



Patient Registration Information

Today's Date _____

Patient Name: _____ Gender: Male Female
Date of Birth: _____ Age: _____ Social Security Number: _____
Address: _____ City/State/Zip: _____
Cell phone: _____ Home phone: _____ Work phone: _____
Employer: _____ Title: _____
Referring Doctor/Primary Care Provider Name: _____
Referring Doctor/Primary Care Provider Address: _____
If Patient is a Minor:
Mother's Name: _____ Father's Name: _____
Emergency Contact name: _____ Phone number: _____
Relationship to Patient: _____ Can we inform them about your medical condition? Yes ___ No ___

Primary Insurance Policyholder

Primary Policyholder's Name: _____ Relation to Patient: _____
Date of Birth: _____ Age: _____ Primary Insurance: _____
Address: _____ City/State/Zip: _____
Cell phone: _____ Home phone: _____ Work phone: _____
Employer/Group #: _____ Social Security #: _____ (We must have to file claims)
Is pre-certification and/or referral authorization required? _____

Secondary Insurance Policyholder

Primary Policyholder's Name: _____ Relation to Patient: _____
Date of Birth: _____ Age: _____ Secondary Insurance: _____
Address: _____ City/State/Zip: _____
Cell phone: _____ Home phone: _____ Work phone: _____
Employer/Group #: _____ Social Security #: _____ (We must have to file claims)
Is pre-certification and/or referral authorization required? _____

Can we leave a phone message reminding you of your future appointments? Yes ___ No ___
Can we leave a message regarding test results on your voice mail at home, cell, or work? Yes ___ No ___
What is the preferred phone number on which to leave a message? _____

Visionary Eye Care periodically provides E-newsletters with eye care and wellness tips to our patients. If you would like to receive these, please list your email address: _____

Who referred you to our practice? _____

Your signature below indicates that you have read and understand the following:

- I authorize release of any medical information necessary to process this claim. I also authorize Medicare and/or other insurance payment of medical benefits to F. Fred Hidaji, M.D. for services provided to me. I understand that I am financially responsible to F. Fred Hidaji, M.D. for charges not covered by this assignment. I authorize refund of overpaid insurance benefits where my coverages are subject to coordination of benefits. In the event of default, I agree to pay all costs of collection, including attorney's fees.
- I also agree to give Medical Insurance Filing Services, Inc. authorization to obtain insurance and financial information needed to process this claim.

Patient/Guarantor Signature: _____ **Date:** _____

Please fill out the back of this page

Financial Policies and Statements

Consent for Treatment and Care

- I, the undersigned, do hereby agree and give my consent for F. Fred Hidaji, M.D. and his associates to provide medical care and treatment which is considered necessary and appropriate in diagnosing and treating the physical condition of me or my dependent.
- I grant my permission to Visionary Eye Care, P.C. (VEC) to release my medical records to any physician this office deems necessary for the treatment of my condition.

Statement of Financial Responsibility

- All services rendered are the responsibility of the patient/guarantor. As a courtesy to our patients, we will file with your insurance carrier. The patient/guarantor is responsible for all fees, regardless of insurance coverage or the usual and customary fees provided by your insurance company.
- Payment is expected at the time of treatment unless prior arrangements have been made with our office. I understand that I am responsible for any costs incurred as a result of my account being turned over to a collection agency. I understand that I am responsible for a \$30 service charge for any returned checks.
- I understand that if the doctor does not participate in my insurance plans, I am still responsible for any charges. I understand that if my insurance plan requires a referral, it is my responsibility to provide this information at time of service, and I will be responsible for charges if I do not follow the insurance company's guidelines.

Insurance Authorization and Benefits Assignment

- I hereby authorize F. Fred Hidaji, M.D. to release all information necessary, including medical records, requested by insurance companies with whom I have coverage and any public agency or its agents to secure payment for myself or my dependents. I hereby authorize payment of benefits to be made directly to F. Fred Hidaji, M.D. for services provided to me or to my dependents.
- I also agree to give Medical Insurance Filing Services, Inc, authorization necessary to file insurance for medical claims on behalf of F. Fred Hidaji, M.D.

Medicare One-Time Authorization

- I request payment of authorized government benefits (Medicare/Medicaid) be made on my behalf to F. Fred Hidaji, M.D. for any services furnished to me by that provider and his associates. 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 payable for related services.

Medigap Authorization

- I request payment of Medigap benefits be made on my behalf to F. Fred Hidaji, M.D. for any services furnished to me by that provider and his associates. I authorize any holder of medical information about me to release any information needed to determine these benefits payable for related services to my Medigap carrier.

Other Notices

- Account credits of \$50 or more will be applied to future visits unless you instruct us otherwise
- Delinquent accounts greater than 30 days old will be subject to a late fee up to 2% of balance
- Appointment cancellations without a 24 hour notice and no shows are subject to a \$50 fee
- I understand that this authorization may be cancelled at any time by my written request

By signing below, I indicate that I have read and understand the statements above:

Patient/Guarantor Signature: _____ Date: _____

Fees For Routine Eye Exams And Refraction

- ❖ **Refraction** is the process of measuring your eyes for corrective eyeglasses. Refraction is an important part of a complete eye examination, and is needed to write a prescription for glasses.
- ❖ Our fee for a refraction is **\$30.00**. This fee due prior to your examination **in addition to any copayment** that your plan may require. If your insurance plan pays us for this service once your claim is settled, we will credit your account accordingly.
- ❖ If you don't want your glasses prescription checked at this visit, please let any of us know, and that part of your examination will be omitted.

- ❖ A **Routine Eye Examination** (sometimes called an "yearly eye check-up") is a thorough check for eye diseases and vision problems and is an important part of maintaining the health of your eyes.
- ❖ Our fee for a routine eye examination is **\$190**.

- ❖ Most medical insurance plans, including medicare, **do not cover the cost of refractions or routine eye exams**.
- ❖ If you have questions regarding refractions and routine eye examinations, please ask any of our staff.

Patient Acknowledgement

I have read the above information and understand that the refraction and/or routine eye examination is a non-covered service. I agree to pay for the cost of this service and understand it is due at time of service. I understand that any co-payment, co-insurance, or deductible I may have is a separate from and not included in the refraction fee.

Patient Signature (Parent or Guardian if Minor)

Date

HIPAA (Health Insurance Portability and Accountability Act)

- ❖ We take the confidentiality of your medical information very seriously. A copy of our HIPAA statement is available upon your request. By signing below you are acknowledging that you had access to our HIPAA statement.

Patient Signature (Parent or Guardian if Minor)

Date

Health History

Name: _____ Birth Date: _____ Today's Date _____

Medical History:

Has the patient had any of the conditions below? (Please check all that apply)

- | | | | |
|--|--|--|------------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Development Delay | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Premature Birth | |
| <input type="checkbox"/> Attention Deficit | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Seizures | |

Patient has had previous SURGERIES Yes ___ No ___ If yes, please list:

Patient takes MEDICATION(S) on a regular basis Yes ___ No ___

If yes, please list: _____

Patient has DRUG or FOOD ALLERGIES Yes ___ No ___ If yes, please list:

Family History

Does the patient have any family members with (Please check all that apply):

- | | | |
|--|---|--|
| <input type="checkbox"/> Benign or Malignant Tumor | <input type="checkbox"/> Droopy eyelid(s) | <input type="checkbox"/> Poor vision/blindness |
| <input type="checkbox"/> Cataracts of childhood | <input type="checkbox"/> Glaucoma | |
| <input type="checkbox"/> Crossed eyes/ lazy eyes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Family History is unknown |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nearsightedness | |

Social History

Does the patient drink alcoholic beverages? Yes ___ If so, list weekly type/amount:

Does the patient smoke? Yes ___ No ___ If yes, please list:

Reason for This Visit

What is the main reason for today's visit to us? _____

Are there any other special health concerns or issues that you want the doctor to know? Yes ___ No ___ If yes, please list:
