**WELCOME TO ROME EYE CARE**

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_ST\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_

Phone (H) \_\_\_\_\_\_\_\_\_\_\_\_\_\_(C)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(W)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Spouse\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do you use a computer regularly? Yes / No \_\_\_\_\_\_\_ hours per day

Employer (Students – List Grade) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Parents’ Name(s) (minors)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have vision insurance?\_\_\_\_\_\_\_ Carrier\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently wear glasses?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sunglasses\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear contact lenses?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_If no, are you interested in contacts?\_\_\_\_\_\_\_\_\_

When was your last eye exam?\_\_\_\_\_\_\_\_\_\_\_\_When was your last medical exam?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of your medical doctor?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Referred to office by whom?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Do you take any medicine? If yes, please list all medications you are currently taking:**                                                                                                                                                                                                                                                                                                      A**re you allergic to any known medications? If yes, please list:**                                                                                                              |

**Do you have or have you ever had any of the following:**

Dry Eyes Yes No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Glaucoma Yes No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cataracts Yes No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Macular Degeneration Yes No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chronic Fatigue Yes No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High Blood Pressure Yes No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes Yes No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer Yes No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequent Headaches Yes No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart Problems Yes No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Asthma/Emphysema Yes No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| ***Does anyone in your family have any of the following:****Diabetes Yes No**High Blood Pressure Yes No**Glaucoma Yes No**Macular Degeneration Yes No*Cataract  *Yes No**Do you smoke? \_\_\_\_\_\_\_\_\_\_\_packs per day* |

Hearing Loss Yes No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sinus Trouble Yes No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Change in Appetite Yes No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Back/Neck Trouble Yes No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tingling in Arms/Legs Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Depression/Anxiety Yes No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dizziness/Fainting Yes No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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*To the best of my knowledge, the questions on this form have*

*been answered correctly. It is my responsibility to inform the*

*doctor’s office of any changes in my (or my child’s) medical*

*status. I also authorize the doctor & his staff to perform*

*any necessary services I may need.*

***(Payment due when services rendered.)***

 *X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available for you, and post it on our web site.

**COMPLAINTS** If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

**FOR MORE INFORMATION**  If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

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ACKNOWLEDGEMENT OF RECEIPT

*(please inform the front desk if you would like to take this copy, otherwise, this notice will stay in your record)*

I acknowledge that I received a copy of *Rome Eye Care, P.C.'s* Notice of Privacy Practices.

 Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *(patient or guardian)*

 ***INSURANCE AUTHORIZATION***

 ***SIGNATURE ON FILE***

***For Our Medicare Patient/ Waiver of Liability***

 I request payment of authorized Medicare benefits be made either to me or on my behalf to

 Rome Eye Care P.C. for any covered services furnished to me. I authorize any holder of medical

 information about me to release to the Health Care Financing Administration and its agents

 any information needed to determine these benefits or the benefits payable for related services.

 I understand Medicare will cover any services determined as routine/screening.

 I understand I will be fully and personally financially responsible for these charges.

These services include but are not limited to refraction, routine eye exams, low vision aides, glasses and contact lens ( with the exception of after cataract surgery or for aphakic patients), no-line bifocal, progressive & transition lenses, non-medically necessary tints, scratch coats, other additional patients options for glasses, contact lens cleaners and/or solutions.

***Medicare /Medigap Supplement or Complementary Crossover Insurance***

 I request that payment of authorized co-insurance benefits be made either to me or on my behalf

 to Rome Eye Care P.C. for any services or materials furnished to me. I authorized any holder of

 medical information about me to release to my supplemental insurance carrier any information

 needed to determine these benefits payable for related services. I understand I will be financially

 responsible for any non-covered services and charges.

 These assignments will remain in effect until revoked by me in writing. A photocopy of this

 is to be considered as valid as the original.

***Signed***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***Date***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***(Patient or Guarantor)***

***Non-Medicare Patient/Accept Assignment***

 I authorize the release of all medical information necessary to process this claim and that is

pertinent to my medical care. I assign all vision, medical and/ or post-op surgical benefits including major medical benefits to which I am entitled to Rome Eye Care P.C.. I understand I will be financially responsible for non-covered services and charges. A photocopy of this assignment is to be considered as valid as the original.

***Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***(Patient or Guarantor)***