Alaska Children's EYE and Strabismus

Date:____________________

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PLEASE COMPLETE AND RETURN TO OUR OFFICE (info@alaskachildrenseye.com or 563-5373 fax)

Patient Name:____________________ Date of Birth:________ Age:____ Sex:___

Mailing Address:____________________ City:__________ State:____ Zip Code:____

Physical Address:____________________ City:__________ State:____ Zip Code:____

Preferred Phone Number:________________ Alternate Phone Number:________________

Email:____________________ Preferred Language:________________

Race:____________________ Ethnicity:________________

Preferred method to receive appointment reminders: Phone Call Text Email

Parent / Guardian Information:

Name:____________________

SSN:____________________

Date of Birth:____________________

Relationship:____________________

Parent / Guardian Information:

Name:____________________

SSN:____________________

Date of Birth:____________________

Relationship:____________________

Emergency Contact:______________ Phone Number:__________ Relationship:________

We are a medical provider, therefore we **DO NOT ACCEPT VISION INSURANCE.** You will be responsible for whatever your insurance does not pay. We are currently considered "Preferred Providers" with some insurance groups. Please call us in advance if you have further questions.

** If Tricare, the VA or Alaska Native Health Service insures you, provide a letter of pre-authorization BEFORE you are seen.**

PLEASE LIST THE FOLLOWING INSURANCE INFORMATION. WE WILL ALSO NEED A COPY OF THE CARD.

Primary Insurance Company:____

ID Number:____________________ Group Number:________________

Name of Insured/Policy Holder:__________ DOB of Policy Holder:________________

SSN:____________________ Relationship to Patient:________________

Secondary Insurance Company:____

ID Number:____________________ Group Number:________________

Name of Insured/Policy Holder:__________ DOB of Policy Holder:________________

SSN:____________________ Relationship to Patient:________________

It often takes **2 hours** for a new patient or complete eye exam. If you are a new patient or here for your yearly eye exam, **your eyes may be dilated.**

Financial Agreement

Thank you for choosing us for your eye care. We are committed to providing you with quality and affordable health care. Some of our patients have had questions regarding patient and insurance responsibility for services rendered, so we have developed this financial agreement. Once you have finished reading please sign in the space provided. A copy will be provided to you upon request.

1. **Insurance:** We participate in most insurance plans, including Medicare. An up-to-date insurance card is expected at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments and deductibles:** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.

3. **Non-covered services:** Please be aware some - and perhaps all - of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. **Proof of insurance:** All patients must complete our patient information from form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. **Claims submission:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company we are not party to that contract.

6. **Coverage changes:** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. **Nonpayment:** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may will refer your account to a collection agency.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Please let us know if you have any questions or concerns.

______________________________ ______________________________

Printed Name Date

______________________________ ______________________________

Signature Relationship to Patient

Dear patient,

Your privacy is very important to us. We need your permission to speak to anyone regarding your care and medications. **Please list below any family members or healthcare providers who may contact us about your current medications or care, including special doctors or therapists.** We will also need your signature at the bottom of this form giving us written permission to communicate with the individuals listed below.

Do you give us permission to communicate with your child's school about their care? Y / N

____________________________ ____________________________

____________________________ ____________________________

____________________________ ____________________________

____________________________ ____________________________

I give Alaska Children's Eye and Strabismus permission to discuss my current care and medications with the individuals or organizations listed above.

Printed Name	Date
Signature	Relationship to patient

Patient Name:_______________________________________

Referred by: ____

Pediatrician/Medical Providers: ____

Preferred Pharmacy and Location: ____

Our Electronic Medical Records can "pull" your medication list from your preferred pharmacy if you'd like. This helps avoid potential drug interactions.

___ I consent to link my information with ACES EMR. ___ I decline to link my information.

Does the patient wear glasses? ( ) Y ( ) N How old are the glasses? ______________________

Family Medical History

- ______ Diabetes
- ______ High Blood Pressure
- ______ Heart Disease
- ______ Seizures
- ______ Cancer
- ______ Thyroid Disease
- ______ Respiratory Illness
- ______ Blindness
- ______ Glaucoma
- ______ Retinal Disease (Mac. Degen/Detachment)
- ______ Strabismus (Misaligned Eyes)
- ______ Amblyopia

Present Medications (If you have a list please provide):

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Patient's Medical History

- ______ Anesthesia Complications
- ______ Diabetes
- ______ High Blood Pressure
- ______ Heart Disease
- ______ Seizures
- ______ Cancer
- ______ Thyroid Disease
- ______ Smoking: Current or Former
- ______ Respiratory Illness (i.e. Asthma)
- ______ Blindness
- ______ Glaucoma
- ______ Retinal Disease (Mac. Degen/Detachment)
- ______ Eye Surgery
- ______ Eye Trauma
- ______ Strabismus (Misaligned Eyes)
- ______ Amblyopia
- ______ ENT (i.e. Sinus Problems, Deafness)
- ______ A.D.D. / A.D.H.D
- ______ Special Needs/Autism/FAS ____________
- ______ Prematurity
- ______ Birth Difficulties
- ______ Syndrome or Other Conditions

Please Specify:______________________________

Allergies:

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