MAYER EYE CARE

WELCOME TO OUR OFFICE

PAYMENT REQUESTED AT TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

PATIENT INFORMATION:

PATIENT FULL LEGAL NAME:_____CELL PHONE: ( )_____

ADDRESS:_____ALT. PHONE: ( )_____

CITY/STATE:_____ZIP CODE:_____

SOCIAL SEC #:_____ SEX: M F DATE OF BIRTH:_____

MARITAL STATUS: S M D W AGE:_____ EMAIL ADDRESS:_____

EMPLOYER:_____ OCCUPATION;_____

HOW DID YOU HEAR ABOUT US OR WHO REFERRED YOU?_____

PRIMARY CARE PHYSICIAN: _____PHARMACY:_____

EMERGENCY/HIPAA CONTACT:_____PHONE: ( )_____

RELATION TO PATIENT:_____

RESPONSIBLE PARTY/INSURED/MOTHER OR FATHER IF MINOR

NAME OF PERSON RESPONSIBLE FOR BILL:_____RELATIONSHIP:_____

ADDRESS (IF DIFFERENT FROM PT):_____

PHONE:( ) _____ SOC SEC#_____DOB:_____

EMPLOYER:_____PHONE:( )_____

PRIMARY MEDICAL INSURANCE:_____ID #_____GROUP#_____

SECONDARY MEDICAL INSURANCE:_____ID#_____GROUP#_____

ROUTINE VISION INSURANCE:_____ID#_____

PAYMENT FOR SERVICES: AT **CHECK-IN,** we collect our best estimate of amount due. Fees for additional tests ordered will be collected at **CHECK-OUT.**

We participate with most insurance plans and adjust our fees to the “allowable”. It is impossible for us to always know what your insurance will pay,. Once your claim is processed, we send a bill for the remaining balance or refund for credit.

By signing below, you attest you have provided accurate information to the best of your knowledge and agree to the terms of service.

Signature of Patient/Guardian: _____Date:_____

Signature of Responsible Party:_____Date:_____

MAYER EYE CARE

Patient Name:_____ **Date**_____

MEDICAL AND OCULAR HISTORY

Reason for visit:_____

Any other eye/vision problems:_____

Have you EVER been diagnosed with any of the following? (Circle all that apply) NONE

Alzheimer's	CVA-Stroke	Heart Failure (CHF)	Rheumatoid Arthritis
Anxiety	Dementia	High Cholesterol	Rosacea
Arthritis	Emphysema/COPD	HIV/AIDS	Sleep Apnea/CPAP
Asthma	Epilepsy/Seizures	Kidney Disease/Dialysis	Tuberculosis
Bipolar Disorder	Headaches/migraine	Lupus	Thyroid-Hyper(high)/Hypo(low)
Bronchitis-chronic	Heart Disease/Attack	Mulitiple Sclerosis	Vertigo

Cancer:_____ Other:_____

HYPERTENSION? YES NO Last BP:_____ **DIABETES? YES NO Date Diagnosed:**_____

IF YES, CIRCLE ALL THAT APPLY: TYPE1 TYPE 2 On Insulin Diet Controlled Neuropathy Kidney damage Retinopathy/Retina Surgery Other:_____

LAST A1C:_____ **Date:**_____ **LAST BS:**_____ **Date:**_____

FAMILY HISTORY:

PLEASE CIRCLE IF ANY OF THE FOLLOWING APPLY:

MOTHER	CANCER	DIABETES	CATARACTS	GLAUCOMA	MACULAR DEGEN (ARMD)	CORNEA DISEASE	RETINA ISSUES	NONE
FATHER	CANCER	DIABETES	CATARACTS	GLAUCOMA	MACULAR DEGEN (ARMD)	CORNEA DISEASE	RETINA ISSUES	NONE
SIBLING	CANCER	DIABETES	CATARACTS	GLAUCOMA	MACULAR DEGEN (ARMD)	CORNEA DISEASE	RETINA ISSUES	NONE
CHILD	CANCER	DIABETES	CATARACTS	GLAUCOMA	MACULAR DEGEN (ARMD)	CORNEA DISEASE	RETINA ISSUES	NONE

YOUR EYE HISTORY:

CIRCLE ALL THAT APPY:

EYE INJURY	CATARACTS	FUCHS	KERATICONUS	GLAUCOMA	LAZY EYE	RETINA ISSUES	DRY EYES	MACULAR DEGEN	NONE

ANY EYE SURGERIES: _____

MAJOR SURGERIES OR RECENT HOSPITALIZATIONS: _____

MEDICATIONS YOU TAKE: _____

HAVE YOU EVER TAKEN:

ACCUTANE	PREDISONE	PLAQUENIL (STEROIDS)	ISONIAZID	ETHAMBUTOL	BLOOD THINNERS	FLOMAX	TAMOXIFEN	ELMIRON

DRUG ALLERGIES:

SULFA	PENICILLIN	PHENYLEPHRINE	TETRACAINE	NONE	OTHER:

SOCIAL HISTORY:

SMOKE: CURRENT FORMER NEVER **ALCOHOL:** SOCIAL ALCOHOLIC NEVER

RECREATIONAL DRUGS: CURRENT FORMER NEVER

DO YOU CURRENTLY WEAR GLASSES: YES NO IF YES: FULL TIME PART TIME

DO YOU WEAR CONTACT LENSES: YES NO IF YES: EVERY DAY PART TIME OVERNIGHT

ARE YOU INTERESTED IN CONTACT LENSES? YES NO

MAYER EYE CARE

Patient Name:_____ Date_____

Consent to Discuss Your Protected Health Info (PHI)

We need permission to speak to anyone about your eye care *other* than a referring or co-managing provider.

PHI= personal information that identifies you with your medical history, treatments, medications, STDs/HIV/AIDS, mental health, drug use, visual disability...

MAYER EYE CARE (MEC) will never share your PHI without your permission and will refer to this form if anyone wants to discuss your appointments or treatment plan. You can update/sign a new form anytime.

I give permission for MEC to VERBALLY DISCUSS MY CARE and PHI with my other physicians AND with:

____**NO ONE**(only myself) _____ **Person(s)** listed below
Initial if NO ONE *Initial* if you consent to share.

_____

_____

Name, Phone, Relation (only if you allow us to discuss care.

Consent to Dilate Your Eyes

Eyedrops are used for a dilated medical eye exam in addition to imaging technology to view your retina.
SIDE EFFECTS: *blurred vision* (mostly near vision), light *sensitivity.* Less common: headache, nausea, dizziness.
DURATION: 4-6 hours (in most cases)

DRIVER: Secure a driver if you are unsure how the drops affect you. Temporary **Sunglasses** are available.

UNCOMMON REACTIONS: Hives, itchy or puffy eyelids, difficulty breathing- If you are allergic to *PHENYLEPHRINE (Sudafed)-inform us BEFORE drops are instilled.*

RARE REACTIONS: *"Acute Angle-Closure Glaucoma"*- **severe** headache, nausea/vomiting. Contact us ASAP if severe symptoms develop.

Please *Initial* the line that applies:

_____ I **CONSENT** *to be dilated, I have read above and agree to arrange for a driver if necessary.*
_____ I **DECLINE** *dilation, I understand that this will not be a comprehensive eye exam.*

HIPPAA Consent & Notice to Privacy Practices (NPP)

Please review our full NPP which describes MEC may use or disclose your PHI while providing your care and billing for services. Any changes to our NPP will be made available.

- ✔ You have the right to review this Notice before signing.
- ✔ You have the right to request the usage/disclosure of your PHI be restricted while MEC is providing treatment, health care operations, and billing for services.
- ✔ You have the right to withdraw this consent at any time in writing (effective from that date forward)

If you refuse to consent or request limited use of PHI, MEC may refuse to provide treatment, other than required emergency services. This consent remains in effect unless and until you withdraw it in writing.

_____I have reviewed the NPP and understand my HIPAA *initial* rights. I have been offered a copy of MEC's NPP.

Cancellation and No-Show Policy

GOAL: Our staff is always focused on quality eye care while improving efficiency to minimize patient wait times.

Your appointment will be considered a ***"NO SHOW"*** if:

1. You miss your appt without **CALLING.**
2. You **CANCEL with LESS than 24 hour notice.**
3. You arrive more than **15 minutes late** – out of respect for other patients, we may need to reschedule if you arrive late.

PATIENTS WHO "NO SHOW' 3 TIMES IN 12 MONTHS:

- **$50 fee -**this non-refundable fee must be paid **IN FULL** *BEFORE* scheduling again. (Medicaid exceptions may apply).

_____ *I have read above and will arrive on time or give initial at least 24 hour notice to rescedule.*

CONSENT TO TREAT: I agree to receive medical eye care and treatment by Dr. Mayer and staff of MEC. I consent to the examinations and tests ordered by my physician. I understand there are no guarantees in medical care, and it is my responsibility to comply with my treatment plan and to report any new symptoms or complications.

_____*Initial*

FINANCIAL AGREEMENT: I agree to pay for all services rendered that are not covered by my insurance. *If I am insured,* I authorize my insurance payment to be made directly to MEC and authorize release of any part of my medical records (including PHI that may be sensitive) to contracted agenTs of my insurance company and MEC as needed to process claims. If this form is not signed, I will be responsible for all charges before services are rendered.

_____*Initial*

_____ _____ _____

Printed name of Patient/Guardian **Signature of Patient/Guardian** **Date**