Michaels 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:	ALTERNATE EMERGENCY PHONE:
GUARDIAN NAME:	RELATIONSHIP TO PATIENT:	GUARDIAN PHONE:	

REASON FOR TODAYS 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 $60-$80 (depending on Rx) in addition to the routine exam fee or copay.
  - ❑ New Contact Lens Wearer: Fitting fee is $80-$100 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.

Do you or your family have any history of the following conditions?:

Self	Family	
❑	❑	Glaucoma
❑	❑	Cataracts
❑	❑	Diabetes
❑	❑	High Blood Pressure
❑	❑	Macular Degeneration
❑	❑	Heart Problems
❑	❑	Retinal Degeneration
❑	❑	Stroke
❑	❑	Thyroid Condition
❑	❑	Crossed/Lazy Eyes
❑	❑	Asthma/ Allergies
❑	❑	Color Blindness
❑	❑	Arthritis
❑	❑	Tuberculosis
❑	❑	HIV/Hepatitis
❑	❑	Cancer
❑	❑	Multiple Sclerosis
❑	❑	Blindness
❑	❑	Other:

Do you currently have any of the following symptoms?:

- ❑ Blurry distance vision
- ❑ Poor night vision
- ❑ Eye Strain
- ❑ Blurry Near Vision
- ❑ Trouble Reading
- ❑ Itchy Eyes
- ❑ Discharge
- ❑ Watering
- ❑ Pain in the eye
- ❑ Burning eyes
- ❑ Sandy/dry eyes
- ❑ Red Eyes
- ❑ Glare/reflections
- ❑ Discomfort in sunlight
- ❑ Double vision
- ❑ Floaters or spots in vision
- ❑ Flashes of light
- ❑ Eye injury
- ❑ History of wearing an eye patch
- ❑ History of eye surgery
- ❑ Headaches
- ❑ Other:

Are you interested in any of the following (check all that apply)?:

- ❑ Eyeglass prescription
- ❑ New eyeglasses
- ❑ Sunglasses
  Do you currently have Rx sunglasses? ❑ Yes ❑ No
- ❑ Safety glasses
  Does your job require you to wear safety glasses? ❑ Yes ❑ No
- ❑ Contact lens prescription
  Which kind do you prefer? ❑ Clear ❑ Colored
- ❑ Lasik surgery
- ❑ Dry eye therapy

How were you referred to us?

- ❑ Family doctor
- ❑ Insurance company
- ❑ Another patient: *tell us their name so we can thank them:* _____
- ❑ Internet Search
- ❑ Other:

MEDICATIONS: ❑ None ❑ List attached

ALLERGIES: ❑ None

SOCIAL HISTORY:

- ❑ Alcohol abuse/use
- ❑ Drug use
- ❑ Tobacco use
- ❑ Other:

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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:	MOBILE 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 — Date

Name of Patient:

_____

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 Date

Name of Patient:

_____

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