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.

ARE YOU CURRENTLY RESIDING IN A SKILLED NURSING FACILITY: _____YES _____NO

_____ _____

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

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.

_____

_____

_____

_____

_____

_____

_____

_____

_____

Are you taking birth control pills? Y N

Have you had any serious eye disease, injuries, or surgeries? Y N

_____

_____

_____

_____

_____

Does glaucoma run in your family? Y N

Does macular degeneration run in your family? Y N

Other family history of eye disease? Y N

If yes, please discuss

_____

_____

Do you smoke? Y N

Do you wear contacts? Y N

Do you wear glasses? Y N

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

Abnormal Bleeding	Y	N	Glaucoma	Y	N	Sinus Problems	Y	N
Alcohol/Drug Abuse	Y	N	Hay Fever	Y	N	Stroke	Y	N
Anemia	Y	N	Heart Attack	Y	N	Thyroid Problems	Y	N
Arthritis	Y	N	Heart Murmur	Y	N	Tuberculosis	Y	N
Artificial Joints/Valves	Y	N	Heart Surgery	Y	N	Ulcers	Y	N
Arhythmia	Y	N	Hepatitis	Y	N			
Asthma	Y	N	Herpes/Fever Blisters	Y	N			
Blood Transfusion	Y	N	High Blood Pressure	Y	N			
Cancer/Chemotherapy	Y	N	HIV/AIDS	Y	N			
Colitis	Y	N	Kidney Problems	Y	N			
Congential Heart Defect	Y	N	Liver Disease	Y	N			
Depression	Y	N	Low Blood Pressure	Y	N			
Diabetes	Y	N	Mitral Valve Prolapse	Y	N			
Difficulty Breathing	Y	N	Pacemaker	Y	N			
Elevated Cholesterol	Y	N	Psychiatric Problems	Y	N			
Emphysema	Y	N	Radiation Treatment	Y	N			
Epilepsy	Y	N	Seizures	Y	N			
Fainting Spells	Y	N	Shingles	Y	N			
Frequent Headaches	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 _____

DES PERES EYE CENTER FINANCIAL POLICY

Updated August 01, 2015

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. If you receive a refraction, you will be charged $40 which is payable at the time of visit. This also applies to the Contact Lens Check that is charged yearly to contact lens wearers.**

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 dated 8/01/2015.

_____ _____

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 at 314-432-6137.

Sincerely, Drs. George Bohigian, David Brigham, Eric Chiu and Kirk Morey

DES PERES EYE CENTER

MEDICAL vs. VISION EXAM

Patient Name: _____ Date of Visit: _____

Who is paying for this office visit?

MEDICAL INSURANCE_____VISION INSURANCE_____
I HAVE NO INSURANCE, I WILL BE PAYING OUT OF POCKET FOR ALL EXPENSES _____

For Patients with **BOTH** Medical and Vision Coverage:

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.**

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, 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.

*** If you are a **CONTACT LENS WEARER**, there is a separate charge of **$30** 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.

_____ _____ _____

Patient or Guardian Signature Date Relationship if not signed by Patient

Thank you for trusting your eye health to us, Des Peres Eye Center

CLAIMS ARE FILED DAILY SO INSURANCE CAN NOT BE CHANGED AFTER THE APPOINTMENT

************************************FOR STAFF USE ONLY************************************

If the Doctor decides the patient needs medical testing, they have the option to:

RESCHEDULE for testing _____ OR CHANGE TO MEDICAL _____ TECH INITIAL _____ PATIENT INITIAL_____

REFERRAL OBTAINED FOR MEDICAL VISIT: YES_____ NO_____

Updated: 08/10/2015

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 and or text 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 of Patient Relationship to Patient Date