WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we will be glad to help you.

PATIENT INFORMATION

Today's Date: ________________ Date of Birth: ________________ Social Security #: _____-_____-_____

Patient Last Name: ____________________ First Name: ________________________ Middle Initial: _____

Address: ____

City: ______________________________________ State: ____________ Zip Code: _________________

Preferred Phone Number: ___________________________ Alternate Phone Number: ____________________

Email address:____ **(sign up for our patient portal which will enable you to request medication refills, schedule appointments and communicate with your doctor)**

Who is your Primary Care Physician? ____

What pharmacy do you use? _____________________________ Location? ____________________________

In case of an emergency, who should we contact? ____________________ Relationship: ___________________

Preferred Phone Number: ____________________________ Alternate Phone Number: ____________________

SEX: ☐ Male ☐ Female

☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ PARTNERED ☐ MINOR ☐ OTHER

WHICH CATEGORY BEST DESCRIBES YOUR RACE? *(Please check any you fee apply)*

☐ White ☐ Native American/Alaska Native ☐ Native Hawaiian/Other Pacific

☐ Black/African American ☐ Asian ☐ Other ☐ Decline

DO YOU CONSIDER YOURSELF HISPANIC/LATINO? ☐ YES ☐ NO ☐ DECLINE

WHAT IS YOUR PRIMARY LANGUAGE SPOKEN? ☐ English ☐ Spanish ☐ Other

INSURANCE

Who is the primary account holder of the policy? ____

Relationship to you: ______________________________ Their Date of Birth: ___________________________

ASSIGNMENT AND RELEASE: I certify that I, and/or my dependent(s), have insurance coverage and assign directly to doctor 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. To the extent permitted by law, the doctor may use my health care information and may disclose such information to my insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

____ Date: ______________________

Patient's Signature

OCULAR / MEDICAL / SOCIAL HISTORY QUESTIONNAIRE

PLEASE MARK/IDENTIFY THE CONDITIONS THAT APPLY TO YOU OR YOUR FAMILY MEMBER, BELOW
(please specify which family member, i.e. mother, sister, grandfather, etc)

Eye Diseases/Problems:

	SELF	FAMILY MEMBER
• Cataracts:	______	____________
• Glaucoma:	______	____________
• Macular Deg:	______	____________
• Dry Eye:	______	____________
• Eye Surgery:	______	____________
• Retinal Disease:	______	____________
• Floaters/Flashes:	______	____________
• Corneal Dystrophy:	______	____________
• Eye Injury:	______	____________
• Lazy Eye/Amblyopia:	______	____________

Systemic Diseases/Problems:

	SELF	FAMILY MEMBER
• Arthritis:	______	____________
• Asthma:	______	____________
• Allergies:	______	____________
• Thyroid:	______	____________
• Heart Disease:	______	____________
• Diabetes:	______	____________
• High Blood Pressure:	______	____________
• High Cholesterol:	______	____________
• AIDS/HIV/STD:	______	____________
• Other:	______	____________

Review of Systems: (*please check all that apply to you*)

☐ GENERAL: weight loss, fever, headache
☐ EAR/NOSE/THROAT: hearing loss, sinus
☐ HEART: chest pain, irregular heart beat
☐ RESPIRATORY: shortness of breath, wheezing, asthma
☐ DIGESTIVE: heartburn, diarrhea
☐ MUSCLES: arthritis, muscle aches
☐ OTHER: ______________________________
☐ NEUROLOGIC: paralysis, numbness
☐ SKIN: rashes, eczema
☐ PSYCHIATRIC: depression, anxiety, mental illness
☐ ENDOCRINE: diabetes, thyroid
☐ CANCER: any type
☐ BLOOD: anemia, sickle cell, bleeding problems

Do you wear glasses? ☐Single Vision ☐Progressive ☐Readers
Do you wear contact lenses? ☐Dailies ☐Monthly ☐RGP
Do you wear bifocals? ☐Yes ☐No

Date of last eye exam?________________

MEDICATIONS

If you have a list, please give to front desk, please include all vitamins, herbals and eye drops:

____
____
____

☐ **I do not currently take any medications**

ALLERGIES

Please list:

____
____
____

☐ **I do not have any known drug allergies**

SOCIAL HISTORY

SMOKING STATUS:
☐ Current every day smoker ☐ Former smoker (year quit:________) ☐ Never smoked ☐ Unknown

Do you drink alcohol? ____________________ Do you use recreational drugs? ____________________

Female patients: Are you pregnant? __________ Number of children: ______________

LEVIN eyecare

Statement of Privacy Policy Posting

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can be used and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by LEVIN EYECARE of their Notice of Privacy Practice containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Practices prior to signing the consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that LEVIN EYECARE restrict how my private information is used or disclosed to carry our treatment, payment, or health care operation. I also understand that LEVIN EYECARE is not required to agree to my requested restrictions, but if LEVIN EYECARE does agree then the organization is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that LEVIN EYECARE has taken action relying on this consent.

PLEASE INDICATE THE PREFERRED MEANS OF CONTACTING OR LEAVING A MESSAGE FOR YOU:

Home Phone: ______________________________ Work Phone: ______________________________

Cell Phone: ______________________________ Other Number: ______________________________

OTHERS WHO YOU GIVE PERMISSION TO HAVE ACCESS TO YOUR HEALTH INFORMATION)other than your physicians)

Name: ____ Relationship: ___________________________
Name: ____ Relationship: ___________________________
Name: ____ Relationship: ___________________________
Name: ____ Relationship: ___________________________

**** CHECK HERE ________ IF YOU PREFER RESTRICTION FROM ALL PARTIES**

PATIENT NAME: ____

PATIENT SIGNATURE: ____ **DATE:** _______/ _______/ 20_______

WITNESS SIGNATURE: ____ **DATE:** _______/ _______/ 20_______

FINANCIAL POLICY

LEVIN EYECARE is dedicated to providing quality patient care and we are also aware that financial concerns are part of our welfare.

Before/during your visit, LEVIN EYECARE is required to verify your member eligibility with your insurance company. In addition, for your protection and in accordance with federal regulations, LEVIN EYECARE is required to verify your identity (valid driver's license or other form of acceptable photo identification). Your failure to provide an acceptable form of photo identification may cause denial of services. Please inform the front desk staff if you have any concerns regarding your insurance benefits or if you are self-pay (you do not have insurance coverage). If you are self-pay, and unable to satisfy your financial obligations to LEVIN EYECARE, you may want to contact your local health department to see if you are eligible for Medical Assistance.

We recommend that patients contact their insurance carrier for specific questions related to you Explanation of Benefits.

NOTE: Please read the following carefully, initial where indicated and sign below. We understand that these may not all apply to you, we want you to understand what our policies are, **please initial each area.**

CO-PAYMENTS & REFRACTION FEES

____ Co-payments and refraction fees are due at the time services are rendered per your contract with your insurance company. Payment can be made by cash, check, MasterCard, Visa, American Express or Discover. We WILL NOT bill for this.

REFERRALS

____ Referrals must be presented at the time services are rendered, if applicable. If you need to have one faxed to us, our office fax number is 443-940-1214, please give this number to you primary care physician. Without a referral, your appointment will be rescheduled, it is the patient's responsibility to obtain the referral; the office staff will not obtain referrals for patients.

FINANCIAL RESPONSIBILITY

____ Patients are responsible for all co-payments, deductibles, refraction fees, and charges not covered by their health insurance. Without valid health insurance, full payment is expected at the time services are rendered.

NO SHOW/SAME DAY CANCELLATION POLICY

____ A $25 missed appointment fee will be charged for any missed appointment where a patient does not notify our office to cancel at least 24 hours prior to their appointment. The fee will be the responsibility of the patient to pay and will not be billed to their insurance company. This same policy applies to any procedure performed at the Northern Baltimore Surgical Center facility. A $100.00 missed surgery appointment fee will be charged for any surgical procedure canceled within 24 hours of a scheduled procedure.

ACCOUNT BALANCES

____ Our office provides you with monthly statements of all activity including charges, payments and contractual adjustments. Failure to pay outstanding balances that are your responsibility may result in the practice forwarding your account to a collection agency or Collection Attorney of our choice and may result in additional fees, including attorney's fees of 30%. If your payment is returned due to insufficient funds or stopped payment, you will be charged the return check fee allowed by Maryland State Law.

THE FOLLOWING APPLIES TO PATIENTS WITH MEDICARE ONLY OR A MEDICARE ADVANTAGE PLAN ONLY!

____ **I hereby authorize and request my insurance company to make payment directly to LEVIN EYECARE and any wholly owned subsidiaries of any benefits that may be due for covered services and supplies rendered to me by TOTAL VISION associates.**

Date: ______________________

Signature of Patient (or legal Guardian): ______________________

Printed Name of Patient: ______________________