American Eye Care Optometric Center

Date_____

First Name_____**Last Name**_____

Address_____

City_____**State**_____**Zip**_____

Phone_____**Email**_____

Employer/School_____

Insurance_____**SS#**_____

Date of Birth_____**Male/ Female** **Height**_____**Weight**_____

Marital Status Married Single Divorced Widowed

Race African American Asian Hispanic White Other_____

Current Medications_____

_____

Allergic to any medications No Yes (if so, what)_____

Smoking Status Never Former Someday Everyday

Date of last eye exam_____Dr._____

Currently wear glasses yes no **Currently wear contact lenses** yes no

Do you suffer from the following? (please circle)

Blurred vision Sudden loss of vision Double vision Pain in the eyes Redness

Discharge Light sensitivity Itching other_____

Anyone in your family ever have? (please circle)

Glaucoma Cataracts Macular Degeneration High blood pressure Diabetes

Blindness Eyeglasses other_____

Payment is due at the time of service. Cash, Mastercard, Visa, Amex, Discover

Signature of patient (if minor, parent sign)_____

Please fill out back side

Name of Family Physician

_____

_____

_____

Allergic/Immunologic ☐ *Neg.*

- ☐ drug allergy
- ☐ environmental allergy
- ☐ rheumatoid arthritis
- ☐ lupus
- ☐ other

Notes:

Cardiovascular ☐ *Neg.*

- ☐ heart disease
- ☐ hypertension
- ☐ stroke
- ☐ vascular disease
- ☐ other

Notes:

Constitutional ☐ *Neg.*

- ☐ developmental disability
- ☐ weight loss
- ☐ fever
- ☐ fatigue
- ☐ trauma
- ☐ other

Notes:

Ears, Nose, Mouth & Throat ☐ *Neg.*

- ☐ Upper Resp. Tract Infect
- ☐ Ringing-Tinitis
- ☐ Ear Ache
- ☐ Runny Nose
- ☐ Sore Throat
- ☐ other

Notes:

Impression:

Endocrine ☐ *Neg.*

- ☐ non-insulin dependent diabetes
- ☐ insulin dependent diabetes
- ☐ thyroid dysfunction
- ☐ hormonal dysfunction
- ☐ other

Notes:

Eyes ☐ *Neg.*

- ☐ GLC
- ☐ CAT
- ☐ AMD
- ☐ Surgery
- ☐ Inflammatory disorders
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ other

Notes:

Gastrointestinal ☐ *Neg.*

- ☐ Crohn's
- ☐ colitis
- ☐ ulcer
- ☐ digestive
- ☐ other

Notes:

Genitourinary ☐ *Neg.*

- ☐ STD - viral herpetic, chlamydia
- ☐ other

Notes:

Hematologic/Lymphatic ☐ *Neg.*

- ☐ anemia
- ☐ large volume blood loss
- ☐ leukemia
- ☐ other

Notes:

Integumentary ☐ *Neg.*

- ☐ eczema
- ☐ rosacea
- ☐ psoriasis
- ☐ other

Notes:

Musculoskeletal ☐ *Neg.*

- ☐ fibromyalgia
- ☐ muscular dystrophy
- ☐ osteoarthritis
- ☐ ankylosing spondylitis
- ☐ other

Notes:

Neurological ☐ *Neg.*

- ☐ multiple sclerosis
- ☐ epilepsy
- ☐ Alzheimers
- ☐ Parkinsons
- ☐ Cerebrovascular
- ☐ other

Notes:

Psychiatric ☐ *Neg.*

- ☐ depression
- ☐ panic disorder
- ☐ schizophrenia
- ☐ other

Notes:

Respiratory ☐ *Neg.*

- ☐ asthma
- ☐ bronchitis
- ☐ emphysema
- ☐ other

Notes:

American Eye Care Optometric Centers

Comprehensive Medical Eye & Vision Examinations - Diseases of the Eye
Eyeglasses & Contact Lenses - Pediatric and Geriatric Eye Care

1657 Owen Drive • Fayetteville, NC 28304 • (910) 323-2100
1739 W. Cumberland Street • Dunn, NC 28334 • (910) 892-3840
www.americaneyecare.org

William C. Elmore, O.D
Practice of Optometry

PATIENT ACKNOWLEDGMENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent form. As provided in our notice, the terms of this notice may change. IF we change our notice, you may obtain a revised copy by contacting Victoria Ebner at (910) 323-2100 phone number.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do we are bound by our agreement.

By signing this form, you consent, in writing, except where we have already made disclosures in reliance on your prior consent.

_____ _____

Patients Signature Date

AMERICAN EYE CARE OPTOMETRIC CENTERS, PA

Signature on File, Assignment of Benefits, Financial Agreement

Beneficiary Name *(Print)*	Medicare Number

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to American Eye Care Optometric Centers for services furnished me by American Eye Care Optometric Centers. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) 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. American Eye Care Optometric Centers accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered 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 American Eye Care Optometric Centers, if possible or otherwise to me.

3. **RELEASE OF INFORMATION:** American Eye Care Optometric Centers 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 American Eye Care Optometric Centers for reimbursement for services rendered, and (2) any health care provider for continued patient care. American Eye Care Optometric Centers 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. **OTHER INSURANCE:** I understand that American Eye Care Optometric Centers maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. American Eye Care Optometric Centers has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by American Eye Care Optometric Centers if I belong to a plan that does not appear on the above mentioned list.

5. **NON-COVERED SERVICES:** I understand that American Eye Care Optometric Center's contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are 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 American Eye Care Optometric Centers to obtain necessary health care service plan authorizations. Including Refractions.

6. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by American Eye Care Optometric Centers, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to American Eye Care Optometric Centers 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 and/or have assessed reasonable rebilling until my account is paid in full. 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 American Eye Care Optometric Centers. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to American Eye Care Optometric Centers. *However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.*

Beneficiary Signature or Authorized Party	Date