LOUISIANA EYE CARE

1330 S. Range Ave.
Denham Springs, LA 70726
225-664-2189

WELCOME Please complete **BOTH SIDES** of this form, **READ & SIGN** page 3 and return it to the front desk.

Date of Service: _____

Patient's Name: _____ Patient SSN: _____ DOB: _____ Age: _____
(First) *(Last)*

Address: _____ City: _____ State: _____ Zip: _____

Home / Cell Phone: _____ Text Messaging? Y / N Email: _____

Sex: M / F Marital Status: Single / Married / Other Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

INSURANCE:

VISION Insurance

Name of Company: _____ ID#: _____

Name of Policy Holder: _____ Relationship to Patient: _____

Policy Holder's DOB: _____ Policy Holder's SSN: _____

Policy Holder's Address if Different From Patient: _____

MEDICAL Insurance

Name of Company: _____ ID#: _____

Name of Policy Holder: _____ Relationship to Patient: _____

Policy Holder's DOB: _____ Policy Holder's SSN: _____

Policy Holder's Address if Different From Patient: _____

Is this a job related injury? Y / N If NO, continue to next page. If YES, please complete the following:

Date of injury/accident: _____ Did you report this to your EMPLOYER? Y / N

Employer: _____

Workman's Comp Contact Person: _____ Phone #: _____

Employer's Address: _____ City: _____ State: _____ ZIP: _____

Work Compensation Carrier: _____ Phone #: _____ Claim #: _____

OVER

MEDICAL HISTORY

Last eye exam: _____ Do you wear glasses? Y / N Do you wear contact lenses? Y / N

Any eye surgeries? Y / N List:_____ Any eye injuries? Y / N List: _____

Have you ever been diagnosed with cataracts, glaucoma, macular degeneration, or any other conditions? Y / N List:

_____

Have any of your family members been diagnosed with glaucoma, macular degeneration, or any other conditions? Y / N List:

_____

REVIEW OF SYSTEMS

Please CIRCLE all that apply or CHECK None

Eyes None _____
Distance vision blur
Near vision blur
Double vision
Distorted vision (halos)
Dryness
Itching
Burning
Sandy/Gritty
Mucous discharge
Excess tearing
Glare/light sensitivity
Eye pain
Flashes of light
Loss of vision
Floaters

Respiratory None _____
Asthma
Bronchitis
Emphysema
COPD
Sleep apnea

Gastrointestinal None _____
Crohn's disease
Colitis
Ulcer

If Female: pregnant or nursing? Y / N

Genitourinary None _____
UTI
Kidney disease
STD: viral, herpetic, chlamydia

Musculoskeletal None _____
Arthritis
Fibromyalgia
Osteoarthritis
Ankylosing spondylitis
Gout

Integumentary None _____
Eczema
Rosacea
Psoriasis
Herpes Simplex/Zoster

Allergic/Immunologic None _____
Drug allergy
Rheumatoid arthritis
Lupus
Sjogren's syndrome
HIV

Neurological None _____
Multiple sclerosis
Seizures
Migraines

Cancer/Other: _____

Psychiatric None _____
Depression
Bipolar
ADD/ADHD
Anxiety

Constitutional None _____
Weight loss
Weight gain
Fever

Endocrine None _____
Diabetes Type I
Diabetes Type II
Thyroid dysfunction

ENT None _____
Upper respiratory infection
Sinus congestion
Hay fever

Cardiovascular None _____
Heart disease
High blood pressure
Stroke
High cholesterol

Hematologic None _____
Anemia
Leukemia

List **MEDICATIONS** you take (including oral contraceptions, aspirin, and over-the-counter medications):

_____

_____

List **MEDICATION ALLERGIES:**

_____

SOCIAL HISTORY

Do you smoke? Y / N Do you drink? Y / N Do you use illegal drugs? Y / N

Pharmacy _____

Acknowledgement of Notice of Privacy Practices

OFFICE POLICY

I acknowledge that payment is due at the time of treatment, unless otherwise noted. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services provided to me, to the minor/child or to the patient for whom I have legal responsibility. I understand that filing a claim with my insurance company does not relieve me from my responsibility. Please note: VISION insurance plans cover ROUTINE vision (i.e. glasses and/or contact lens) exams only. Any condition requiring medical treatment or services, other than corrective lenses, may be covered by your MEDICAL insurance. ALL non-covered services must be paid in full.

INSURANCE ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____
(Name of Insurance Company)
and assign directly to Louisiana Eye Care all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Louisiana Eye Care may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This assignment will remain in effect until revoked in writing.

Your signature below verifies that you:

- Understand our policy regarding insurance assignment and release
- Consent to allow us to call you at any number listed above and leave messages when you do not answer
- Consent to mail information regarding scheduled or recommended appointments or services
- Consent to the treatment and management of your eye condition or referral to the appropriate specialty, if necessary
- Consent to the release of medical information to any specialties that we may refer you to

The law requires that Louisiana Eye Care, A.P.C. make every effort to inform you of your rights related to your personal health information. By signing below, you are also acknowledging that you were given the opportunity to read, have read, or had the Louisiana Eye Care, A.P.C.'s Notice of Privacy Practices explained to you prior to any services offered.

I authorize Louisiana Eye Care, A.P.C. to release my personal health & financial information to the following individuals: (Please list the relation to the patient)

_____ _____ _____

I have read and understand this form, and I am signing this form voluntarily.
Please note: If you are signing as a personal representative of the patient, please indicate your relationship. If you are signing for a minor, by signing below, you attest that you have legal authority to make medical decisions for the minor.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative with Relation Date

_____ _____
Printed Name of Patient, Parent, Guardian or Personal Representative with Relation Relationship to Patient

LOUISIANA EYE CARE

Dr. Cynthia Baker, O.D. ● Dr. Celeste DiCarlo, O.D. ● Dr. Meagan Fazzio, O.D. ● Dr. Megan Fisher, O.D.

Routine Exam vs. Medical Exam & Refraction

ROUTINE EXAM- A routine exam, by definition, is an exam for people who have no eye disease or symptoms of disease. Your eyes will be examined for any needed correction (glasses or contact lenses) and any potential indicators of eye disease. If our doctor finds anything abnormal during your vision exam, billing your medical insurance is required. If further testing is needed, it is required that your medical insurance will be used for this as well.

Routine eye examinations through most vision discount plans require prior authorizations. You must provide us with your vision policy information prior to services.

MEDICAL EXAM- Exam for evaluation of a medical-related complaint or follow-up of an existing medical condition. Examples that will necessitate your visit being submitted to your medical insurance include eye infections, headache, eye irritation, dry eyes, floaters, diabetes, glaucoma, cataract(s), double vision, macular degeneration, high risk medications, etc.

REFRACTION- A necessary test that measures the eyes' need for corrective lenses, and also assists in monitoring medical conditions of the eye. This test, however, will not provide sufficient information to write a prescription for contact lenses, which requires a corneal evaluation and contact lens fitting.

Insurance companies separate the components of an eye exam, one being the comprehensive exam and the other being the refraction. Typically, vision plans cover both the exam and the refraction, while most medical policies cover only the exam. Medicare enforces the policy of requiring eye doctors to separately charge and collect for refractions. As many private insurance carriers adopt the policies of the federal government, many of our contracts with private insurance carriers now require us to separately collect for this non-covered service also.

We hope that this information will help you understand how your visit will be submitted to your insurance policy for today's visit and future visits. If you are uncertain about your vision/medical benefits, please contact your insurance carrier.

_____ _____

Patient/ Responsible Party Signature Date

1330 S. Range Ave. ● Denham Springs, LA 70726 ● Telephone: 225.664.2189 ● Fax: 225.665.6309