



**Michael's Eyecare, Inc.**

363 Delaware Street  
Tonawanda, NY 14150-3951  
TEL: (716) 695-2024 • FAX: (716) 389-3514  
www.michaelseyecare.com • michaelseyecareinc@yahoo.com

**NEW PATIENT FORM**

Account No.:	
Printed:	

**PATIENT INFORMATION**

PATIENT NAME:		GENDER:	SOCIAL SECURITY NUMBER:
ADDRESS:		DATE OF BIRTH:	
CITY, STATE & ZIP:		EMAIL:	
HOME PHONE:	MOBILE PHONE:	WORK PHONE:	
PRIMARY CARE PHYSICIAN:		PRIMARY CARE PHYSICIAN'S PHONE:	
EMERGENCY CONTACT NAME:	RELATIONSHIP TO PATIENT:	EMERGENCY CONTACT PHONE:	
GUARDIAN NAME:	RELATIONSHIP TO PATIENT:	GUARDIAN PHONE:	

**REASON FOR TODAY'S VISIT (check all that apply):**

- Routine Exam** (will include eyeglass prescription and health evaluation of eyes) without insurance, fee is \$75. If dilation is required, fee is \$15 additional.
- Contact Lens Fitting Evaluation** (will include contact lens prescription and trial contacts if available)
  - \*A valid contact lens prescription is required by law to purchase contact lenses. Prescriptions expire in 1 year.
  - Current Contact Lens Wearer:** Fitting fee is \$45-\$75 (depending on Rx) in addition to the routine exam fee or copay.
  - New Contact Lens Wearer:** Fitting fee is \$60-\$85 and will include tutorial on lens insertion and removal, trial pair of contact lenses in your prescription, contact lens cleaning solution, storage case for contacts, additional follow-up visits with doctor to address any contact lens related problems and finalize contact lens prescription.
    - \*Contact lenses are considered cosmetic and most insurance plans do not cover the cost of contact lens fitting evaluation
- Medical/Emergency Office Visit** you are suffering from physical eye symptoms (i.e. red eye, infection, sty, scratched cornea, etc.) or sudden abnormal visual symptoms (i.e. double vision, flashes, floaters, loss of vision, etc.) These visits are billed to your medical insurance as long as we are a participating provider. Vision insurance (Eyemed, Davis, VSP, etc.) does **not** cover eye related emergencies. Specialist co-pay will apply. Without insurance, fee is \$90.

<p>Do you or your family have any history of the following conditions?:</p> <table border="0"> <tr> <th style="text-align: left;">Self</th> <th style="text-align: left;">Family</th> <th></th> </tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Glaucoma</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Cataracts</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Diabetes</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>High Blood Pressure</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Macular Degeneration</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Heart Problems</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Retinal Degeneration</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Stroke</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Thyroid Condition</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Crossed/Lazy Eyes</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Asthma/ Allergies</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Color Blindness</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Arthritis</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Tuberculosis</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>HIV/Hepatitis</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Cancer</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Multiple Sclerosis</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Blindness</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Other:</td></tr> </table>	Self	Family		<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Condition	<input type="checkbox"/>	<input type="checkbox"/>	Crossed/Lazy Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Asthma/ Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Color Blindness	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	HIV/Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	Blindness	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<p>Do you currently have any of the following symptoms?:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Blurry distance vision</li> <li><input type="checkbox"/> Poor night vision</li> <li><input type="checkbox"/> Eye Strain</li> <li><input type="checkbox"/> Blurry Near Vision</li> <li><input type="checkbox"/> Trouble Reading</li> <li><input type="checkbox"/> Itchy Eyes</li> <li><input type="checkbox"/> Discharge</li> <li><input type="checkbox"/> Watering</li> <li><input type="checkbox"/> Pain in the eye</li> <li><input type="checkbox"/> Burning eyes</li> <li><input type="checkbox"/> Sandy/dry eyes</li> <li><input type="checkbox"/> Red Eyes</li> <li><input type="checkbox"/> Glare/reflections</li> <li><input type="checkbox"/> Discomfort in sunlight</li> <li><input type="checkbox"/> Double vision</li> <li><input type="checkbox"/> Floaters or spots in vision</li> <li><input type="checkbox"/> Flashes of light</li> <li><input type="checkbox"/> Eye injury</li> <li><input type="checkbox"/> History of wearing an eye patch</li> <li><input type="checkbox"/> History of eye surgery</li> <li><input type="checkbox"/> Headaches</li> <li><input type="checkbox"/> Other:</li> </ul>	<p>Are you interested in any of the following (check all that apply)?:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Eyeglass prescription</li> <li><input type="checkbox"/> New eyeglasses</li> <li><input type="checkbox"/> Sunglasses           <ul style="list-style-type: none"> <li>Do you currently have Rx sunglasses? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> </ul> </li> <li><input type="checkbox"/> Safety glasses           <ul style="list-style-type: none"> <li>Does your job require you to wear safety glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> </ul> </li> <li><input type="checkbox"/> Contact lens prescription           <ul style="list-style-type: none"> <li>Which kind do you prefer? <input type="checkbox"/> Clear <input type="checkbox"/> Colored</li> </ul> </li> <li><input type="checkbox"/> Lasik surgery</li> <li><input type="checkbox"/> Dry eye therapy</li> </ul> <p>How were you referred to us?</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Family doctor</li> <li><input type="checkbox"/> Insurance company</li> <li><input type="checkbox"/> Another patient: <i>tell us their name so we can thank them:</i> _____</li> <li><input type="checkbox"/> Internet Search</li> <li><input type="checkbox"/> Other:</li> </ul>
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<input type="checkbox"/>	<input type="checkbox"/>	Other:																																																												

<p>MEDICATIONS: <input type="checkbox"/> None <input type="checkbox"/> List attached</p>	<p>ALLERGIES: <input type="checkbox"/> None</p>	<p>SOCIAL HISTORY:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Alcohol abuse/use</li> <li><input type="checkbox"/> Drug use</li> <li><input type="checkbox"/> Tobacco use</li> <li><input type="checkbox"/> Other:</li> </ul>
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### INSURANCE INFORMATION

Patient Name:	
Account No.:	
Printed:	

GUARANTOR	
GUARANTOR NAME:	GENDER: SOCIAL SECURITY NUMBER:
ADDRESS:	DATE OF BIRTH:
CITY, STATE, ZIP:	PATIENT'S RELATIONSHIP TO GUARANTOR:
HOME PHONE:	WORK PHONE:
PRIMARY VISION INSURANCE	SECONDARY VISION INSURANCE
COMPANY NAME:	COMPANY NAME:
POLICY ID NO.:	POLICY ID NO.:
POLICY GROUP:	POLICY GROUP:
INSURED PARTY:	
PRIMARY MEDICAL INSURANCE	SECONDARY MEDICAL INSURANCE
COMPANY NAME:	COMPANY NAME:
POLICY ID NO.:	POLICY ID NO.:
POLICY GROUP:	POLICY GROUP:
INSURED PARTY:	INSURED PARTY:

**MEDICAL INSURANCE POLICY:** As part of our services at this practice we are happy to assist you in determining the benefits of your individual policy and in collecting your reimbursement of insurance benefits for medical services. To avoid any misunderstandings please read the following statements carefully:

1. The legal obligations of your insurance provider are between yourself and your provider, not between this practice and your provider.
2. When your insurance provider (s) has settled your plan's covered items, you will be notified by a monthly statement if there were any unpaid balances. Unpaid balances can include non-covered items or services, co-pays, deductibles, lapses, ineligibility or termination of coverage's. Unpaid balances are the sole responsibility of the patient.
3. To keep the cost of records and collections down any patient portion amounts on your order will be due at the time of service.
4. I authorize the use of this form on all insurance submissions as well as authorizing the release of information to all my insurance companies as well as allowing the doctor to act as my agent to help me in obtaining payment from my insurance companies.
5. I authorize payment to be made directly to the provider and permit a copy of this authorization to be used in place of the original.

**CONSENT FOR TREATMENT:** I hereby authorize Michaels Eyecare, Inc. to administer diagnostic and medical procedures as may be necessary for proper health care.

\_\_\_\_\_  
Signature of patient or authorized representative  
Name of Patient:

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized representative's name



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**HIPAA CONSENT**

Patient Name:	
Account No.:	
Printed:	

**CONSENT TO USE AND DISCLOSE HEALTH INFORMATION**

**Permission to Use and Disclose My Health Information:** By signing this form, I give Michaels Eyecare Inc. permission to use and/or disclose my health information to provide treatment, obtain payment, and/or conduct health care operations.

**Right to Refuse:** I have the right not to sign this consent. If I refuse to sign this consent, Michaels Eyecare Inc. has the right to refuse to treat me. However, treatment required by law –such as emergency care– can be provided to me whether or not I sign this consent.

**Right to Review Notice of Privacy Practices:** I have been provided with a copy of the Notice of Privacy Practices for Michaels Eyecare, Inc. which describes how Michaels Eyecare, Inc. may use and disclose my health information. I have the right to review this Notice before signing this consent.

**Changes to the Notice of Privacy Practices:** Michaels Eyecare, Inc. may change the Notice of Privacy Practices as needed. I may obtain a current copy of the Notice of Privacy Practices for Michaels Eyecare, Inc. by contacting Michaels Eyecare, Inc..

**Right to Request Restrictions on Use/Disclosure:** I have the right to request that the usage of my protected health information by Michaels Eyecare, Inc. be restricted in how it is used and/or disclosed for the purpose of providing treatment, obtaining payment, and/or conducting health care operations. However, Michaels Eyecare, Inc. is not required to agree to any restriction that I request. If Michaels Eyecare, Inc. does decide to agree to my request, the use and/or disclosure of my health information by Michaels Eyecare, Inc. must be restricted as I requested. If I wish to request restrictions I can contact Michaels Eyecare, Inc.. Michaels Eyecare, Inc. will notify me on whether my restrictions have been accepted or declined.

**Right to Withdraw Consent:** I have the right to withdraw this consent at any time. I must do so in writing by contacting Michaels Eyecare, Inc. at 363 Delaware St., Tonawanda, NY 14150-3951. My withdrawal of this consent will not be effective for uses and/or disclosures that have already been made based on my prior consent. If I withdraw this consent, then Michaels Eyecare, Inc. may refuse to provide to me further treatment or follow-up, other than required emergency services.

**Effective Period:** This consent is good unless and until I withdraw it in writing.

**References to “I” or “me”:** References to “I” or “me” in this Consent include the individual for whom the signing party is authorized to sign. If I am signing this consent on behalf of another person, it is because I am that person’s parent, legal guardian, or agent under an active Power of Attorney for Health Care; and I am legally authorized to sign this Consent on behalf of that person.

\_\_\_\_\_  
 Signature of patient or authorized representative  
 Name of Patient:

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Authorized representative’s name

**FOR OFFICE USE ONLY**

Complete this section if this form is not signed and dated by the patient or an authorized representative for the patient.

**I have made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices for Michaels Eyecare, Inc. but was unable to for the following reason:**

- Patient refused to sign
- Patient is unable to sign
- Other \_\_\_\_\_

\_\_\_\_\_  
 Signature of employee

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Employee’s name