MASON FAMILY VISION

PATIENT INFORMATION

Patient Name ______________________________ **Gender** ☐ Male ☐ Female
Last First Middle

Preferred First Name ____________ **Marital Status** ☐ Minor ☐ Single ☐ Married ☐ Widowed

Patient Home Address ______________________________
Street Apt City State Zip

Phone Home____________ Work ____________ Cell ____________
Texting OK ☐ Yes ☐ No

Email______________________________

Patient DOB ____/____/____ **Age**______ **Patient SSN** ____-____-____

Patient's Employer ______________________ **Occupation** ______________

Emergency Contact ______________________________
Name Relationship Phone

How did you hear of us? ☐ Physician Referral, if yes name of Physician ______________

☐ Mail ☐ Internet ☐ Yellow Pages ____________ Friend/Family Member ____________ Other

In accordance with health care reform, please help our office report meaningful use measures:

Pref Language ☐ English ☐ Spanish **Communication Preference** ☐ Phone ☐ Postal ☐ Email

Race ☐ Asian ☐ Black/African American ☐ Hispanic ☐ Native Hawaiian/Other Pacific Islander ☐ White

Height ______ **Weight** ______

ADVANCE BENEFICIARY NOTICE: I understand that Medicaid does not pay for Retinal Imaging and Vision Therapy and Medicare does not pay for the refraction fee and both Medicaid and Medicare do not pay for contact lens evaluation fee.

INSURANCE INFORMATION

Do you have vision insurance?

☐ Yes ☐ No

Insurance Co ______________
Policyholder Name ____________ DOB______
ID#____________ SSN____________

Do you have medical insurance?

☐ Yes ☐ No

Primary Insurance Co ______________
Policyholder Name ____________ DOB______
ID#____________ SSN____________

Secondary Insurance Co ______________
Policyholder Name ____________ DOB______
ID#____________ SSN____________

RESPONSIBLE PARTY

☐ Self ☐ Spouse ☐ Parent ☐ Guardian ☐ Other ________

☐ Name/Address same as above

Name ____________________ DOB ________
Address ______________________________
Phone ________________ SSN____________

ASSIGNMENT AND RELEASE

I hereby state the information given is true and complete. I hereby authorize and request the payment of services from Medicare, Medicaid, and/or other insurance plans or payers be made on my behalf to Mason Family Vision, PC.

I hereby assign to Mason Family Vision, PC all payments for treatment services. I understand and agree that I am responsible for paying any amount not covered by Medicare, Medicaid, and/or other insurance plans or payers.

SIGNATURE ______________________ **DATE**___/___/___

Today's Date:______________ Name of your primary care physician:____________________________

Your Name:____ Date of Birth:________________

PAST MEDICAL HISTORY: CHECK ALL THAT APPLY

Do you now or have you ever had:

Systemic Conditions:

- ❑ High blood pressure
- ❑ Heart Disease
- ❑ High cholesterol
- ❑ Thyroid Disorder
- ❑ Diabetes (type I or II): A1C:______
- ❑ Crohn's Disease
- ❑ Hepatitis
- ❑ Kidney Disease- Genitourinary
- ❑ Sexually Transmitted Disease
- ❑ Anemia
- ❑ Leukemia
- ❑ Sickle Cell Trait /Disease
- ❑ Tuberculosis
- ❑ Herpes Simplex /Zoster
- ❑ HIV/AIDS
- ❑ Sarcoidosis
- ❑ Psoriasis
- ❑ Rosacea
- ❑ Lupus
- ❑ Rheumatoid Arthritis
- ❑ Headache /Migraines
- ❑ Epilepsy (Seizures)
- ❑ ADD /ADHD
- ❑ Anxiety Disorder
- ❑ Depression /Bipolar
- ❑ Asthma
- ❑ COPD
- ❑ Sleep Apnea
- ❑ Cancer (type)_________
  ____

Please list any other medical issues:

____

____

Ocular Conditions:	**You**	**Family Member/Relation to Patient**
❑ Amblyopia or Lazy Eye	❑	❑__________________
❑ Blindness Due to Disease	❑	❑__________________
❑ Blindness Due to Injury	❑	❑__________________
❑ Crossed or Turned Eye	❑	❑__________________
❑ Diabetic Retinopathy	❑	❑__________________
❑ Hypertensive Retinopathy	❑	❑__________________
❑ Double Vision	❑	❑__________________
❑ Flashes of Light	❑	❑__________________
❑ Floaters or Spots in Vision	❑	❑__________________
❑ Glaucoma	❑	❑__________________
❑ Macular Degeneration	❑	❑__________________
❑ Retinal Detachment or Tear	❑	❑__________________
❑ Cataracts	❑	❑__________________
❑ Other (please list)______________	❑	❑__________________

DO YOU WEAR:

- ❑ Glasses (age of current pair):______________________________
- ❑ Contact Lenses (brand, if known)____________________________

Surgical History:	**Year:**	**Which Eye:**	**Performing Physician:**
❑ Cataract Surgery	________	________	________________
❑ Retinal Surgery	________	________	________________
❑ Eye Muscle Surgery	________	________	________________
❑ Traumatic Eye Injury	________	________	________________
❑ Lasik Surgery	________	________	________________
❑ PRK or RK Surgery	________	________	________________

❑ Any other major, non-eye surgery (please list below)

____

Medications Taken:

__________ __________

__________ __________

__________ __________

__________ __________

__________ __________

__________ __________

Medication Allergies:

____

____

____

Food/Other Allergies:

____

____

Social History:

- ❑ Tobacco Use (per day)________
- ❑ Alcohol Use(per day)________
- ❑ Blood Transfusion (year)________
- ❑ Pregnant (weeks)__________
- ❑ Nursing

Pre-Screen Questionnaire

1. Are you experiencing ANY of the following emergency symptoms: severe shortness of breath and difficulty breathing, persistent chest pain or pressure, new confusion or inability to arouse, bluish lips or face, loss of consciousness, slurred speech, and/or severe, constant dizziness or lightheadedness?
   - □ Yes
   - □ No

2. Are you experiencing any of the following symptoms? Please select all that apply.
   - □ Fever, chills or sweating
   - □ New or worsening cough
   - □ Fatigue
   - □ Body aches
   - □ Diarrhea
   - □ Reduced sense of smell and/or taste
   - □ Mild to moderate difficulty breathing
   - □ Sore throat
   - □ Runny nose
   - □ None of the above

3. Have you been told by a health official that you may have been exposed to COVID-19?
   - □ Yes
   - □ No

   If yes, give the date of most recent exposure: ______________________________

4. Have you been around someone who is known to have COVID-19?
   - □ Yes
   - □ No

   If yes, give the date of most recent exposure: ______________________________

5. Have you ever tested positive for COVID-19?
   - □ Yes
   - □ No

   If yes, explain and give dates: ______________________________

6. Have you ever tested negative for COVID-19?
   - □ Yes
   - □ No

   If yes, explain and give dates: ______________________________

7. Are you waiting for test results for COVID-19?
   - □ Yes
   - □ No

   If yes, explain and give dates: ______________________________

Signature: ____________________________________ Date: ______________

MASON FAMILY VISION
Financial Policy Agreement

THANK YOU for choosing Mason Family Vision for your eye care needs. We appreciate your trust in us and we look forward to providing you with quality and affordable eye care. Our financial policy is intended to facilitate excellent service to you while minimizing our administrative costs. Please read, sign and date this agreement.

√ PATIENT PAYMENTS

Full payment is due **at the time of service**. We accept cash, credit card, debit card, and CareCredit. In cases of financial hardship, and prior to receiving services, you may apply for the CareCredit healthcare credit card and establish an account to make monthly payments. Apply online at www.carecredit.com or call (800) 677-0718. We reserve the right to charge interest and/or apply late fees on a past due balance. Accounts with balances 90 days past due will be referred to an outside collection agency.

√ INSURANCE COVERAGE

We make no claim to know what services your insurance covers. While we make a good faith attempt to verify coverage, we are not able to guarantee that the information given to us by your insurance is correct. It is your responsibility to supply us with the correct insurance information at the time of your visit. **If your insurance plan requires a referral from a primary care physician and you do not present one, you will be financially responsible for payment of these services.** We encourage you to refer to your benefits manual if you have any questions about covered services. Be aware that some or all of the services provided may be not be covered by your insurance. You will be responsible for payment of all non-covered services at the time they are rendered.

√ INSURANCE PAYMENTS

As your vision care provider, our relationship is with you, our patient, not with your insurance company. We require certain co-payments, deductibles or prepayment amounts depending on the type of insurance and insurance carrier. **Be assured our office works diligently to obtain payment from your insurance company.** However, if we file your insurance, and the claim has not been paid for any reason within 90 days, we require that you pay the balance using one of the approved payment methods. In the event that your insurance pays us after that time, you will be reimbursed.

√ THIRD PARTY PAYORS

Our office does not bill third party payors such as PIP (Personal Injury Protection), worker's compensation carriers or attorneys.

√ MISSED / LATE CANCELLED APPOINTMENTS

Please give us at least 24 working hours notification if you cannot keep an appointment. This courtesy will allow others to be seen. If you fail to notify us you will be billed a $50.00 fee. We realize that emergencies arise; however, habitual late cancels or no-shows, may cause our relationship to be terminated.

√ PRODUCT RETURNS

All prescription optical materials are customized and fabricated specifically for each individual patient. Fees for these materials are non-refundable, and once ordered, become the financial responsibility of the patient. All materials not picked up after 90 days become property of Mason Family Vision.

√ CONTACT LENS EVALUATION FEES

If you are a contact lens wearer, the doctor needs to evaluate the comfort, fitting characteristics, and vision obtained with a particular contact lens. A separate contact lens evaluation is required to determine the contact lens prescription. Contact lens evaluation fees are due at the time of service.

We welcome the opportunity to discuss any aspects of this agreement. Please let us know if you have any questions, comments, or concerns. We thank you for your support, and look forward to serving you.

I have read, understand, and agree to abide by the terms stipulated above.

Patient Signature (or Parent of minor/Legal Guardian): ______________________________ **Date:** ________

Mason Family Vision - 141 Wildewood Park Drive

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgement"

I, ____________________ have been informed of this office's Notice of Privacy Practices.

____
Print Name

____
Signature

____
Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

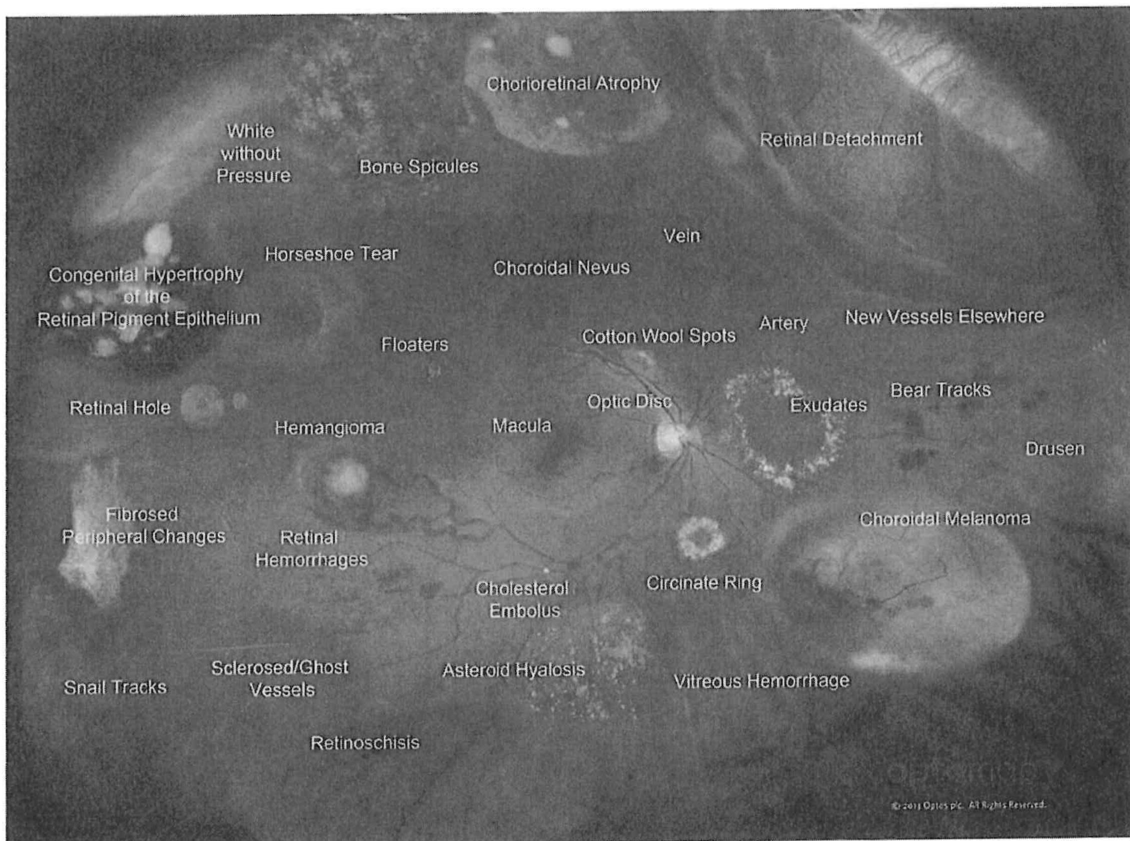
____
____
____

MASON
FAMILY VISION

<u>The optomap (digital image of the retina) will be done annually for every patient UNLESS a waiver is signed.</u>

*Dr. Mason wants **ALL** patients to have a digital image of the retina annually with the new scanning digital imaging system. The test is only $39.*

Retinal problems such as macular degeneration, cancer, glaucoma, retinal holes, retinal detachments and diabetic retinopathy can now be seen <u>without dilation</u> for most patients.



Early detection is crucial!