RAMSEY EYE CARE CENTER
1151 GATEWAY BLVD STE 101
ROCK SPRINGS, WY 82901
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visionsource-ramseyeyecare.com

INTAKE FORM

Patient information - Please complete prior to your appointment. **Please use your legal name**.

First Name: ____

Middle Name or Initial: ____

Last Name: ____

Date of Birth: ____

SSN: ____

Language, Race, Ethnicity: ____

Gender: O Male O Female

Marital Status: Single Married Domestic Partner Divorced Widowed

Dominant Hand? R L N ____________________

Address: ____

Apt./Unit #: _______________________

City, State, Zip ____

Mobile Phone:________________________Home Phone: _______________________

Email: ____

Employer: ________________________________Occupation:______________________

full-time / part-time

Emergency Contact: ____

Phone number: ____

Please choose your practitioner: O Coby Ramsey O Taylor Hibbs

Parent or Guarantor Information if patient is a minor"

Name: ____________________________________ DOB: _________________

Relation: ___________________________________ SSN :__________________

Address: ____

Phone: ____________________________________ Email: __________________

VISION PLAN (VSP, Davis, EyeMed, Spectera): ______________________________

Policy Number (ID/SSN): ____

Member Name: ________________________________DOB: _________________

Patient relationship to insured member (self, spouse, child, other): ____________________

Medical Insurance Plan: ____

Policy Number (ID/SSN): ____

Member Name: ________________________________DOB: _________________

Patient relationship to insured member (self, spouse, child, other): ____________________

Reason for today's visit? ____

Do You Currently Wear Glasses? Yes No

Do you smoke? Yes No

Do You Currently Wear Contacts? Yes No

Have you ever smoked? Yes No

Pregnant or Nursing O Yes O No

Height ________ Weight ________

Date of Last Eye Exam if known: ____

Please list current Medications, Dosage and Times per Day:

Are your currently experiencing, or have experienced, any of the following? Check all that apply.

_____Blurry Vision Near

_____Blurry Vision Distance

_____Burning Redness

_____Discharge

_____Double Vision

_____Dryness

_____Sandy /Gritty Feeling

_____Excess Tearing/Watering

_____Eye Infection

_____Eye Pain or Soreness

_____Floaters or Spots

_____ Halos

_____Headaches

_____Itching

_____Light Flashes

_____Seasonal Allergies

_____Allergies to Medication

Have you or an immediate family member (parents, siblings, children) experienced or been treated, for any of the following? Indicate. Self and/or Immediate Family

_____Cataracts O SELF O Immediate Family

_____Crossed Eye O SELF O Immediate Family

_____Glaucoma O SELF O Immediate Family

_____Lasik or PRK O SELF O Immediate Family

_____Lazy Eye O SELF O Immediate Family

_____Macular Degeneration O SELF O Immediate Family

_____Retinal Detachment O SELF O Immediate Family

_____Keratoconus O SELF O Immediate Family

___Aids/HIV O SELF O Immediate Family

___Allergies O SELF O Immediate Family

___Arthritis O SELF O Immediate Family

___Asthma O SELF O Immediate Family

___Blood/Lymph Disorder O SELF O Immediate Family

___Cancer O SELF O Immediate Family

___Diabetes Type 1 O SELF O Immediate Family

___Diabetes Type 2 O SELF O Immediate Family

___Ears, Nose, Throat O SELF O Immediate Family

___Gastrointestinal Conditions O SELF O Immediate Family

___Heart Disease O SELF O Immediate Family

___High Blood Pressure O SELF O Immediate Family

___High Cholesterol O SELF O Immediate Family

___Kidney Disease O SELF O Immediate Family

___ Lupus O SELF O Immediate Family

___Neurological Conditions O SELF O Immediate Family

___Psychiatric Disorder O SELF O Immediate Family

___Seizures O SELF O Immediate Family

___Skin Conditions O SELF O Immediate Family

___Stroke O SELF O Immediate Family

___Thyroid Dysfunction O SELF O Immediate Family

Privacy Notice Consent Form

Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, Ramsey Eye Care Center creates and maintains health records and other information describing among other things, my health history, which includes, but not limited to: chief complaint, symptoms, examination, test results, diagnoses, treatment and any plans for future care or treatment.

I have been provided access to the "Notice of Privacy Practices" at https://visionsource ramseyeyecare.com that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I also understand that Ramsey Eye Care Center reserves the right to change their notice and practices. In this case, a copy of any revision could be posted in the office, posted on company web-site, and/or mailed to me. I understand that I have the right to object to the use of my healthcare information. I also understand that I have the right to restrict to how my healthcare information may be disclosed to carry out treatment, payment or other matters in regard to healthcare operations. I also understand that Ramsey Eye Care Center is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of my protected healthcare information for the purpose of treatments, payment and any other healthcare operations. I have the right to revoke this consent in writing, except where disclosures have already made a reliance on my prior consent.

Patient First Name: * ____

Patient Last Name: * ____

Patient Middle Name or Initial: ____

Signature * ____

Date ____

Assignment and Agreement to Pay

<u>Financial Assignment and Agreement</u>

Insurance is considered a method of reimbursing the patient for a fee paid to the doctor and is not a substitute for payments. Some companies pay fixed allowances for certain procedures, and others pay a percentage of that charge. IT IS YOUR RESPONSIBILITY TO PAY ANY DEDUCTIBLE, CO-INSURNACE, COPAY OR FEES NOT PAID FOR BY YOUR INSURANCE COMPANY.

I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to be released to the Health Care Administration, its agents or any other insurance carrier I may have including, any information needed to determine these benefits or the benefits payable for related services. **Patient Signature***

Refraction Policy

Refraction is the process of determining the eye's refractive error, or need for corrective spectacle and/or contact lenses. It is an essential part of an eye examination, but is NOT a covered service by Medicare or most insurance companies. Ramsey Eye Care Center's fee for refraction is $30.00 and this fee is collected in addition to the patient's copay. The REFRACTION FEE AND COPAYS ARE DUE AT TIME OF SERVICE.

Contact Lens Exam

A contact Lens patient requires additional testing and monitoring over and above what is done during a routine eye examination. In order to prescribe or renew your prescription, your doctor performs additional procedures that that are apart from a regular eye examination. Depending on the level of examination there is a fee associated with a contact lens examination that is not covered by Medicare and most insurance companies. THIS FEE AND ANY COPAYS ARE DUE AT TIME OF SERVICE.

Thirty Day Return Policy

Glasses and specialty contact lenses are custom. If for any reason you are not satisfied, eyewear must be returned within 30 days from purchase date. We guarantee a onetime remake for product returned within this time period. Refunds will not be available on product returned after 30 days. Warranty does not apply if lost, stolen, or glued.

Return Check Policy

I understand that if my check is returned unpaid, I will be charged and be responsible for the value of the check and a $35.00 return check fee.

Acknowledgement I have read the above information and understand and accept full financial responsibility for any additional costs or copays that are not covered by Medicare or my insurance company.

Prescriptions for Glasses and Contacts

I understand that my prescriptions are accessible in my health portal and I agree to receive them electronically through the health portal www.revolutionphr.com or I may request copies be mailed to me.

Patient Signature * Date

Authorization to Disclose Protected Health Information

Ramsey Eye Care Center is authorized by me to disclose my "Protected Health Information" with the individuals I have named below.

PATIENT NAME:____

*Please specify what type of information you wish to disclose.

_____All information _____ Personal Identifying information _____Financial Information

_____Medical Records _____Appointment Information _____Optical Information

Name:______________________________________ Relationship: ________________________

Name:______________________________________ Relationship: ________________________

Name:______________________________________ Relationship: ________________________

I give permission to Ramsey Eye Care Center (empolyees and/or staff) to contact me by (write below):

____

O.K. to phone O.K. to email O.K. to mail O.K. to fax to this # _________________________

O.K. to leave a detailed message O.K. to leave a message with a callback number only

Patient Signature * Date