Eyesight Ophthalmic Services, P.A.

155 Borthwick Ave, Suite 200 East, Portsmouth, NH 03801 (603) 436-1773

Patient Information (Please Print Clearly)					
Last Name, First Name, Middle Initial:		Marital Status:	Social Security #:	Date of Birth:	Birth Sex:
Language:	Ethnic Group & Race:	Preferred Contact Method: ☐ Phone ☐ Email ☐ Patient Portal ☐ Mail	Emergency Contact Name: _____ Phone #: _____		
Patient Home Phone #:	Patient Work Phone #:		Patient Cell Phone #:		
Preferred Phone Number: Home ☐ Home ☐ Work ☐ Cell	Is it okay to leave a detailed message? ☐ Yes ☐ No		Email Address (required for portal access):		
Patient Mailing/Billing Address:					
Primary Care Physician: (Name/City, State)	Referring Physician: (Name/City, State)				

If an email and cell phone are provided, we will email you a billing statement and send appointment reminders via text or email. Once you receive your first bill or appointment reminder, you will be given the option to OPT OUT. This will stop electronic billing statements and appointment reminders. All future billing statements will be mailed and appointment reminders will be a phone call.

Does your insurance require a referral? (If your card says **HMO** or **EPO** referrals **are usually required**) ☐ **YES** ☐ **NO**
(If you have Medicare, they do NOT require a referral and they do NOT cover Routine Eye Care)

Is this visit to follow a medical diagnosis? (Example: Cataracts, Dry Eye, Glaucoma, Diabetes, etc.) ☐ **YES** ☐ **NO**

If this visit is NOT to follow a diagnosis, do you have a Routine Eye Care Benefit under your Medical Plan (NOT through a Vision Service Plan)? ☐ **YES** ☐ **NO**
(Examples of vision service plans: Davis Vision, EyeMed, VSP, Blue View Vision, Cigna Vision, and Spectera, etc.)

I understand Eyesight does NOT participate with any Vision Service Plans. _____(Please Initial)

<u>If my insurance does not cover my exam, or it is subject to a deductible, co-pay, coinsurance, etc.,</u> I understand that I will be responsible for any such balance and Eyesight is contractually required to hold me responsible for such balance. The insurance policy I have presented today is my own and it is my responsibility to know my benefits. _____(Please Initial)

Refraction is the procedure in which your doctor will test your vision using different lenses to see if your visual acuity can be improved. A glasses prescription can be written from this test. Insurance coverage for refraction is variable and plan specific. <u>MEDICARE DOES NOT COVER THIS SERVICE</u>.
I understand that a refraction may be necessary as part of my exam and is often a non-covered service with insurance. <u>A refraction fee is $50.00 and I may receive a bill for this service</u>. _____(Please Initial)

Have you received your Pneumonia Vaccine? ☐ **YES** ☐ **NO**
Do you have an Advanced Directive (Living Will, Health Care Proxy, Power Attorney, etc.)? ☐ **YES** ☐ **NO**
Do you smoke? ☐ **YES** ☐ **NO**

Signature Of Patient/Guardian _____ Date _____

<u>Patient HIPAA Acknowledgement</u>

Eyesight Ophthalmic Services, P.A.

155 Borthwick Ave, Suite 200 East, Portsmouth, NH 03801 (603) 436-1773

I acknowledge that I have been given access to and/or received a copy of the Notice of Health Information Practices with the effective date of June 18, 2018.

☐ I decline to list anyone on my HIPAA at this time.

☐ I authorize Eyesight Ophthalmic Services, P.A. to speak with the following people regarding my medical history, treatment, and billing/account information:

Name:	Relationship To Patient:	Phone Number:
_____	_____	_____
_____	_____	_____

Patient Name (Please Print):	Patient Date of Birth:	Today's Date:
_____	_____	_____

Patient or Legal Guardian Signature: _____

Electronic Prescribing Consent:

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care by reducing errors and enhancing patient care. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an e-Prescribe program.

These include:

Formulary and benefit transactions - Gives the prescriber information about which drugs are covered by the drug benefit plan.

Medication history transactions - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

Fill status notification - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form, you are agreeing that Eyesight Ophthalmic Services can request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payors for treatment purposes. Understanding all of the above, I hereby provide informed consent to Eyesight Ophthalmic Services to enroll me in the e-Prescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Name of Pharmacy:	Street Name, City, State:	Patient Or Legal Guardian Signature:
_____	_____	_____