptions (INCLUDING REFRACTION). Medical testing is NOT covered.

*** If you are a **CONTACT LENS WEARER**, there is a separate charge of **$40** to examine your contacts on your eyes and update the annual prescription. SOME Vision insurance plans offer discounts for a contact lens exam. This exam is NEVER covered with any Medical insurance.

MEDICAL insurance can be applied to medical exams. These exams include but are not limited to: corneal disorders, such as dry eye; diabetes; cataracts; glaucoma/ glaucoma suspect; double vision; infections, pain etc. **If any extra testing is involved with your exam, we must use medical insurance.** Some medical insurance requires a referral from your Primary Care Doctor; It is your responsibility to obtain referrals for your visit if required. Deductibles, copays and coinsurance may be due once insurance is billed.

CLAIMS ARE FILED DAILY AND WILL NOT BE CHANGED AFTER THE APPOINTMENT

Patient Name: _____ **Date of Visit:** _____

PLEASE INITIAL 1 LINE ONLY

I am here for a ROUTINE VISION EXAM (USING VISION INSURANCE) _____ (Initial)

Please note: if you discuss any medical findings with your doctor or set up surgery at todays' appointment, we will change your visit to be billed medically, or ask you to return for a medical visit at a later date.

I am here for my ANNUAL EXAM (USING MEDICAL INSURANCE) _____ (Initial)

I am here for a MEDICAL EXAM OR PROBLEM (USING MEDICAL INSURANCE) _____(Initial)

My insurance is NOT IN-Network &/OR Accepted at Des Peres Eye Center.
I am SELF PAY TODAY_____ (Initial)

DES PERES EYE CENTER

ACKNOWLEDGMENT OF PRIVACY PRACTICES AND HIPAA DISCLOSURE AUTHORIZATION

Receipt of Notice of Privacy Practices:

_____ *(Initial)* I acknowledge I have received or I have been provided the opportunity to receive a copy of Des Peres Eye Center's (DEC) Notice of Privacy Practices that explains when, where and why my protected health information may be used or shared by DEC.

HIPAA Disclosure Authorization(s):

_____ *(Initial)* I authorize DEC to leave a message on my voicemail &/or other electronic means at the following number(s):

_____

_____ *(Initial)* I authorize DEC to provide the following person(s) with my protected health information:

Print Name:_____ Relationship to Patient_____ #_____

Print Name:_____ Relationship to Patient_____ #_____

Print Name:_____ Relationship to Patient_____ #_____

_____ *(Initial)* I DO NOT authorize DEC to disclose my protected health information to anyone other than myself, except as permitted by HIPAA as described in DEC's Notice of Privacy Practices.

I understand the HIPAA Disclosure Authorization(s) above may be revoked in writing at any time; however, the revocation will not affect disclosures of information previously authorized.

SIGNATURE REQUIRED ON BACK SIDE OF FORM

INFORMED CONSENT FOR TELEMEDICINE SERVICES

Telemedicine involves the use of electronic communications (phone, computer, etc) to enable health care providers to share medical information with a patient.

EXPECTED BENEFITS:

- Improved access to medical care by enabling a patient to remain in his/her location while the healthcare provider provides medical information at a distant site.
- Limiting the spread of COVID-19 and other communicable diseases.
- Ability to obtain consultation from a distant medical specialist without traveling.
- Allow medial evaluation and management of patients who are unable to travel.

POSSIBLE RISKS: As with any medical procedure, there are risks associated with the use of telemedicine. These risks include, but not limited to:

- Information transmitted may not be sufficient to allow for appropriate medical decision making by the health care provider. For instance, certain parameters of the eye exam cannot be tested remotely, such as eye pressure. In addition, there could be poor resolution of images. This could cause delay in evaluation and treatment.
- Security protocols could fail, causing a breach of privacy of personal medical information.
- A lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other medical errors.

CONSENT:

- You have read this informed consent form, or someone has read it to you.
- You understand the information in the informed consent and all of your questions have been answered.
- You have been offered a copy of this informed consent form.

NAME OF PATIENT _____ DATE OF BIRTH_____

Signature of Patient (OR person authorized to sign for patient): _____
If Authorized signer, relationship to patient: _____

DATE _____