

MEDICAL HISTORY QUESTIONNAIRE

Patient's Name: _____

Date of Visit: _____

Date of Birth _____ Date of last eye exam _____

List any eye medications/eye drops you currently use: _____

List any other medications you currently take (prescription and over-the-counter): _____

List any allergies to medications: _____

List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc): _____

List any eye surgeries you have had (cataract, LASIK, etc) & approximate date: _____

List any other surgeries you have had (tonsillectomy, appendectomy) & approximate date: _____

History of excessive scarring (keloids)?	YES	NO			
Alcohol consumption:	none	occasionally	1/day	2-3/day	4+/day
Smoking habits:	none	occasionally	1/2 pack/day	1 pack/day	1+pack/day
Have you ever tried to wear contact lenses?	YES	NO			
Do you currently wear contact lenses?	YES	NO	If yes, how long? _____		
Do you currently wear glasses?	YES	NO	If yes, how long have you had your current prescription? _____		

Do you currently have any problems in the following areas? If YES , please provide information.	YES	NO	DETAILS
EYES			
Loss of vision			
Blurred vision			
Fluctuating vision			
Distorted vision (halos)			
Glare or light sensitivity			
Visual difficulty when driving			
Problems with night vision			
Loss of side vision			
Double vision			
Dryness			
Mucous discharge			
Redness			
Sandy or gritty feeling			
Itching			
Burning			
Foreign body sensation			
Excess tearing or watering			
Eye pain or soreness			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			

MEDICAL HISTORY QUESTIONNAIRE – CONTINUED

Patient's Name: _____

Date of Visit: _____

	YES	NO	DETAILS
GENERAL/CONSTITUTIONAL (fever, weight loss, other)			
EARS, NOSE, THROAT (stuffy nose, ear ache, cough dry mouth etc.)			
CARDIOVASCULAR (high blood pressure, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, etc.)			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD/LYMPH (cholesterolemia, anemia, etc.)			
ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, etc.)			

FAMILY HISTORY

M=mother F=father S=sibling GP=grandparent

DISEASE	YES	NO	RELATIONSHIP TO PATIENT
Blindness			
Glaucoma			
Cataract			
Age-related macular degeneration			
Arthritis			
Cancer			
Diabetes			
Heart disease			
High blood pressure			
Stroke			
Thyroid disease			
Other			

OTHER

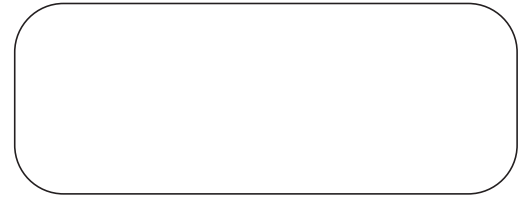
Current occupation: _____

Living arrangements (nursing home, assisted living, rehabilitation): _____

Do you drive: YES NO

Patient's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____



REGISTRATION FORM

Please Print

Patient #:		Date:		Email Address:	
Last Name:		First Name:		Middle:	Nickname:
Address:			City:	State:	Zip Code:
Marital Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> Sep <input type="checkbox"/> Other		Birthdate:	Age:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security #:
Home Phone:		Work Phone:		Cell Phone:	
Employment Status: <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Temp <input type="checkbox"/> Student <input type="checkbox"/> Retired		Employer/School Name:		Occupation:	
Billing Address, If Different From Above Address:					
Referring Doctor (First & Last Name):		Clinic or Location:		Phone:	
Family/Primary Care Physician:		Clinic or Location:		Phone:	
<input type="checkbox"/> Spouse's Name or <input type="checkbox"/> Parent's Name:		Spouse/Parent Work Number:		Spouse/Parent Social Security #:	
I heard about this clinic from:					
Patient: _____ <input type="checkbox"/> TV <input type="checkbox"/> Internet <input type="checkbox"/> Radio <input type="checkbox"/> Mailing <input type="checkbox"/> Other _____					
NOTIFY IN CASE OF EMERGENCY (OTHER THAN SPOUSE & OTHER THAN YOUR ADDRESS)					
Name:		Relationship:		Phone Number:	
Address:					
City:		State:		Zip Code:	

Signature on File, Assignment of Benefits, Financial Agreement



INSURANCE INFORMATION

1) Primary Insurance Name:			
Policy #:		Group #:	
Subscriber Name:		Subscriber Birthdate:	
Address: (If different from above)			
City:	State:	Zip:	Home Phone Number:
Patient Relationship to Subscriber of Insurance:			
<hr/>			
2) Secondary Insurance Name:			
Policy #:		Group #:	
Subscriber Name:	Subscriber Birthdate:	Patient Relationship to Subscriber of Insurance:	

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Minnesota Eye Consultants for services furnished me by Minnesota Eye Consultants. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Minnesota Eye Consultants accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

2. **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Minnesota Eye Consultants, if possible or otherwise to me.

3. **RELEASE OF INFORMATION:** Minnesota Eye Consultants may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Minnesota Eye Consultants for reimbursement for services rendered, and (2) any health care provider for continued patient care. Please see our Notice of Privacy Practices for information on your rights under the HIPAA Regulations, 45 CFR Parts 160 and 164. Minnesota Eye Consultants may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

4. **INSURANCE COVERAGE:** Minnesota Eye Consultants contracts with most of the major health plan payers; however, I acknowledge that it is my responsibility to confirm specific health plan coverage and benefit levels. Our business office is available for assistance at 952-567-6063. I understand that I am responsible to pay for any health care services for which my health plan denies coverage.

5. **NON-COVERED SERVICES:** I understand that Minnesota Eye Consultants contracts with health care plans that identify items and services which are "covered services." Accordingly, the undersigned accepts full financial responsibility for all items or services, which are ultimately determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Minnesota Eye Consultants to obtain necessary health care service plan authorizations. Payment for non-covered services is expected at time of service.

6. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Minnesota Eye Consultants, I will pay my account at the time service is rendered or will make financial agreements satisfactory to Minnesota Eye Consultants for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Minnesota Eye Consultants. If copayments and/or deductibles are designed by my insurance company or health plan, I agree to pay them to Minnesota Eye Consultants. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

7. **EYE DROP ADMINISTRATION:** I understand, as a patient, or parent/guardian of a minor child, that my eyes may be dilated as part of the exam. Dilation and other drops used during my visit can affect vision and function for a period of time. By signing below, permission is granted to dilate and give other drops.

8. I understand that in order to provide patient access to the most advanced ophthalmic technology, Minnesota Eye Consultants, P.A., works closely with numerous ophthalmic and pharmaceutical partners to participate in clinical trials and/or outcome studies involving the latest new procedures, equipment and medications, and to teach other ophthalmologists about these advances. The doctors also consult with these companies to identify new treatments so that we can help patients with conditions previously considered untreatable and to improve existing treatments with the goal of helping patients heal faster with better outcomes. At Minnesota Eye Consultants, P.A. we are doing all we can to continually improve our ability to enhance our patients' eyesight.

9. **To Our Patients:** This is to inform you that your surgeon/physician may have a proprietary interest in the Minnesota Eye Laser and Surgery Centers and any hearing services provided by Minnesota Eye Consultants, P.A. If you have further questions please contact your physician or the surgery center Clinical Director. Thank you.

Patient/Responsible Party Signature

Date



BILLING & INSURANCE INFORMATION

We are pleased you have chosen Minnesota Eye Consultants, P.A. for your eye care needs. To help answer some of your billing and insurance questions, we have compiled some information to guide you through the process.

MEDICARE

If you have Medicare, our office will bill Medicare and/or your secondary insurances. You are responsible for the following:

- Any deductibles and co-pays
- 20% co-pay of the allowed charges
- Any non-covered services
- Services ordered by the physician that do not meet Medicare guidelines for medical necessity
- Routine eye examinations or refraction charges

MEDICAID (Minnesota Only)

If you have Medicaid, you are required to present a current Medicaid card at every visit. You are responsible for the following:

- All non-covered services
- A co-pay of \$3.00 which is due at the time of service

HMO & PPO PLANS

If you have HMO or PPO coverage, you are required to obtain an insurance referral for most services. It is your responsibility to obtain all insurance referrals before services are rendered. You can do this by calling the referral department of the clinic listed on your insurance card. If you fail to obtain an insurance referral and services are denied, the balance will become your responsibility. Please call us at **952-567-6063** and we will be happy to assist you in obtaining this referral.

COMMERCIAL PLANS

If you have a commercial plan, we will bill your insurance company as a courtesy. If payment from your insurance company has not been received within 30 days, you are responsible for the balance in full. You are also responsible for the co-pay and/or any non-covered services. Co-pays are due on the day of service.

BILLING CYCLE

If your insurance information is verified at registration, you will not receive a bill until:

- Your insurance company has denied the claim
- Your insurance company has paid the claim, leaving a co-insurance, deductible or non-covered service.

OR

- Your insurance company has not responded to the claim.

<OVER>



ROUTINE VISION PLANS

Some employers have separate vision benefit plans specifically for routine eye exams, called “carve out” plans. These plans are separate from your medical insurance coverage and are handled by a different company. We do **NOT** participate with these plans. These include, but are not limited to:

- VSP(Vision Service Plan)
- Cole Managed Vision
- EyeMed
- Amerisight
- Spectera

If you have this type of vision plan, you will be responsible for payment in full for your services. If you are scheduled for a routine vision exam, please review your vision benefits carefully. *(This does not pertain to LASIK services and/or Refractive Evaluations)*

ROUTINE EXAMINATION AND REFRACTION CHARGES

Benefit coverage for routine eye examinations and refraction charges vary by health plan and by employer. Specific benefit coverage can also change from year to year.

An examination is considered **routine** when performed for a patient who has no specific illness, symptom, complaint, or injury that needs to be treated or diagnosed.

A **refraction** is a test that is used to determine any optical defect present in the eye. A refraction is necessary

- to prescribe the best corrective lenses
- to determine the progression or diagnosis of certain ocular diseases
- to ascertain the basis for your visual complaints.

You will want to check benefit coverage with your insurance carrier to determine if vision care is a covered service.

Minnesota Eye Consultants will submit this charge on your behalf to your insurance carrier for determination of benefit coverage. However, if you know this charge will not be paid by your insurance carrier, you may make payment on the date of service and receive a 20% **prompt pay discount**.

For questions regarding your account, call our Billing Department at:

952-567-6063



CONTACT LENS REMOVAL POLICY

Refractive or Cataract Surgery Evaluations ONLY

Our physicians and staff at Minnesota Eye Consultants want to make every effort to ensure you have the best visual result following your surgical procedure. Therefore, we ask that you adhere to the recommended protocols regarding the removal of contact lenses. Wearing contact lenses, especially over a long period of time, can temporarily alter the shape of the front surface of the eye (the cornea). This pressure can influence critical measurements that must be taken prior to the treatment.

It is essential that contact lenses are removed and your eyes are allowed to rest for a period of time before your measurements are taken for the procedure.

Please adhere to the following guidelines in removing your contact lenses:

For those who have not had an exam to take the necessary measurements:

- Rigid contact lenses, including gas permeable should be removed for a minimum of 3 weeks prior to your **refractive or cataract evaluation.**
- Soft contact lenses should be removed for a minimum of 2 weeks prior to your **refractive or cataract evaluation.**

For those who have had an evaluation and the necessary measurements taken by your family eye doctor but have not been evaluated by Minnesota Eye Consultants:

- Rigid contact lenses, including gas permeable should be removed for a minimum of 3 weeks prior to your **surgery date.**
- Soft contact lenses should be removed for a minimum of 2 weeks prior to your **surgery date.**

Warning: If contact lenses are worn during the required removal period, there is a strong likelihood that the ancillary tests and vision correction procedure will have to be rescheduled for a later date.

Please discuss any specific contact lens issues you might have with one of our patient care coordinators or your eye doctor.