It is important that you are aware of your insurance and vision plan benefits and how they apply to your visit. We have prepared this sheet to help you understand how your visit is submitted to your health insurance plan and/or vision plan (VSP) for your visit. **If you have any questions about your coverage at our office, you should contact your plan directly to view your benefits. You are responsible for any fees incurred at our office that your vision plan or insurance plan does not cover.**

VISION PLANS vs MEDICAL INSURANCE

If you are using a vision/discount plan (VSP) for your visit, be aware that your vision plan will cover an eye exam for glasses and an eye health screening ONLY. **If Dr. Regier-Hermon finds a medical problem with your eyes during the visit, your vision plan may not cover the visit, and your medical benefits will apply.**

PREVENTATIVE EYE CARE vs MEDICAL EYE CARE

Benefits and fees will vary based upon the reason for your visit. **Most insurance plans have different benefits for "ROUTINE EXAMS" vs "MEDICAL EXAMS"**

ROUTINE EYE EXAMS: Your vision plan covers "routine care" only. Your plan defines "routine care" as a comprehensive eye exam when you do not have any medical condition(s) affecting your eyes. Dr. Regier-Hermon will perform a thorough exam from updating your glasses prescription to performing an eye health exam. Contact lens services may have additional fees.
MEDICAL EYE EXAMS: Annual comprehensive eye exams that result in a medical diagnosis, or visits outside of the annual exam to monitor/evaluate/treat medical conditions related to the eye will result in a claim being sent to your medical insurance.

Examples that will necessitate your visit being submitted as a medical exam might include:

+ Annual diabetic eye exam*
+ Referrals from outside physicians
+ Use of high risk medication (Plaquenil, steroids, etc)
+ Complications related to contact lens wear
+ Macular degeneration
+ Visits that result in a prescription for medication
+ Glaucoma
+ Eye irritation (red eyes)
+ Eye muscle imbalance
+ Dryness or itchy eyes
+ Allergies
+ Floaters and/or Flashes of light

* Please note that if you have diabetes, and you would like us to send a letter to you primary care physician regarding your eye exam, the visit must be coded as a "medical eye exam" and a claim will be sent to your medical plan.

The findings during the visit will determine which insurance benefit will be used. If Dr. Regier-Hermon determines that the visit relates to a medical problem, your visit may be billed as a medical exam instead of a routine exam, which will be subject to co-pays and deductibles according to your medical insurance plan. We will submit a separate claim to your vision plan for the refraction (evaluation for glasses prescription) when applicable. **If you have preferences in how your insurance or vision plan are billed that are different than our above stated policies, it is your responsibility to inform us of this prior to your appointment. You will then be responsible for paying for all services out of pocket at the time of service and we will supply you with itemized receipts so that you may submit to your insurance or vision plan directly for reimbursement.**

_____ _____ _____

PRINT NAME SIGNATURE DATE

_____ _____ _____ _____ □Male □Female
First Name MI Last Name Preferred Name

_____
Street Address City State Zip

_____ _____-_____-_____ _____
Date of Birth Social Security Number Person Responsible for Account

_____**Home/Work/Cell** _____**Home/Work/Cell** Preferred
Phone # Alternate Phone #

Email Address*_____ How did you hear about our office?_____
*By providing your e-mail address, you are authorizing us to communicate with you by e-mail. We must remind you that e-mail communications, particularly those over the internet, are inherently unsecure. So, we cannot assure the confidentiality of information communicated by e-mail.

PRIMARY MEDICAL INSURANCE INFORMATION

_____ _____
Name of Insurance Company Primary Insured's Name □M □F

_____ _____ _____
Insured's I.D. Number Group Number Insured's DOB

Patient Relationship to Insured
□Self □Spouse □Child □Other

Patient Status □Single □Married □Other
□Employed □Full-Time Student □Part-Time Student □Other

PRIMARY VISION INSURANCE INFORMATION

_____ _____
Name of Insurance Company Primary Insured's Name □M □F

_____ _____ _____
Insured's I.D. Number Group Number Insured's DOB

OUR INSURANCE AND BILLING POLICY:
In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than raise our fees. As a courtesy, we will gladly file claims with your insurance company. We will do our best to determine your benefits prior to your visit; however, this is not a guarantee of benefits. The undersigned will ultimately be responsible for any amounts that your insurance does not cover. Accounts 30 days old are subject to late fees. There will be a service charge on all returned checks.

Payment from my insurance is to be paid directly to Kearney EyeCare, PC or Kelli M. Regier-Hermon, OD, PA. I authorize the release of any medical or other information necessary to process this claim. I agree to pay any non-covered charges and co-pays as instructed by my insurance company.

_____ _____
Signature of Patient or Guardian Date Signed

PATIENT HISTORY AND INFORMATION

_____

Primary Care/Referring Physician and Clinic Name Phone Number

What is the main reason for today's exam? _____

YOUR MEDICAL HISTORY Please circle any conditions you have or mark NONE if applicable.

		NONE
Constitutional	Cancer Fatigue Syndrome Development Disabilities Other:	
Ear, Nose, Throat	Laryngitis Sinusitis Dry Mouth Hearing Loss Other:	
Neurological	Cerebral Palsy Migraine Multiple Sclerosis Epilepsy Other:	
Psychiatric	Bipolar Disorder Anxiety Disorder Depression Attention Deficit Other:	
Cardiovascular	Stroke Vascular Disease Congestive Heart Failure High Blood Pressure Heart Disease Other:	
Respiratory	COPD Asthma Emphysema Bronchitis Sleep Apnea Other:	
Gastrointestinal	Acid Reflux Crohn's Disease Ulcer Celiac Disease Colitis Other:	
Kidney/Bladder	STD Kidney Disease Prostate Disease Other:	
Females Only	Are you pregnant? Nursing?	
Muscle, Bones, Joints	Fibromyalgia Gout Arthritis Muscular Dystrophy Ankylosing Spondylitis Other:	
Skin	Eczema Shingles Psoriasis Cold Sores Rosacea Other:	
Endocrine	Diabetes Thyroid Dysfunction Other:	
Blood/Lymph	High Cholesterol Anemia Leukemia Other:	
Allergy/Immunologic	Rheumatoid Arthritis Sjogren's Syndrome Lupus Drug Allergies Environmental Allergies Other:	

Current Medications:_____

_____ Current Eye Drops:_____

Do you have any allergies to medications? **YES** **NO** If YES, list the meds:_____

Do you drink alcohol? □None □Occasional □1 Per Day □2-3/day □4+/day

Do you smoke? □None □Occasional □1/2 pack/day □1 pack/day □1+pack/day

Have you ever been a regular smoker? YES NO

YOUR EYE HISTORY Please check any eye conditions you have had or currently have.

□Dry Eye □Amblyopia (Lazy Eye) □Retinal Hole □Inflammatory Disorder
□Keratoconus □ Injury_____ □Cataract □Glaucoma Suspect
□Glaucoma □Nystagmus □Surgery_____ □ Eye patching
□Strabismus (Eye Turn) □Retinal Detachment □ Retinal Degeneration □Macular Degeneration
□Other_____

FAMILY HISTORY Please list immediate family members (Mother, Father, Grandparent, Sibling) who have or have had any of the following:

Thyroid Disease_____	Lazy Eye_____	Glaucoma_____
High Blood Pressure_____	Dry Eye_____	Severe Far-sighted_____
Diabetes_____	Glaucoma Suspect_____	Cataract_____
Cancer_____	Eye Turn_____	Severe Near-sighted_____
Macular Degeneration_____	Nystagmus_____	Retinal Detachment_____

Other_____

YOUR SOCIAL HISTORY
Current Occupation_____Employer_____

SPECTACLE LENS HISTORY
Do you currently wear glasses? YES NO If no, have you ever worn glasses? YES NO

Glasses Owned □Single Vision □Bifocals □Trifocals □Progressive □Back-up □Safety □Sports

Have you had trouble in the past with glasses? YES NO _____

CONTACT LENS HISTORY Have you ever tried contact lenses? YES NO

Reason for stopping_____ Do you currently wear contact lenses? YES NO

If not a contact lens wearer, are you interested in trying contact lenses at the time? YES NO

Brand of contact lenses you currently/most recently wore_____

Are these lenses comfortable? YES SOMETIMES NO

Do you see well with these lenses? YES SOMETIMES NO

How many hours each day do you usually wear your contact lenses? _____

How many days do you usually wear each pair of contact lenses before you throw them away?_____

How many nights each week do you sleep in your contact lenses?_____

What solution do you use to clean your contacts lenses?_____

_____ _____

Name of Patient (Printed) Date of Birth

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The law requires that Kearney EyeCare make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

☐ I have read or had explained to me Kearney EyeCare's Notice of Privacy Practice and agree to continue my care with Kearney EyeCare under said terms.

☐ I have read or had explained to me Kearney EyeCare's Notice of Privacy Practice and do not wish to continue my care with Kearney EyeCare under said terms.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____

Signature of Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship

_____ _____

Representative Relationship to Patient

CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATION

I, _____, hereby authorize representatives of Kearney EyeCare, to release
Print Patient's Name

protected health information regarding me or my condition/treatment to:

_____ my _____

Print Name of Representative Relationship to Patient

_____ my _____

Print Name of Representative Relationship to Patient

_____ my _____

Print Name of Representative Relationship to Patient

_____ _____

Signature of Patient (or Representative of Patient) Date

Please note that if circumstances change and you no longer consent for your protected health information to be released to any of the above named representatives that it is your responsibility to notify us of these changes in writing.