Karns Vision

Welcome to our office! It is our pleasure to serve you! **Date____/____/____**

Name: Last_____First_____M.I.___Preferred_____
Address:_____**Zip Code** _____
Birthdate:____/____/____**Age:** **Marital status:** Single Mar Div Wid **Sex:** Male Female
Home Phone:_____**Cell Phone**_____**Work Phone** _____
Email address_____**@**_____**SS#** _____
Employer_____**Occupation**_____**Retired?** Yes No
How long ago was your last eye exam? 1 year 2 years longer **Were your eyes dilated?** Yes No
Do you get regular physical examinations from your primary care doctor? Yes No
Name of primary care doctor:_____Primary Care Phone # _____
Name of pharmacy:_____Pharmacy Phone # _____

For children under 18: Name of parents: _____

How did you hear about our office? (Please circle)
Friend/Family Healthcare Provider Google/online Insurance Company Social Media

To whom may we disclose your protected health information – Please choose one of the following (not both)

_____I do not want my information released to anyone other than myself, including my spouse.
_____You may speak with____my spouse,____my parent(s),____person(s) listed below
_____
regarding my medical conditions, treatment and billing.

Emergency Contact:

Name:_____**Relationship to Patient:**_____**Phone:** _____

Eyeglass History

Do you currently wear glasses? Yes No Full time Distance only Near only Computer
Are you interested in new glasses today? Yes No
Do you use a computer frequently? Yes No **Do you have problems with night vision?** Yes No

Contact Lens History

Do you currently wear contacts? Yes No **Have you ever tried to wear contacts before?** Yes or No
Would you like to be fit with contacts today? Yes No
Fitting fees are: *Standard/Established $80* *New/Multifocal $110* *RGP/Specialty $150+*
(Any contact lens prescription given requires a yearly fitting/evaluation fee.)

Do you have a back-up pair of glasses in your current Rx? Yes No
What type or brand of contact lenses do you wear now? _____
Do you sleep in your contact lenses? Yes No

Karns Vision

Medical History **Name: _____** **Date: _____/_____/_____**

Eye History: Do you suffer from any of the following?

Distance vision blur	Yes No	Seeing flashes?	Yes No	Dry eyes?	Yes No
Near vision blur	Yes No	Distorted vision?	Yes No	Itching?	Yes No
Intermediate blur	Yes No	Glare/light sensitivity?	Yes No	Red eyes?	Yes No
Double vision	Yes No	Loss of side vision?	Yes No	Eye Pain?	Yes No
Headaches	Yes No	Seeing flashes?	Yes No	Mucous discharge?	Yes No

Review of Physical Symptoms:

Do you currently have any of the following problems?

Immune problems (frequent infections, allergic reactions to food, dust, etc.)…….. Yes No
Heart problems (Chest pain, irregular heartbeat, swelling of feet)…… Yes No
Chronic fever, unexpected weight loss/gain, fatigue……. Yes No
Ear/Nose/Throat problems (hearing loss, sinus problems, sore throat)…….. Yes No
Endocrine problems (frequent urination, thirst, feeling hot or cold all the time)…….. Yes No
Gastrointestinal problems (heartburn, abdominal pain, diarrhea, vomiting)……. Yes No
Genitourinary problems (painful urination, blood in urine, sex organ problems)……. Yes No
Blood/lymph problems (bruising, weakness, unusual paleness, swollen glands)……. Yes No
Skin problems (rashes, excessive dryness, growths, or lumps)……. Yes No
Musculoskeletal problems (muscle/joint aches, swollen joints)…… Yes No
Neurological problems (numbness, weakness, headaches, "blackout")…… Yes No
Psychiatric problems (depression, anxiety)…….. Yes No
Respiratory problems (shortness of breath, wheezing, coughing)…… ……. Yes No

Have you ever been treated for any medical conditions? (Examples: diabetes, high blood pressure, thyroid, high cholesterol, arthritis, etc.) **Yes No** If **Yes**, please list: _____

Have you ever had any eye disease? (Examples: glaucoma, cataract, retina detachment, lazy eye, etc.) **Yes No**
If **Yes**, please list: _____

Have you ever had surgery or been hospitalized? Yes No
If **Yes,** please list surgeries or reason for hospitalization: _____
Please list all medications that you take, both prescribed and "over the counter."

_____

Do you have any food or drug allergies? Yes No
Please list allergies to medications:_____
Family History: Do any **Medical Eye Diseases** run in your family? (Blood Relatives) (Ex. Diabetes, High blood pressure, cancer, glaucoma, macular degeneration? **Yes No** If **Yes,** specify:_____

_____

Social History (Required by most insurance companies. Will be kept strictly confidential.)
Do you drink **alcohol? Yes No** Amount/frequency_____
Do you **smoke? Yes No** _____packs/day Do you engage in **recreational drug use? Yes No**

Acknowledgement of Receipt of Privacy Practices (HIPAA)

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The Notice of Privacy Practices you have been given describes these uses and disclosures in detail.
I acknowledge that I have received the notice of Privacy Practices for Karns Vision Center.

_____ _____

Patient Signature (guardian if under 18) Date

I acknowledge that I have been informed of the Notice of Privacy Practices and have elected to NOT receive a copy.

_____ _____

Patient Signature (guardian if under 18) Date

About Your Insurance

There are two types of health insurance that will help pay for your eye care services and products. You may have both and our practice accepts both:

1. **Vision care plans (such as VSP and EyeMed)** 2. **Medical Insurance (such as BCBS and Medicare)**
    - Vision care plans ONLY cover routine vision exams and may cover some materials (such as glassesor contacts). Vision plans only cover a basic screening for eye disease. They do not cover diagnosis, management or treatment of eye diseases.
    - Medical insurance must be used if you have any eye health problem or systemic health problem that has ocular complications. Your doctor will determine if these conditions apply to you, but some are determined by your case history.
    - If you have both types of insurance plans it may be necessary for us to bill some services to one plan and other services to the other. We will use coordination of benefits to do this properly andto minimize your out-of-pocket expense.
    - We will bill your insurance plan for services if we are a participating provider for that plan. We will try to obtain advanced authorization of your insurance benefits so we can tell you what is covered. If some fees are not paid by your plan, we may bill you for any unpaid deductibles, co-pays or non-covered services as allowed by the insurance contract.

I have read and agree with these policies.

_____ _____

Patient Signature (guardian if under 18) Date

Insurance Signature on File

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and /or Medicare benefits and I authorize payment of these benefits directly to Presson Eye Care, PLLC, on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in item 9 of the CMS-1500 Claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer oragency shown, and authorizes my doctor to act as my agent, as above.

_____ _____

Patient Signature (guardian if under 18) Date

Financial Policy

Initials:_____

If you have medical or vision insurance, our goal is to help you achieve the maximum benefits due to you. To achieve this goal, we need your assistance and understanding regarding our payment policy. Payment is due at the time of service. We accept cash, check, Visa, MasterCard, Discover, American Express & Care Credit. If your insurance is one with which we participate, we will file your insurance for you. You are, however, expected to pay your percentage due, co-payment or any deductible you have not met at the time of service. We will try to answer any questions regarding your insurance but understanding your own insurance benefits is ultimately your responsibility. Please, realize that, as medical providers, our relationship is with you, not your insurance company. All charges are your responsibility. If you receive a response from your insurance company showing no payment, please contact us promptly for assistance in the management of your account.

*** It is your responsibility to provide us with your vision or medical insurance information **BEFORE** services are rendered. We cannot be responsible for retrieving your private insurance information (including available benefits and copayments) without your consent and direction.*

What is the name of your vision insurance: _____

Practice Culture and Patient Responsibilities

Initials:_____

Karns Vision Center works to cultivate and adhere to a culture of inclusion and respect. We want you to be happy with the services and products that we provide. If ever your expectations are not met, we would like to address your concerns in a manner that is courteous and respectful to both parties. We reserve the right to refuse service or dismiss any patient who is disrespectful or hostile to our staff members. Karns Vision Center is thankful for your trust and choosing us to take care of you and your family.

_____ _____

Signature of Patient or Legal Representative **Today's Date**

Policy on Minors

Initials:_____

If you are the parent or legal guardian of a child under the age of 18, please read carefully as our policy has changed in the treatment of minors. All patients under the age of 18 must be accompanied by a parent or guardian for their first visit. If your minor child is being brought in the office by someone other than a parent or guardian, you will need to sign on behalf of the minor and state your relationship to them. If your child is of legal driving age, they may bring themselves in for routine appointments after this initial visit. Should any incident or abnormal finding happen during the exam, the parent or legal guardian will be contacted immediately by the doctor.

Minor Patients: In addition to the mother, father, or legal guardian, the following individuals may authorize treatment for my minor child. Please include the name and relationship of each person listed.

1. _____
2. _____