BOWDEN
EYE & ASSOCIATES
Eyes • Aesthetics • Hearing

Patient Name: _____
Account #: _____

CONFIDENTIAL PATIENT INFORMATION

Patient's Name: _____ Date: _____

Sex: M F Date of Birth: _____ Age: _____

Home Address: _____ Apt: # _____

City: _____ State: _____ Zip: _____

Home Phone Number: _____ Cell/Alternate: _____

Social Security Number: _____ Email Address : _____

If Child, parent's/guardian's name: _____

Primary Care Physician: _____ Referring Physician: _____

Employer: _____ Work Number: _____

Emergency Contact Name: _____

Relation:_____ Phone Number: _____

Would you like us to communicate to any other family members, Power of Attorney, or other individuals pertaining to your medical records, treatment plan, billing/insurance questions, appointments, etc.? If so, please list below.

Name :_____ Relation to You: _____

Do you allow us to release your medical records to a referring physician or primary care physician if they request such to jointly treat your medical condition? If so, PLEASE INITIAL HERE. _____

FOR MEDICATION PRESCRIPTIONS AND REFILLS, PLEASE LET US KNOW WHAT PHARMACY YOU PREFER:

Pharmacy: _____ **Address:** _____ **Phone Number:** _____

Patient HIPAA Consent:

In each of our offices, we have our Notice of Privacy Practices published. This Notice contains a Patient Right's Section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have a right to request how protected health information about you is used or disclosed for your treatment, payment, and health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. Marketing- we may use or disclose your Health Information to make a marketing communication to you that occurs in a face-to-face encounter with us or which concerns a promotional gift of nominal value provided by us.

By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment, and health care operations. You have the right to revoke this consent, in writing, signed by you at any time; however, that does not affect any disclosures we have already made in reliance with your prior consent. This consent is required so that Bowden Eye is in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Patient Signature: _____ **Staff Initials:** _____

Relationship if other than patient: _____

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INSURANCE/PAYMENT INFORMATION:With the ever changing healthcare industry, we want to make sure every patient is aware of our insurance and billing policies. The more you know, the better we can service your eyecare needs.

Payment is due at the time of your exam.
Do to the increasing costs of providing medical care, we require patients to pay their co-pay, deductible and all out of pocket expenses before they leave the office. Failure to pay this at the time services are rendered will result in a $25 billing charge.

Patients on HMO Policies:
Our staff will strive to make sure that all patients on an HMO plan has a referral for their visit, however it is the patient's responsibility to insure the office has this before services are rendered. Patients on an HMO policy are required to present a referral from the Primary Care Physician on every visit to our office. We cannot bill your insurance without the referral.

Non-Covered Services:
If we suspect that your insurance company may not cover a service, we will ask that you sign a form in advance acknowledging that you have been advised the service may not be covered and that you will be financially responsible. This applies to services that we feel is needed in your treatment plan, but that your insurance company may deem non-covered. All other non covered services will be billed to you in accordance with your specific insurance policy. All cosmetic surgery, refractive surgery such as LASIK, and elective procedures are paid 1 week prior to services being rendered.

Refraction Policy:
It may be necessary for our office to perform a basic Refraction Test. While Medicare and some major insurance carrier do not cover this test, it is necessary to determine your visual acuity. This test can be used to determine your need for glasses, but it can also detect vision loss. Some of the time vision loss is slow and progressive and the patient may not even notice, that is why a physician will check the patient's vision by refracting them. This test can also uncover other problems a patient may be unaware of. This test is charged separate from the exam because Medicare has deemed that a refraction is not a "medical service". However, this is the ONLY way to detect some types of vision loss. The Office of Inspector General has deemed that not charging a patient for a service is an "inducement" to the patient, and therefore illegal, which is why we charge for this service to be done. A refraction may not be done at every visit. This varies based on the patient's diagnosis and at times more than a basic refraction will be needed. **The fee for a basic refraction is $70, and due at the time of service in addition to any copays or deductibles.**

Billing to your Insurance:
Our office will bill all covered services to a Primary and Secondary Insurance policy. We do not bill to more than two insurance carriers. By giving us your insurance information you authorize our office to request payment be sent directly to us. We will also make reasonable appeals for payment when necessary. **We will give insurance carriers a maximum of 60 days to pay the claim. Failure for them to pay in a timely manner will result in the balance being turned over to you.** We encourage you, the patient, to be involved and make sure your insurance is paying in a timely manner.

Unpaid Claims:
After 120 days if the balance on your account has not been paid, and a payment arrangement has not been set up with our Billing Department, the balance will be forwarded to our collection agency. The patient is responsible for any collection charges, attorney fees, court costs and finance charges that accrue. Continued access to our practice will be terminated if billing policies are ignored. If financial obligations arise, please contact our Billing Department immediately. Monthly payment plans can be set up with payments as low as $100 a month.

The patient or responsible party agrees to the Physician's reasonable and customary fee for medical services. The receptionist will accept cash, check or credit card for routine visits as you leave. If financial problems arise, please make special arrangements. By signing this form, you acknowledge financial responsibility and authorize Bowden Eye & Associates to release any information acquired in the course of your exam or treatment to other physicians, etc for health reasons and consent to the use of photographs for the purpose of documentation, publications in medical journals or presentations during medical meetings.

Patient Signature: _____ **Date:** _____

Staff Initials: _____ *updated 9/2021*

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Patient Name: _____
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List your medication allergies: _____

List your current medications you are taking:

_____ _____ _____

_____ _____ _____

Please check the box if the condition applies to you, and explain when necessary.

____ Eye pain
____ Red eyes
____ Watery eyes
____ Film over eyes
____ Road Signs are blurry
____ Small print is blurry
____ Dry or scratchy eyes
____ Eye swelling or itch
____ Migraine Headaches
____ Droopy Eyelids
____ Other Headaches? Explain_____
____ Difficulty driving due to vision
____ Glare from car lights or sunlight
____ Double vision
____ Vision blackout
____ Flashes of light, floaters or spots in vision. Explain _____
____ Do you wear glasses? If yes, are they:
____Prescription and/or _____ Reading glasses
____ Do you have a known eye disease? If yes, what type? _____
____ Have you ever had eye surgery? If yes when? _____

Please check the box if you are experiencing any symptoms or have been diagnosed with a condition in these areas:

____ Chronic Fever, unexpected weight gain/loss, fatigue? If yes, when? _____
____ Ear, nose, throat problems? (e.g. Hearing loss, sinus, sore throat) _____
____ Heart problems? (e.g. Murmur, CHF, stroke, heart attack, irregular heart beat) _____
____ High blood pressure? If yes, is it _____ controlled or _____ uncontrolled?
____ Respiratory problems? (e.g. Asthma, emphysema, TB, shortness of breath) If so, when? _____
____ Urinary problems? (e.g. Pain or discomfort, kidney stones, dialysis, kidney disease) _____
____ Diabetes or other endocrine problems? _____
____ Blood or lymphatic disease? (e.g. Free bladder, bleeding disorders, leukemia, etc) _____

Have you ever been told that you have:

Gastrointestinal problems? (stomach ulcer, abdominal pain, etc) If yes, when? _____
Allergic or immunologic problems? _____
Cancer? If yes, what type ____ skin ____ pituitary ____ lung ____ colon ____ breast ____ stomach *Other:* _____
Musculoskeletal problems? (e.g. Joint pain, arthritis) If so, when? _____
Skin conditions? Please describe: _____
Neurological problems? (e.g. Numbness, weakness, tingling, headache) _____
Psychological problems? (e.g. depression, anxiety) _____

PAST HISTORY:

Do you have any other medical conditions that you have NOT listed in the categories above? _____
Have you had any surgery in the past 10 years? ____ YES ____ NO If yes, when? _____

CURRENT HISTORY:

Have you ever had general anesthesia? ____YES ____ NO
Have you ever had an HIV (AIDS) test? ____YES ____ NO If so, was it _____ Positive or ____ Negative
Why was it done? _____
Do you have hepatitis of any form? ____YES ____ NO If so, what type? _____
Have you had any type of blood transfusion since 1980? ____YES ____ NO If yes, why? _____
Have you ever been diagnosed or treated for alcoholism or drug abuse? ____YES ____ NO Please describe. _____

FAMILY HISTORY: Does/Did anyone in your immediate family have any of the following:

Glaucoma	____ YES	____ NO	____ Father	____ Mother	____ Brother	____ Sister	____ Grandparent
Blindness	____ YES	____ NO	____ Father	____ Mother	____ Brother	____ Sister	____ Grandparent
Diabetes	____ YES	____ NO	____ Father	____ Mother	____ Brother	____ Sister	____ Grandparent
Heart Disease	____ YES	____ NO	____ Father	____ Mother	____ Brother	____ Sister	____ Grandparent
High Blood Pressure	____ YES	____ NO	____ Father	____ Mother	____ Brother	____ Sister	____ Grandparent

DOCTOR'S SIGNATURE :_____ **DATE:** _____

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MEDICAL EXAM VS. VISION SCREENING EXAM

What is the difference between a Medical Exam and a Vision Exam?
Insurance coverage for eye exams vary. Some plans only cover routine, well eye exam visits. Other plans will not pay for your exam unless you have a medical eye condition or disease. Some plans require a referral from your primary care physician. Be sure to check your policy(s) to determine your coverage prior to your appointment.

For insurance purposes, eye examinations are divided into two categories:
Vision Exam: These are routine or "Well Vision" exams for patients who have no eye conditions or systemic conditions that affect the vision or ocular health. Your eyes will be examined for any needed vision correction devices such as glasses or contact lenses. If your doctor finds anything abnormal during your well vision exam, further testing of a medical nature will be required at another visit. In rare cases during the technician's work up we will find medical conditions that require us to convert to a medical examination. Some conditions cannot simply be ignored by a physician solely because of one's insurance plan. This is best for your ocular health. If we must convert to a medical exam your insurance coverage would be utilized instead of your well care vision plan. ***Routine WELL vision exams do not include medication prescriptions of any kind. (New or Refills)*** Yearly diabetic eye exams will not be billed to insurances under vision coverage.

Medical Exam: This is a comprehensive ocular examinations for the detection, diagnosis, and treatment of diseases and conditions of the eye performed by a physician or surgeon. This exam evaluates the reasons for the systems and assesses any treatment needed. Some conditions evaluated with medical eye exams include cataracts, glaucoma, diabetic retinopathy, macular degeneration and many other potentially sight-threatening diseases. There are many systemic health and family history conditions that can adversely affect the vision.

Patient's Initials: _____ Date: _____

Most patients will have a refraction done during both types of exams. A refraction is a diagnostic test used to determine your best corrected vision. For some medical conditions, a refraction is needed even when eyeglasses are not prescribed. If your insurance does not cover your refraction, you will be asked to pay the fee of $70 at the time of service.

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Lifestyle Questionnaire

This questionnaire is designed to assist your Eyecare Professional in helping you select the perfect lenses, frames, and/or contacts to suit your visual needs and lifestyle. Please take a few minutes to guide us:

Which of the following visual demands do you encounter on a regular basis? (circle all that apply)

Artificial Lighting	Computer Work	Potential Eye Hazards	Reading
Board Work	Natural Lighting	Close Up Work	Paperwork

Which of the following hobbies or activities do you participate in? (circle all that apply)

Biking	Golf	Sewing/Arts/Crafts	Boating/Water Sports	Home Repairs
Snow sports	Bookkeeping	Hunting/Shooting	Spectator Sports	Tennis
Running	Gardening	Watching TV	Computer Work	Welding
Diving	Pilot	Competitive Sports	Fishing/Boating	Other: _____

Do your eyes seem bothered by glare from any of the following situations? (circle all that apply)

Car Headlights	Haze	Traffic Lights	Computer Monitor
Night Driving	Sunshine	Other: _____	

If you wear contacts, do you have: (circle all that apply)

Current pair of Prescription Glasses Sunglasses

To be completed by clinical staff.

Discussion Notes to Optician:

Frame Preference: *Metal, plastic, rimless, drill mount*
Lens Recommendations: *Single Vision, Progressive, Computer, Polarized Suns*
Lens Treatments: *Anti-glare, impact resistant, light weight, thin, blue light, uv protection, polarized, transitions, tint*

Please let us know which of our specialty services would most benefit your daily life so we may ensure you are fully informed:

Vision Correction Services:

___ **All Laser Custom LASIK Surgery-** Reduce the need for contacts and glasses
___ **Custom Premium Cataract Surgery-** Reduce the need for contacts and glasses after the cataract is removed
___ **Implantable Contact Lenses (ICL)-** Reduce the need for contacts and glasses
___ **INTACS-** Treatment for Keratoconus
___ **Lipiflow-** Dry Eye Relief for itchy, burning, watery eyes
___ **Allergy Testing-** Proper diagnosis of your allergens that can lead to the correct treatment for your dry, itchy, watery eyes

Aesthetic Services by Sarah Darbandi, M.D.

___ **BOTOX and Fillers-** Reduce the appearance of facial volume loss, fine lines and wrinkles, or even plump your lips
___ **Correction of Droopy Eye Lids or Brows**
___ **Permanent Make Up Application-** Permanent eyebrows, eyeliner, lip liner, or full lip color
___ **Photofacial treatment-** Reduce age spots, acne, rosacea, or uneven skin tone
___ **Lower Eyelid Blepharoplasty-** Improve the look and functionality of your eyelids
___ **CO2 Laser Resurfacing-** Skin Rejuvenation procedure
___ **Removal of Lesions around the eyes**