ASCEND VISION PARTNERS

240317

PATIENT REGISTRATION

Contact Information

Today's Date: _____

First Name: _____ Last Name: _____

Street Address: _____ City/State: _____

Zip Code: _____ DOB: _____ Birth Sex: _____

Phone Number (day): _____

Email Address: _____

Emergency Contact: _____

Phone Number: _____ Relationship: _____

Ethnicity: ☐ African ☐ American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other: _____

Preferred Pharmacy

Name: _____

Phone Number: _____

Fax Number: _____

City or Zip Code: _____

Cross streets/Intersection: _____

Referring Provider/Primary Care Provider

Name: _____

Practice Name: _____

Address: _____

Phone Number: _____

Fax Number: _____

I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE OR MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO ASCEND VISION PARTNERS AND OR ANY OF ITS AFFILIATED COMPANIES FOR ANY SERVICES FURNISHED TO ME BY THE PROVIDER/CLINIC. I AUTHORIZE ANY HOLDER OR MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE INSURANCE COMPANY OR TO CMS (CENTERS FOR MEDICARE AND MEDICAID SERVICES) AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE TO RELATED SERVICES.I UNDERSTAND MY SIGNATURE REQUESTS THAT PAYMENT BE MADE AND AUTHORIZES RELEASE OF THE MEDICAL INFORMATION NECESSARY TO PAY THE CLAIM. IN THE MEDICARE ASSIGNED CASES, THE PHYSICIAN OR SUPPLIER AGREES TO ACCEPT THE CHARGE DETERMINATION OF THE MEDICARE CARRIER AS THE FULL CHARGE, AND THE PATIENT IS RESPONSIBLE ONLY FOR THE DEDUCTIBLE ARE BASED UPON THE CHARGE DETERMINATION OF THE MEDICARE CARR ER. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THE ASSIGNMENT IS TO BE CONSIDERED VALID AS ORIGINAL. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT PAID BY THE SAID INSURANCE COMPANY.

Patient Signature: _____ Date: _____

Print: _____

STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY AND RELEASE TO PROVIDE PROTECTED HEALTH INFORMATION

If you are not covered by a health plan or fall to provide the information necessary for us to file a claim, you are expected to pay for your services at the time of your appointment or meet with our financial representative to make other arrangements. Any physician at Ascend Vision or one of its affiliated companies will need to disclose some of your Protected Health Information (PHI) to either Medicare of your insurance to obtain payment. In addition, some charges may not be covered by your insurance, including your deductible, your copayment, and any services which are not considered medically necessary (non-covered procedures such as iLux, specialty lenses, and other non-covered services deemed by the practice). You will be responsible for theses charges. For each month a balance remains unresolved, you may be charged a late fee of up to 1.5%. The practice may use the services of a collection agency to pursue unresolved accounts. I have read the above policy and understand that I am responsible for paying for provided services. I also understand that my PHI may be released to Medicare or my Insurance company to obtain payment and that payment will go directly to Ascend Vision Partners or one of its affiliated practices.

PATIENT CONSENT FOR USE OF CREDIT CARD, DEBIT CARD AND FINANCING - DISCLOSURE OF PROTECTED HEALTH INFORMATION

If you pay by credit card, debit card or financing we may need to release your Protected Health Information (PHI) to credit card companies, banks, or financing companies to obtain your payment. By signing this form, you irrevocably consent to allow any provider at Ascend Vision Partners or one of its affiliated practices to disclose your PHI to any credit card company, bank, or financing company if they request this information to process your payment. If you pay with a credit card, debit card, or third-party financing, your PHI will be released to them if requested by the credit card company, bank or third-party financing company.

By signing below, it is understood that your PHI Information will be sent to your credit card company in order to settle any dispute, I understand that the physicians at Ascend Vision Partners or one of its affiliated practices encourage patient follow-up to address any issues. I also understand that this-agreement is irrevocable.

REFRACTION TEST & CONTACT LENS FITTING POLICY

A refraction is a test that measures your ability to see the eye chart with lenses of various powers. This test is done for two reasons.

- One reason is to determine your prescription in the event that you want or need an eyeglass or contact lens prescription.
- The second is to determine whether any vision problem that you may have is correctable by glasses, or is actually because of an eye disease that is not correctable by glasses. Therefore, a refraction may be required to determine if you have an eye disease.

If you want a prescription for glasses or contact lens, this test is required. If you have vision worse than 20/20 or if you feel your vision is blurry, this test is strongly advised, since your doctor may not be able to diagnose the cause of your problem without the test.

We are required to inform you that a refraction is a non-covered service by Medicare and most insurance companies. Keep in mind that if your Primary Care Physician referred you here to our office it is for medical reasons, and your insurance company will not cover this service. Some plans may offer the refraction and eyewear to you at no charge at a participating provider’s (optometrist) office.

Should you choose to get a refraction and your doctor feels it is necessary to do one, payment will be expected at the time of check out. The fee for the refraction is **$65.00.**

The fee for contact lens fitting depends on the type of fitting. Contact lens fitting includes refraction. If your current prescription for contacts is expired, it can’t be refilled. Our doctors need to check the health of your eyes to ensure we can extend your prescription. The fee for **contact lens fitting will be provided to you at time of service**.

Patient Signature: _____ Date: _____

Print: _____

Explanation of terms: - "Protected Health Information" (PHI): This means your name and address. Credit card companies usually request this information to process a payment, and we cannot legally give them even your name without your permission. - "Irrevocably consent": In general, you have the right

to revoke our permission to release protected health information. e.g, if you initially wanted us to release records to another office but changed your mind. In this instance, you do not allow us to release your name to your credit card company, we cannot process your payment. This protects from patients giving us a payment by credit card, then not allowing us to process the payment.

HISTORY & INTAKE FORM

Medication

List all current medications:

_____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____

Past Medical History

Select any of the following medical conditions you currently have:

- ☐ None
- ☐ Anxiety disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Cerebrovascular accident / Stroke
- ☐ Chronic obstructive lung disease
- ☐ Coronary arteriosclerosis
- ☐ Depressive disorder
- ☐ Diabetes mellitus, type: _____
- ☐ Disease caused by 2019-nCoV
- ☐ End-stage renal disease
- ☐ Epilepsy
- ☐ Acid reflux
- ☐ Graves' disease
- ☐ H/O: hypertension
- ☐ Hearing loss
- ☐ HIV
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Malignant lymphoma
- ☐ Malignant tumor of colon
- ☐ Obstructive sleep apnea of adult
- ☐ Radiation therapy treatment
- ☐ Transplantation of bone marrow
- ☐ Other:

_____

_____

_____

_____

Past Surgical History

Have you had any surgeries in the past?

_____
_____
_____
_____
_____

Past Ocular History

- ☐ None
- ☐ Allergic conjunctivitis ☐ L ☐ R
- ☐ Cataract ☐ L ☐ R
- ☐ Corneal dystrophy ☐ L ☐ R
- ☐ Macular degeneration ☐ L ☐ R
- ☐ Dry eyes ☐ L ☐ R
- ☐ Elevated intraocular pressure ☐ L ☐ R
- ☐ Epiretinal membrane ☐ L ☐ R
- ☐ Glaucoma ☐ L ☐ R
- ☐ Glaucoma suspect ☐ L ☐ R
- ☐ Keratoconus ☐ L ☐ R
- ☐ Nonproliferative retinopathy due to diabetes ☐ L ☐ R
- ☐ Narrow angle glaucoma ☐ L ☐ R
- ☐ O/E - background diabetic retinopathy ☐ L ☐ R
- ☐ Ophthalmic migraine ☐ L ☐ R
- ☐ Posterior vitreous detachment ☐ L ☐ R
- ☐ Proliferative retinopathy due to diabetes ☐ L ☐ R
- ☐ Pseudoexfoliation glaucoma ☐ L ☐ R
- ☐ Retinal tear without detachment ☐ L ☐ R
- ☐ Strabismus ☐ L ☐ R
- ☐ Other: _____ ☐ L ☐ R

_____ ☐ L ☐ R

_____ ☐ L ☐ R

_____ ☐ L ☐ R

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Past Ocular Surgery

- ☐ None
- ☐ Amniotic membrane graft to cornea ☐ L ☐ R
- ☐ Chalazion removal ☐ L ☐ R
- ☐ Corneal collagen cross linking ☐ L ☐ R
- ☐ Corneal transplant ☐ L ☐ R
- ☐ Descemet's membrane endothelial keratoplasty (DMEK) ☐ L ☐ R
- ☐ Descemet's stripping endothelial keratoplasty (DSEK) ☐ L ☐ R
- ☐ Cataract extraction ☐ L ☐ R
- ☐ Dacryocystorhinostomy ☐ L ☐ R
- ☐ Excision of pterygium with graft ☐ L ☐ R
- ☐ Insertion of drainage tube into anterior chamber ☐ L ☐ R
- ☐ Laser trabeculoplasty ☐ L ☐ R
- ☐ Pan-retinal photocoagulation (PRP) ☐ L ☐ R
- ☐ Penetrating keratoplasty (PKP) ☐ L ☐ R
- ☐ Photorefractive keratectomy ☐ L ☐ R
- ☐ Repair of blepharoptosis ☐ L ☐ R
- ☐ Repair of eyelid ☐ L ☐ R
- ☐ Repair of hole of macula lutea ☐ L ☐ R
- ☐ Repair of retinal detachment ☐ L ☐ R
- ☐ Repair of retina for retinal tear or defect ☐ L ☐ R
- ☐ Strabismus surgery ☐ L ☐ R
- ☐ Trabeculectomy ☐ L ☐ R
- ☐ Vitrectomy ☐ L ☐ R
- ☐ Injection of drug into vitreous ☐ L ☐ R
- ☐ Insertion of punctal plug ☐ L ☐ R
- ☐ LASIK ☐ L ☐ R
- ☐ Laser iridotomy ☐ L ☐ R
- ☐ Laser therapy for retinal lesion ☐ L ☐ R
- ☐ Simple excision of pterygium ☐ L ☐ R
- ☐ YAG laser capsulotomy of lens ☐ L ☐ R
- ☐ Other:
  - _____ ☐ L ☐ R
  - _____ ☐ L ☐ R
  - _____ ☐ L ☐ R
  - _____ ☐ L ☐ R
  - _____ ☐ L ☐ R

Allergies

List all allergies and reactions if known:

_____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____

Social History

Smoking Status:
- ☐ Current every day smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Unknown if ever smoked

Alcohol Intake:
- ☐ None
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day

If you are over 65, how many times this year have you had 5 or more drinks in 24 hours? _____

Occupation and Workplace:

_____

_____

_____

Family History

_____ Member: _____
_____ Member: _____
_____ Member: _____

_____ Member: _____
_____ Member: _____
_____ Member: _____

Quality Measures

- Have you received a pneumonia vaccination on or after your 60th birthday? ☐ Yes ☐ No
- Do you have a health care proxy in the event you are unable to make your own medical decisions? ☐ Yes ☐ No
- Which statement(s) best reflects your wishes on advanced care recommendations?
  - ☐ Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.
  - ☐ Do Not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if its necessary to save my life.
  - ☐ Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

Review of Systems

Are you currently experiencing any of the following? Please check Yes or No

	System	Yes	No
High Blood Pressure	Cardiovascular	☐	☐
Diabetes	Endocrine	☐	☐

Other Symptoms: _____

_____

_____

Medical Alerts

Please check Yes or No

Alerts	Yes	No
Allergy to adhesive	☐	☐
Allergy to lidocaine	☐	☐
Allergic to Sulfa Drugs	☐	☐
Artificial heart valve	☐	☐
Artificial joints within past two years	☐	☐
Blood thinners / aspirin	☐	☐
Defibrillator	☐	☐
Flomax	☐	☐
MRSA / methicillin-resistant Staphylococcus aureus	☐	☐
Narrow angles	☐	☐
Pacemaker	☐	☐
Pregnancy or planning a pregnancy	☐	☐
Pseudoexfoliation syndrome	☐	☐
Steroid responder	☐	☐
	☐	☐