ADVANCED EYECARE PROFESSIONALS

AEPeyecare.com

Welcome to Advanced Eyecare Professionals! We would like to thank you for trusting us with your vision care needs. Please take a moment prior to your appointment to review this packet as it contains valuable information to help you prepare for your upcoming visit with us.

In order for us to make your visit as efficient as possible, please complete the attached forms and bring them with you to your visit, along with the following items:

- Photo ID
- Vision and Medical Insurance Cards
- A list of all of your current medications and information for preferred pharmacy
- Current eyeglasses, prescription & non-prescription sunglasses, and/or contact lenses

If you do not have your paperwork filled out when you come for your visit please arrive 20 minutes early. This will allow time for you to fill out paperwork and our office to get your information into our electronic medical system.

If your insurance requires a prior authorization for your visit, please obtain this prior to your visit. In order to avoid unexpected out of pocket expenses, it is important for you to meet all of your insurance plan requirements. We do our best to help you understand and maximize your benefits but, we do ask that you know your plan.

Payment is collected at the time of service. Please be prepared to pay any copays or other out of pocket expenses at the time of your visit. For your convenience, we accept payment by cash, check, credit card, or Care Credit.

An initial medical eye exam will take approximately 60-90 minutes and your eyes will likely be dilated for a complete exam or retinal evaluation. Dilation will cause sensitivity to light and will compromise your near vision (up close). *It would be beneficial to bring along a pair of sunglasses*. You should be able to drive safely home after dilation, as your distance vision is not affected, however some patients feel more comfortable having someone else drive them home. It is entirely up to you! Your eyes will remain dilated for approximately 3-6 hours after your exam, but you should be able to see fairly normal in half of that time. Some patients have experienced longer lengths of time though.

An initial vision exam will take approximately 45-70 minutes and your eyes will not likely need to be dilated. If you are unsure of which type of exam you are scheduled for, please contact our office for more information.

If the patient is under the age of eighteen, a parent or legal guardian must be present at the initial appointment. A signed notice from the parent or guardian for consent to treat may be left on file for future visits.

Please visit our website, www.AEPeyecare.com, for more information regarding our practice such as our locations and maps to those locations. You can also use our website to set up future appointments, learn how glasses are made, or sign up to become a member to receive discounts. If you have further questions or concerns, please do not hesitate to contact our office.

We look forward to seeing you and look forward to serving your vision care needs!

Sincerely,

The Doctors and Staff
Advanced Eyecare Professionals

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How did you hear about our Office? (circle one: Website, Newspaper, Phone Book, Family/Friend, Doctor Referral, Other)

If it was a referral please let us know their name so we may thank them:

_____

Please Print Today's Date:_____

Name:_____ Mr, Mrs, Ms, Miss, Rev, Dr Sex: M F
First Middle Last (circle one)

Patient's Social Security # _____ - _____ - _____ Date of Birth _____-_____-_____ Status S M D W

Mailing address: _____
Street Apt# PO Box City State Zip code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Occupation: _____ Patient Employer: _____

Employer address:_____
Street City State Zip code

Guarantor: _____ _____ _____ _____ _____
(Person responsible for bill if other than patient) Phone Date of Birth Social Security # Relationship to patient

Guarantor's Employer: _____
Company Name Street City State Zip code

Will this claim be covered under Workers Compensation? _____ *Yes* _____ *No*

If yes, Company name:_____ Authorized by _____ Phone: _____

Company Address: _____
Street City State Zip code

In Case of emergency Contact or Secondary contact (person not living with patient)

Name: _____ Relationship: _____ Phone: _____

Address: _____
Street City State Zip code

Family Doctor:_____Phone:_____

Address: _____
Street City State Zip code

Preferred Pharmacy: _____

HASTINGS
915 West Green St.
Suite 101
Hastings, MI 49058
269.945.3866

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2001 E Bluewater Hwy.
Suite 100
Ionia, MI 48846
616.522.1000

LOWELL
1335 West Main St.
Suite A
Lowell, MI 49331
616.897.7000

SHERIDAN
301 North Main St.
Sheridan, MI 48884
989.291.6464

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Medical Insurance Information

(if you need Prior Authorization from your family physician, please obtain it prior to your visit)

Primary Insurance Carrier _____**Policy #**_____ **Group#**_____

Policy Holder's Name: _____ Social Security # _____-_____-_____ Date of Birth ____-____-_____

Policy Holder's Employer or Retiree's former employer: _____

Secondary Insurance Carrier _____**Policy #**_____ **Group#**_____

Policy Holder's Name: _____ Social Security # _____-_____-_____ Date of Birth _____-____-_____

Policy Holder's Employer or Retiree's former employer:_____

Vision Insurance Carrier _____**Policy #**_____ **Group#**_____

Policy Holder's Name: _____ Social Security # _____-_____-_____ Date of Birth ____-____-_____

Policy Holder's Employer or Retiree's former employer:_____

Financial Policy

It is the policy of Advanced Eyecare Professionals to require **PAYMENT AT TIME THE SERVICES ARE PROVIDED.** By signing below I am stating that I understand this policy.

Remember that insurance is a form of reimbursement made on behalf of the patient to the doctor for service rendered and **NOT A SUBSTITUTE** for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. ***It is your responsibility to know what your insurance pays and to pay any deductible amount, co-insurance or any other balance not paid for by your insurance.***

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to: Advanced Eyecare Professionals 915 West Green St. Suite 101 Hastings MI, 49058 or If my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows: Advanced Eyecare Professionals 915 West Green St. Suite 101 Hastings MI, 49058.

For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. Any products returned to Advanced Eyecare Professionals maybe assessed a restocking fee.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of my patient records, as per HIPPA policy.

I hereby assign all medical and or surgical benefits, to include major-medical benefits to which I am entitled including Medicare, private insurance and other health plans to **Advanced Eyecare Professionals.** I also authorize the Doctor to deposit checks received on Patient's account when made out to the Patient.

This assignment will remain in effect until revoked by me in writing. A photo copy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I understand that I am responsible for all services not covered by insurance plans. I hereby authorize said assignee to release all information necessary to secure the payment.

Patient/Parent or Guardian Signature: _____ **Date** _____

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Patient History Form

Please answer the following questions about your medical status and history

1. Have you ever been treated for any **Medical Conditions**? (E.g. Diabetes, High blood pressure, Arthritis, etc.)?	**5.** Family and Social History Do you have any medical or eye diseases that run in your family?
☐ NO	☐ NO
☐ YES, If yes please list:	☐ YES, If yes please list:
	6. Do you have any allergies? (Food, drug, or other)
2. Have you ever had any **Eye Disease**? (E.g. Glaucoma, Cataract, "Lazy Eye", Retinal Detachment)?	
☐ NO	
☐ YES, If yes please list:	**7. Do you smoke?**
	☐ NO
	☐ YES, If yes how much?
	8. Do you consume any Alcohol?
3. Have you ever had <u>any</u> **Surgeries**?	☐ NO
☐ NO	☐ YES, If yes how much?
☐ YES, If yes please list:	
	9. Do you consume any products with caffeine?
	☐ NO
	☐ YES, If yes how much?
4. Have you ever been **Hospitalized**, other than surgeries?	
☐ NO	**10. Medications:** (including any eye medications / vitamins / over the counter)
☐ YES, If yes please list:	

Do you Currently have any of the following problems?	**YES**	**NO**	**if YES, please explain:**
Chronic fever, unexpected weight loss/gain, fatigue	☐	☐	_____
Ear/nose/throat problems (hearing loss, sinus, sore throat)	☐	☐	_____
Heart problems (chest pain, irregular heart beat)	☐	☐	_____
Respiratory problems (shortness of breath, wheezing)	☐	☐	_____
Gastrointestinal problems (heartburn, abdominal pain, diarrhea)	☐	☐	_____
Urinary problems (pain or discomfort, blood in urine)	☐	☐	_____
Skin problems (rashes, excessive dryness)	☐	☐	_____
Musculoskeletal problems (muscle aches, joint pain)	☐	☐	_____
Neurologic problems (numbness, weakness, headaches)	☐	☐	_____
Psychiatric problems (depression, anxiety)	☐	☐	_____

Patient/Parent or Guardian Signature: _____ **Date** _____

Physician Signature_____**Date**_____

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