MAUMEE CENTER FOR EYECARE

PATIENT FINANCIAL INFORMATION SHEET

Name of Patient:_____ **DOB**_____

Name of Insured:_____ **DOB**_____

Name of Medical Insurance Carrier:_____

ID#_____ **Group#**_____

Authorization and Release:

I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____

Signature of patient or parent if minor Date

HIPAA PRIVACY PRACTICE ACKNOWLEDGEMENT

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other healthcare practitioners.

I accept release of records:

_____ _____

Signature **Date**

I decline release of records:

_____ _____

Signature **Date**

Office Policy
Maumee Center for EyeCare

New patients and current patients:

Thank you for choosing us as your vision care provider. We are committed to your treatment being successful. Please understand that payment of services is considered a part of your treatment. This letter is to help us, as well as our patients understand our office and financial policies which we require you to read and sign prior to any future treatment. In order for us to keep our fees lower we need to obtain control of very costly monthly billing.

All patients must complete our Information and Insurance form before seeing the doctor.

Full payment is due at time of service unless otherwise arranged prior. We accept cash, checks, Visa, MasterCard & Discover.

Invoices are due upon receipt. If your account must be sent for collection activity, you may be asked to seek vision care elsewhere. In the event you are sent to collections we reserve the right to charge you the collection fee.

Usual and Customary Rates:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. They vary from one insurance company to another.

Minor Patients:

The adult accompanying a minor is responsible for full payment. We cannot do third party billing. If this is a divorce or custody situation we will bill the adult accompanying the minor. We no longer bill the non-present adult this is your responsibility.

Contact Lens Return Policy:

Unopened contact lenses must be returned within 30 days of purchase for credit.

Missed Appointments:

Unless cancelled, at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments. There are patients that would be willing to take the appointments at short notice. It is very costly for the doctor and staff to have wasted down time without patients. If more than one appointment is missed we may not reschedule.

I have read the office policy. I understand and agree to this new policy:

X_____ **Date:**_____

Thank you!

Maumee Center for Eyecare

Phone: (419) 891-1023
www.maumeecenterforeyecare.com

DEAR PARENTS,
Your child's vision develops in conjunction with such other functions as walking and talking and is affected by certain illness as well his/her family history. Therefore, your thorough answers to this form will aid us in determining how your child's vision has developed as well as permitting us to utilize all of the office time for a complete optometric examination.

Child's full name:_____ Nickname:_____
Address_____City_____Zip_____
Home Ph. #_____ Birth date_____ Age now _____ Grade_____
School_____ Teacher's name_____
Parents' names_____
Step-parents/Guardian (if applicable)_____
Parents Ph. # _____ Parent's email Address:_____
Parents' occupations: _____

PRESENT SITUATION:
Does your child seem to have any visual difficulty?_____
_____

Does your child experience any of the following:

a) headaches	__Yes	__No	When?_____
b) blurred vision	__Yes	__No	When?_____
c) double vision	__Yes	__No	When?_____
d) eyes "hurt or seem tired	__Yes	__No	When?_____

OCULAR HISTORY:

a)__ holding reading close
b)__ uses fingers when reading
c)__ reverse words
d)__ skips words
e)__ closes or covers one eye
f)__ frowning or squinting
g)__ eyes frequently reddened
h)__ frequent styes
i)__ excessive eye rubbing
j)__ getting lost in books
k)__ tilting head when reading
l)__ bumping into objects
m)__ poor general coordination
n)__ large pupils in bright lights
o)__ bothered by light
p)__ "car sickness"

ACADEMIC HISTORY:

Age at time of entrance into Kindergarten _____
Age at time of entrance into First Grade _____
Child likes school/teacher ____yes ____no
Repeated grade/s (if any) ____
Child likes to read? ____yes ____no

Explain any difficulty with school_____

_____

List subjects, which seem difficult for your child_____

_____

List reasons for which child is having remedial work_____

_____

DEVELOPMENTAL HISTORY:

Pregnancy: ____ full term ____ premature

Birth: ____normal ____ caesarean

Complications before, during or immediately following delivery: _____

_____

Crawled: ____yes ____no

Walked at age: ____months ____ unknown

Speech: First words at age ____ ____ sentences ____unknown

Give a brief thumbnail description of child's personality: _____

_____

When fatigued child: ____ sags ____ becomes irritable ____becomes excited

MEDICAL HISTORY:

Primary Care Physician or Clinic: _____

List all past illnesses and significant injuries: _____

_____

_____

MEDICATIONS:

List all current medications:_____

_____

_____

ALLERGIES:

List all current allergies/reactions (medications or environmental) _____

_____

_____

PREVIOUS VISUAL HISTORY:

Examination date: _____ Results: _____

Does you child currently wear glasses? ____yes ____no

Does your child currently wear contacts? ____yes ____no

List all family members who have had visual attention and why: _____

_____

List any unusual family eye conditions: _____

_____