YAKIMA EYE
SPECIALISTS

1410 Lakeside Ct Ste 103 * Yakima, WA 98902 Phone (509) 453-2010 * Fax (509) 225-6421

Thank you for scheduling an appointment with Yakima Eye Specialists, PLLC. We look forward to participating in your health care. Enclosed you will find forms for your medical records that require completion prior to your appointment. The demographic form asks you about you; address, contact information, employment, and insurance coverage. The demographic form also requires your signature at the bottom. A medical history form asks about your past and present medical history. Please list your current medications on the medication form.

Please complete the packet and return it to our office prior to your appointment, if possible, or bring it with you (completed) to your appointment, along with your insurance card(s) and ID. If you fail to bring the completed paperwork, insurance card(s) and/or ID, your appointment will need to be rescheduled. If you are more than 15 minutes late for your appointment, you will be rescheduled.

If you have vision insurance, please verify your benefits before your exam. At the time of your appointment, please specify if you want a vision only examination.

CO-PAYS AND DEDUCTIBLES: We collect ALL co-payments at the time of your visit. There is a $10.00 billing fee if the co-pay is billed. Patients without insurance coverage are expected to pay in full on the date of service and a 10% time of service discount will be applied. If you do not have your insurance card you will be asked to pay privately for your visit or reschedule your appointment.

REFERRALS: If you have an insurance that requires a referral before being seen, it is your responsibility to be sure we have a current referral prior to your visit. If we do not have a referral at the time of your visit, it will be necessary for you to pay for your visit or reschedule your appointment.

If you cannot make it to your appointment, please give us at least 24 hours' notice.

Thank you for making an appointment with our office. We appreciate your cooperation and we look forward to serving your visual needs.

Sincerely,

Yakima Eye Specialists, PLLC

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Patient Name Last: _____ **First:** _____ **MI:** _____ **Sex: M / F**

Date of Birth: _____/_____/_____ **SSN#:** _____ **Nickname:** _____

Mailing Address: _____

City: _____ **State:** _____ **ZIP:** _____

Cell: (_____) _____-_____ **Home:** (_____) _____-_____ **Text reminders? YES☐ NO☐**

Marital Status: _____ **Spouses Name:** _____

Email: _____

Employer: _____ **Phone Number:** (_____) _____-_____

Emergency Contact: _____ **Phone Number:** (_____) _____-_____

Primary Language (circle one): English / Spanish / Other: _____

Referring Doctor: _____ **Phone Number:** (_____) _____-_____

Primary Medical Doctor: _____ **Phone Number:** (_____) _____-_____

IF YOU HAVE INSURANCE YOU WOULD LIKE US TO BILL YOU MUST FILL OUT THE FOLLOWING

PRIMARY INSURANCE – Plan Name: _____

Insured Party, if other than patient - Name: _____ Birth Date: _____

SS# and/or Policy#: _____ Insured's Relationship to Patient: _____

SECONDARY INSURANCE (IF APPLICABLE) Plan Name:

_____

Insured Party, if other than patient - Name: _____ Birth Date: _____

SS# and/or Policy#: _____ Insured's Relationship to Patient: _____

VISION INSURANCE (IF APPLICABLE) – Plan Name:

_____

Insured Party, if other than patient - Name: _____ Birth Date: _____

SS# and/or Policy#: _____ Insured's Relationship to Patient: _____

IF THIS IS A LABOR AND INDUSTRIES CLAIM, PLEASE COMPLETE THE FOLLOWING

Date of Injury: _____ Claim Number: _____

IF THE PATIENT IS A MINOR OR IS NOT RESPONSIBLE FOR THE BILL, PLEASE FILL OUT THE FOLLOWING:

Responsible Party: _____ SS#: _____

Phone Number: _____ Relationship: _____ Birth Date: _____

Employer: _____ Employer Phone Number: _____

Yakima Eye Specialists, PLLC is authorized to render service, medication and treatment as necessary. I also authorize any insurance benefits to be paid directly to the provider. I assume all responsibility for any unpaid balance, deductibles or denials.

PATIENT *OR* **Parent Signature:** _____ **Date:** ____/____/_____

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PATIENT RESPONSIBILITY & FINANCIAL AGREEMENT

FINANCIAL RESPONSIBILITY: I assign any benefits to Yakima Eye Specialists, PLLC that I may have for reimbursement for my medical treatment received by Yakima Eye Specialists, PLLC, which I may be entitled to from any insurance coverage, worker's compensation benefits, disability benefits, and all settlements, judgments and verdicts against any liable third party. I also understand and agree to pay a $30 fee incurred for any returned checks.

PROOF OF INSURANCE: All patients must provide valid and up-to-date proof of insurance coverage and a copy of your driver's license. If you provided incorrect or expired insurance information you will be responsible for the balance of the claim. Insurance denials for termination of coverage will be automatically billed to you.

ALL PAYMENTS ARE DUE AT THE TIME OF SERVICE: While Yakima Eye Specialists, PLLC, as a courtesy to patients, will bill most insurance companies. If your insurance company fails to pay all or part of your bill, you are responsible for all charges. Knowing your insurance benefits-including eligibility, and covered benefits is your responsibility. Please contact customer service at your insurance company for questions you may have regarding your coverage. By signing this agreement, I agree to accept full responsibility of all Yakima Eye Specialists, PLLC charges.
If you do not have insurance, we offer a 10% discount when the charges are paid in full at the time of your exam. If you are unable to pay in full you will be required to pay half of the charges on the day of the exam and then a monthly payment of at least 10% of the balance.
CO-PAYS: co-pays are due at the time of service. If you are unable to pay your co-pay, you will be charged a $10.00 billing fee.

I have read and understand the payment policies set forth. I understand my responsibility for payment of my account with Yakima Eye Specialists, PLLC and have provided to the best of my ability the information requested accurately and completely.

Signature: _____ Date: _____

Printed Name: _____

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HIPAA Notice of Privacy Practices

We are required by law to maintain the privacy of, and provide individuals with, the notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the "HIPAA Notice of Privacy Practices", please ask to speak with our HIPAA Compliance Officer in person or by phone at 509-453-2010.

Please indicate the personal contacts (family and/or friends: not healthcare providers) with whom your personal health information may be shared:

_____ _____

_____ _____

_____ _____

"I acknowledge that I understand the HIPAA Notice of Privacy Practices."

Patient Name: _____

Signature: _____ Date: _____

****

REFRACTION NOTICE

PLEASE NOTE: At some time during your examination a refraction may be performed. Refraction is the process used to determine your glasses prescription.

If a refraction is done, you will be given your prescription (which is good for two years) even if you are happy with your current prescription. You will be charged for this service.

Some insurance companies do not pay for the refraction, including Medicare.

I understand that my insurance may not pay for a refraction. As a result, I accept the responsibility to pay the $60.00 refraction fee. If I pay for the refraction at the time of service and DO NOT have Yakima Eye Specialists, PLLC bill my insurance, I will receive a 25% discount and pay $45.00 for my refraction.

By signing below, you acknowledge that you are aware of the discount offered.

Signature: _____ Date: _____

Name_____ Date: _____/_____/_____

Occupation _____ Last Medical Exam: _____/_____/_____

MEDICAL HISTORY: List all major injuries, surgeries and/or hospitalizations you've had:

_____

_____

Circle any of the following you've had: crossed eyes, lazy eye, drooping eyelid, glaucoma, retinal disease, cataracts, eye surgery, chronic eye infections or eye injury.

Are you pregnant or nursing? No ☐ Yes ☐

Do you wear glasses? No ☐ Yes ☐

If yes, how old is your current pair of lenses? _____

Do you wear contact lenses? No ☐ Yes ☐

If yes, how old is your current pair of lenses? _____

FAMILY HISTORY: *Please note any family history (parents, grandparents, siblings or children (living or deceased):*

			Relationship to You
Blindness	No ☐	Yes ☐	_____
Cataract	No ☐	Yes ☐	_____
Crossed Eyes	No ☐	Yes ☐	_____
Glaucoma	No ☐	Yes ☐	_____
Macular Degeneration	No ☐	Yes ☐	_____
Retinal Detachment	No ☐	Yes ☐	_____
Retinal Disease	No ☐	Yes ☐	_____
Arthritis	No ☐	Yes ☐	_____
Cancer	No ☐	Yes ☐	_____
Diabetes	No ☐	Yes ☐	_____
Heart Disease	No ☐	Yes ☐	_____
High Blood Pressure	No ☐	Yes ☐	_____
Kidney Disease	No ☐	Yes ☐	_____
Lupus	No ☐	Yes ☐	_____
Thyroid Disease	No ☐	Yes ☐	_____

SOCIAL HISTORY *(all information is kept strictly confidential.)*

Do you drive? No ☐ Yes ☐

Do you:

Drink alcohol? No ☐ Yes ☐ If yes, what frequency? _____

Use tobacco? No ☐ Yes ☐ If yes, what frequency/how long? _____

Use illegal drugs? No ☐ Yes ☐ If yes, type/frequency/how long? _____

Please check the appropriate box if you have been exposed to or infected with the following:

☐ Gonorrhea ☐ Hepatitis _____A _____B _____C ☐ HIV ☐Syphilis

****DO YOU HAVE OR HAVE YOU EVER BEEN DIAGNOSED WITH MRSA****

(methicillin-resistant Staphylococcus aureus)

YES ☐ NO ☐

OVER

REVIEW OF SYSTEMS: Do you currently, or have you ever had any problems with the following:

	YES	NO
Constitutional		
Fever, Weight loss/gain	☐	☐
Skin Disorders	☐	☐
Neurological		
Headaches	☐	☐
Migraines	☐	☐
Seizures	☐	☐
Eyes		
Loss of Vision	☐	☐
Blurred Vision	☐	☐
Distorted Vision/Halos	☐	☐
Loss of Side Vision	☐	☐
Double Vision	☐	☐
Dryness	☐	☐
Mucous Discharge	☐	☐
Redness	☐	☐
Sandy/Gritty Feeling	☐	☐
Itching	☐	☐
Burning	☐	☐
Foreign Body Sensation	☐	☐
Excess Tearing/Watering	☐	☐
Glare/Light Sensitivity	☐	☐
Eye Pain or Soreness	☐	☐
Chronic Infection Eye/Lid	☐	☐
Sties or Chalazion	☐	☐
Flashes in Vision	☐	☐
Floaters in Vision	☐	☐
Tired Eyes	☐	☐
Endocrine		
Thyroid/Other Glands	☐	☐

	YES	NO
Ears, Nose, Mouth, Throat		
Allergies/Hay fever	☐	☐
Sinus Congestion	☐	☐
Runny Nose	☐	☐
Postnasal Drip	☐	☐
Chronic Cough	☐	☐
Dry Throat/Mouth	☐	☐
Respiratory		
Asthma	☐	☐
Chronic Bronchitis	☐	☐
Emphysema	☐	☐
Vascular/Cardiovascular		
Diabetes	☐	☐
Heart Pain	☐	☐
High Blood Pressure	☐	☐
Vascular Disease	☐	☐
Gastrointestinal		
Diarrhea	☐	☐
Constipation	☐	☐
Genitals/Kidney/Bladder	☐	☐
Bones/Joints/Muscles		
Rheumatoid Arthritis	☐	☐
Muscle Pain	☐	☐
Joint Pain	☐	☐
Lymphatic/Hematologic		
Anemia	☐	☐
Bleeding Problems	☐	☐
Allergic/Immunologic	☐	☐
Psychiatric	☐	☐

If you answered **YES** to any of the above or **have a condition not listed**, please explain:

_____

_____

_____

_____

Name_____ Date: _____/_____/_____

Please list all medications, including aspirin, over-the-counter medications, vitamins and home remedies.

Medication/Strength/Dosage	Reason for Taking

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ **YES** ☐ **NO**

If yes, please list:

Medication	Reaction

If your medication or allergy list is too long to fit on the page, bring in a list for us to copy.

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If Medicare or a Medicare Replacement Plan is your primary or secondary insurance, please complete.

MEDICARE LIFETIME AUTHORIZATION

Patient's Name and Address: _____

_____

_____

Patient's Medicare ID or
Medicare Replacement Plan ID: _____

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I request that payment under the medical insurance program be made either to me or to the provider named above on any bills for services furnished to me. I understand that this is a lifetime authorization and will remain effective until further notice in writing from the patient. I authorize the above-named provider to release to the Social Security Administration or its intermediaries or carriers any information needed for this claim or any related Medicare claim. I further permit a copy of this authorization to be used in place of the original.

Signature: _____ Date: _____

Printed Name: _____