Meriden Eye Care
816 Broad Street, Suite 13
Meriden, CT 06450
(P) 203.237.2020

PATIENT REGISTRATION

Date: _____

Patient's Name: (Last) _____ (First)_____

Home Address: _____ City _____ State _____ Zip _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____ May we call you at work? Yes ☐ No ☐

Date of Birth: _____ Sex: M / F / Other SS # _____

Occupation: _____ Employer: _____

INSURANCE INFORMATION

PRIMARY Insurance: _____ ID: _____ Group #: _____

Policy Holder: Self ☐ Spouse ☐ Parent ☐ Policy Holder's SS #: _____

Policy Holder's Name (if other than self): _____

Policy Holder's date of birth: _____

SECONDARY Insurance: _____ ID: _____ Group #:_____

Policy Holder: Self ☐ Spouse ☐ Parent ☐ Policy Holder's SS #: _____

Policy Holder's Name (if other than self): _____

Policy Holder's date of birth: _____

PHYSICIANS

Primary Care Physician: _____

Telephone: _____

PHARMACY INFORMATION

Pharmacy Name: _____

Address: _____

Signed: _____

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MEDICAL HISTORY

Name of **EYE DROPS** you use: _____

Name of **CURRENT MEDICATIONS** you use: _____

_____

Do you have **ALLERGIES** to any medications: Yes ☐ No ☐

If yes, please list: _____

Other allergies: _____

Do you **SMOKE**? Yes ☐ No ☐ How many packs/day? _____ For how many years? _____

Do you drink **ALCOHOL**? Yes ☐ No ☐

Are you **PREGNANT AND/OR NURSING**? Yes ☐ No ☐

Please list any surgeries you have had: _____

Please circle any of the following that apply to anyone in **YOUR FAMILY**:

Glaucoma	Retinal Detachment
Corneal Disease	Cataracts
Macular Degeneration	Blindness
Hypertension	Stroke
Heart Problems	Asthma
Diabetes	Cancer
Arthritis	

Do **YOU** wear **CONTACT LENSES**? Yes ☐ No ☐

Please circle the **TYPE OF LENSES** you use:

Soft Hard (RGPs) Hybrids (SynergEyes)

Daily Wear Extended Wear Lenses

What **BRAND OF LENSES** do you use?

_____

What **BRAND OF CONTACT LENS SOLUTIONS** do you use?

_____

Please circle any of the following that apply to **YOU**:

Glaucoma	Retinal Detachment
Corneal Disease	Cataracts
Macular Degeneration	Blindness
Retinal Disease	Trauma to the eyes
Iritis/Uveitis	Dry Eyes
Surgery to the eyes	Multiple Sclerosis
Stroke	Heart Attack
Heart Disease/Failure	Irregular Heart Beat
High Blood Pressure	Dry Mouth
Lung Disease	Asthma
Diabetes	Cancer
Arthritis	Exposure to Tuberculosis
Stomach Problems	Thyroid Disease
Kidney Disease	Blood Disorders
Venereal Disease	Rheumatoid Arthritis/Lupus
Bowel Disease	Sarcoidosis
Blood Transfusions	Hepatitis

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HIPPA ACKNOWLEDGEMENT

Name: _____

I wish to receive a copy of the Notice of Privacy Practices: Yes _____ No _____

Authorized person with whom we may discuss your protected health information:

Name: _____ Relationship to patient: _____

Signature of patient or guardian: _____ Date: _____

BILLING AND COLLECTIONS

- ALL co-pays are due at the time of service.
- Deductibles and any patient responsible balances will be billed to the patient and outstanding balances are due within 30 days of the statement date. Payment plans can be offered to pay in a timely manner.
- With more healthcare costs paid directly by patients, we have had to adjust our business procedures. As a result, you are required to pay balances that are not covered by your insurance company.
- A $20 processing fee will be added to a balance after 30 days have passed.
- A $30 fee will be charged for all returned checks and your account will be placed on a "cash or credit basis ONLY".
- For any children seen, the accompanying parent or adult is responsible for full payment at the time of service.
- Missed appointments and late cancellations will be charged a $25 fee for eye exam and $40 fee for a contact lens exam. Cancellations are requested 24 hours in advance prior to appointment. After a third missed appointment, we may discharge you from the practice.
- If you aren't aware of coverage under a vision plan other than your medical insurance coverage, and later determine that you have a vision plan, you will have to contact that provider directly for reimbursement.
- There will be a 30% non-refundable fee charged for the cancellation of any contact lens supply order.

Participation with Insurance Companies:

- All services will be submitted as a courtesy to your insurance. If the insurance does not cover services that were performed, any balance will become the patient's responsibility.
- If we don't participate with your insurance company, payment is due at the time of service. We can print out an itemized bill for you to give to your insurance company for a possible reimbursement.
- We suggest you contact your health insurance plan in advance of your appointment to discuss coverage and reimbursement. It is important for you to understand your benefits as they relate to services your physician may provide or prescribe.

PLEASE PRESENT YOUR MEDICAL INSURANCE CARD, VISION INSURANCE CARD AND A PHOTO ID AT EVERY VISIT BEFORE YOU ARE BEING SEEN BY THE DOCTOR. THANK YOU!

Signed: _____

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Vision Discount Plans vs. Medical Insurance PLEASE READ CAREFULLY

There is significant confusion regarding vision discount plans. If you are enrolled in a Vision Discount Plan (VSP, Anthem Vision, EyeMed , Superior Vision, Davis Vision, etc.), your plan will generally ONLY cover a basic "well visit", which is a basic evaluation/screening test for patients who have NO significant complaints, with NO medical issues that can affect ocular health NOR any previously diagnosed eye conditions. We have very specific criteria on when to submit your visit to your Medical insurance as opposed to your Vision discount plan.

-In **MANY** cases, your Eye Examination today will be billed to your **MAJOR MEDICAL INSURANCE** (including all copays and deductibles) and **NOT** YOUR VISION PLAN if you meet **ANY** of these conditions.

1. If you have ANY problems or complaints that MAY be attributable to a medical condition which often requires a more in-depth investigation and additional medical decision-making to rule out any underlying pathology, **we will accordingly bill your MEDICAL insurance, NOT your vision plan.** These include, but are not limited to:
   - New or sudden blurry vision
   - Flashes or floaters
   - Eyestrain or double vision
   - Eye pain, redness or itchiness
   - Headaches
   - Dimming of vision
2. There are a variety of systemic conditions that can profoundly and permanently affect a patient's vision that require a more in-depth investigation, which may include additional testing, follow up visits, and reports to your primary care physician. This type of examination is **NOT** covered under "vision" plans, **and we will accordingly bill your MEDICAL insurance, NOT your vision plan**. These include, but are not limited to:
   - Diabetes
   - High blood pressure
   - Thyroid conditions
   - Lupus or other autoimmune issues
3. If you have previously been diagnosed by another eye doctor for any eye issues that require medical decision-making, treatment or management, **we will accordingly bill your MEDICAL insurance, NOT your vision plan**. These include, but are not limited to:
   - Cataracts
   - Amblyopic/lazy eye
   - Glaucoma/previous diagnosis of high eye pressure
   - Macular degeneration
   - Retinal problems
   - History of Eye Surgery

Please be aware that all visits billed through your Medical insurance are subject to all appropriate copays and deductibles, which may be different than your Vision plan copay.

If you meet any of the requirements above, but want our office to ONLY use your routine vision benefit, we will be happy to arrange an appointment with another eye care provider (Optometrist or Ophthalmologist) to evaluate/monitor or treat your medical condition/complaints. ***Upon receipt of a full exam report*** *that they are currently treating/monitoring all of your medical issues and medical complaints as stated above, we will be happy to provide a routine visit with refraction only. Otherwise****, due to provider liability and professional standards of care, we will provide the necessary level of care and bill the appropriate insurance company as stated above.***

IF YOU HAVE ANY QUESTIONS regarding our policies of billing your examination, please ask the doctor or staff PRIOR to your examination.

All professional charges are ultimately the responsibility of the patient. We file insurance as a courtesy, and we try to estimate the correct patient responsibility of charges, but any denied claims, co-insurance payments, deductibles, etc. are ultimately determined by YOUR insurance company and you will be responsible for ANY unpaid amounts as determined by your insurance contract. By signing below you accept the above terms and responsibilities.

Signature of Patient or Guardian: _____

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Our practice offers a state-of-the-art digital scanning technology that allows us view the inside of your eye without the use of dilation drops. The OPTOMAP allows us to evaluate your retina for problems such as retinal tumors and holes, retinal tears/detachments, hypertensive and diabetic retinopathy. The scanning is completely safe for kids and adults and allows you the opportunity to see the inside of your eye just as the Doctor sees it.

Dilated Exam

1. Blurred near vision for 4-6 hours
2. Light sensitivity for 4-6 hours
3. Longer office visit to wait for drops to take effect
4. No permanent visual record of retina
5. Only the Dr. can see the retina

OPTOMAP Exam

1. NO blurred vision
2. NO light sensitivity
3. Map takes less than 2 minutes to process
4. Permanent digital image that can be reviewed/compared each year
5. You can see your retina

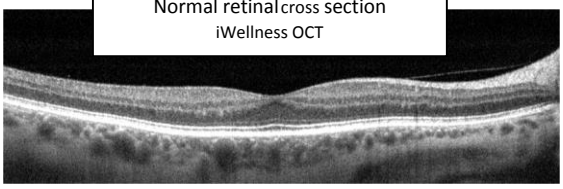
EARLY DETECTION IS CRUCIAL!

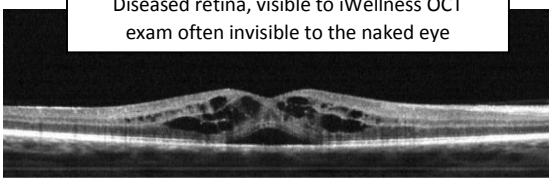
Our Doctors recommend that ALL patients have a thorough examination of their retina every year. **Without the Optomap or dilated examination, the doctor cannot fully assess the health of your eye.** In most cases, this procedure is not covered by the insurance. Dilation may still be required in rare instance.

Sight threatening diseases such glaucoma, macular degeneration, diabetic retinopathy and others have **no outward signs and symptoms,** which is why eye exams, including thorough retinal evaluation, are important to protect vision. **In an effort to provide a more thorough eye exam, our practice has incorporated the iWellnessExam SD-OCT retinal scan as part of our comprehensive eye exams.**

As part of your pre-examination work-up, our technician will perform this test which our Doctors will review with you during your examination today. The results of this exam will become a part of your permanent patient record.

The $25 copay is typically not covered by your medical or vision insurance unless being used to actively follow disease. This cost will be added into the price of your visit today. Any questions you have about these tests can be discussed during your examination with the Doctor.


Normal retinal cross section
iWellness OCT


Diseased retina, visible to iWellness OCT
exam often invisible to the naked eye

- The Optomap and iWellessExam are eligible for Flexible Spending Accounts (**FSA**) and Health Savings Accounts (**HSA**)

_____ I elect to have only Optomap today ($25)
_____ I elect to have Optomap AND iWellnessExam today ($45)
_____ I elect to have only iWellnessExam and Dilation exam ($45)
_____ I prefer a dilated exam of my retina ($35 or some insurance coverage)

_____ (Patient Signature) _____ (Date)