SEC # _____
(OFFICE USE ONLY)

Stingl Eye Clinic Patient Registration Form

How did you hear about us? Phonebook/Internet / TV /Newspaper _____

Family / Friend / Insurance Plan / Hospital / Doctor Referral /By Whom? _____

Your Primary Physician's Name: _____

Your Last Name: _____ First: _____ MI: _____

Age: _____ DOB: _____ SSN: _____ Sex: _____

Street: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ May we leave messages on your answering machine? Y / N

Cell Phone: _____ E-mail address: _____

Work Phone: _____ Your Occupation: _____

Spouse's name: _____ Spouse's Occupation: _____

Do you give us permission to advise family of your medical status? Y / N Date and initial: _____

Whom do we call in case of an emergency? _____

Phone: _____ Relationship to you: _____

IF PATIENT IS A MINOR OR HAS A LEGAL CUSTODIAN, THE RESPONSIBLE ADULT IS:

Last Name: _____ First Name: _____

DOB: _____ SSN: _____

Street: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ E-mail address: _____

*The following demographics information requested is for insurance and EMR (Electronic Medical Records) purposes that can be helpful as some diseases are more relevant in certain races or ethnicities, which can be important to patient care. Please circle what applies to you. **You also have the right to decline giving this information.**

Race: White - Black/African American – Asian – American Indian or Alaskan Native – Native Hawaiian or Pacific Islander

Ethnicity: Hispanic, Latino or Spanish Origin or NOT Hispanic, Latino, or Spanish Origin

Preferred Language: English/Spanish/other (please note: _____)

Decline to Answer: _____ Initial

Updated 2/1/2017

SEC # _____
(OFFICE USE ONLY)

Patient History

What is the main reason for your visit today? _____

_____

PAST EYE HISTORY/SURGERY: Have you OR any family members ever had any of these eye PROBLEMS? N/Y

	Self	Family		Self	Family
Cataract:	___	___	Serious eye injury (e.g., black eye):	___	___
Iritis/uveitis:	___	___	Poor vision / Lazy eye (Strabismus and/or Amblyopia):	___	___
Glaucoma:	___	___	Eye not straight (Strabismus):	___	___
Diabetic eye disease:	___	___	Wore an eye patch as a child (Amblyopia):	___	___
Macular Degeneration:	___	___	Blindness/Loss of eye(s):	___	___
Retinal Detachment:	___	___	**Eye surgery (including laser):** _____		
Other: _____					

Have you OR any family members ever had any of these eye SYMPTOMS? NO/YES (check all that apply):

	Self	Family		Self	Family
Red Eyes:	___	___	Blurred distance vision (e.g., driving):	___	___
Dry Eyes:	___	___	Blurred intermediate vision (e.g., computers):	___	___
Itching/burning eyes:	___	___	Blurred near vision (e.g., reading):	___	___
Mattering/tearing:	___	___	Glare, halos, star-bursts around lights:	___	___
Foreign body sensation:	___	___	Problems with driving:	___	___
Eye pain:	___	___	Problems with night vision:	___	___
Other: _____					

GLASSES / CONTACT LENSES

Wear Glasses? No / Yes **What % of the time?** _____ **How old are the glasses?** _____

Contact lenses? No / Yes **What % of the time?** _____ **How old are the contacts?** _____

Any Problems? No / Yes **What:** _____

Last eye exam? _____ **Where:** _____

Are you interested in getting a new prescription (refraction) for *glasses* ? No / Yes

Are you interested in getting a new prescription (refraction) for *contact lenses* ? No / Yes

MEDICATIONS

List all eye drops /medication:

Name	Dosage	Times per day	Which eye	Compliance(Y/N)
_____	_____	1 2 3 4	right left both	_____
_____	_____	1 2 3 4	right left both	_____
_____	_____	1 2 3 4	right left both	_____

List all *systemic medications* (not involving the eyes):

Medication Name	Dosage Amount	(Schedule) Times per day	Admin Route	For what condition	Compliance (Y/N)
_____	_____	1 2 3 4		_____	
_____	_____	1 2 3 4		_____	
_____	_____	1 2 3 4		_____	
_____	_____	1 2 3 4		_____	
_____	_____	1 2 3 4		_____	

Do you have any intolerances or allergies (to medications or otherwise)? NO/ YES (list below)

Medication Name	Reaction: Allergy (hives/swelling/anaphylaxis) vs. Intolerance (rash, GI upset, side effects)
_____	_____
_____	_____

Updated 2/1/2017

SEC # _____
(OFFICE USE ONLY)

Medical-- List physicians involved in your care: _____

Pharmacy (Name & Location): _____ **Phone:** _____

Do you OR a family member have/ had any of these medical conditions? NONE / YES (check):

	Self	Family		Self	Family		Self	Family
AIDS/HIV	____	____	Dizziness (Vertigo)	____	____	Intestinal problems	____	____
Hay Fever	____	____	Depression	____	____	Lung Diseases	____	____
Anemia	____	____	Reflux/heartburn	____	____	Lupus	____	____
Anxiety	____	____	Gout	____	____	Sjogren's syndrome	____	____
Arrhythmia	____	____	Headaches/Migraines	____	____	Stroke	____	____
Arthritis	____	____	Heart Disease	____	____	Thyroid disease	____	____
Asthma	____	____	Hepatitis	____	____	Tuberculosis	____	____
Cancer	____	____	High Blood Pressure	____	____			
Diabetes	____	____	High Cholesterol	____	____			

Review of Systems: Do you have any of these symptoms? Please specify.

Allergy (runny nose, sneezing, allergy symptoms): _____
Cardiovascular (chest pains): _____
General (weight loss, loss of appetite): _____
Endocrine (weight loss or gain): _____
Gastrointestinal (nausea, vomiting, diarrhea): _____
Genitourinary (discomfort with urination): _____
Blood (easy bleeding, bruising): _____
Head/Ears/Nose/Throat (sinus problems, ear pain): _____
Infectious Disease (lesions): _____
Skin (rash, sores, acne): _____
Musculoskeletal (arthritis, sore muscles): _____
Neurologic (headaches, double vision): _____
Psychiatric (depression, anxiety, mood swings): _____
Breathing (shortness of breath, sleep apnea): _____
Other: _____

What medical illnesses or conditions required a hospital stay?

Illness or Condition	Date/year (or your age)
_____	_____
_____	_____

List any surgeries (not involving the eyes):

Type of surgery	For what condition	Date/year (or your age)	Surgeon (if known)
_____	_____	_____	_____
_____	_____	_____	_____

Social:

Marital status:	Married	Divorced	Single	Widowed	Separated
Smoking:	Non-smoker	Smoker	Ex-Smoker	Packs/Day: ___	# of years: _____
Alcohol:	None	Unknown	Social/Occ.	Daily	amount/day: _____
Drug use:	None	Unknown	Recreational	IV drug abuse	Type: _____

Optional: Please tell me one unique or interesting thing about you: _____

_____

Updated 2/1/2017

SEC # _____
(OFFICE USE ONLY)

CONSENT FOR TREATMENT/CONSENT FOR FILING INSURANCES

I HEREBY AUTHORIZE the Stingl Eye Clinic to examine and treat me or the individual for whom I am responsible. Initial: _____

I AUTHORIZE the Stingl Eye Clinic to release information acquired in the course of my examination and treatment to my insurance carriers. Initial: _____

I FURTHER UNDERSTAND that I have primary responsibility for payment of my charges. Initial: _____

Consent for the use of dilating eye drops

Dilating eye drops are used to enlarge the pupils, allowing our physician to examine the inside of your eye. For many types of eye examinations, this is usually a requirement.

Dilating eye drops will usually cause blurred vision. The length of time that your vision will be blurred, and the degree to which your eyesight is impaired as a result, varies from person to person. It is not possible for your ophthalmologist to predict how much or how long your vision will be affected.

Driving, even in low-light conditions, may be difficult or impossible after an examination with dilating drops, and, if possible, you should not drive yourself afterwards. Instead, we strongly suggest you make alternative arrangements for transportation after your examination. If you do choose to drive yourself, you acknowledge that you understand the risks and accept full responsibility for any injuries to yourself and others. Also, we strongly suggest you use sunglasses to reduce your increased sensitivity to light while driving.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the use of dilating drops. This is extremely rare and treatable with immediate medical attention.

I _____ (Patient Name)
hereby authorize Dr. Daniel Stingl and/or his assistants
to administer dilating eye drops during the course of my treatment. Initial: _____

I understand that these eye drops are necessary to diagnose my condition. I further understand and acknowledge that I have been warned of the potential risks that dilating eye drops may have on my ability to drive and will take appropriate steps to reduce this risk by not driving immediately after my eyes have been dilated; or by wearing sunglasses while driving. I further understand that should I decline having my eyes dilated for an exam, that certain conditions may not be discoverable by my doctor and I hereby release Dr. Daniel Stingl and the Stingl Eye Clinic of any liability.

Initial: _____

Patient (or patient's authorized representative): X _____

Signature of Patient (or guardian)

X _____

Printed Name

Updated 2/1/2017

SEC # _____
(OFFICE USE ONLY)

CREDIT POLICY AND FINANCIAL AGREEMENT

- Eligibility from our office is only an estimation of patient responsibility and should not be considered as a guarantee of coverage. Patient is responsible for knowing their benefits offered by their insurance plan and is ultimately responsible for the payment of all charges that may include deductibles, co-pays, coinsurance amounts and non-covered services. Payment is customarily made at the time that services are rendered unless special arrangements are made in advance. . **Reasons why services may not be covered include, but are not limited to: diagnosis (varies by insurance provider), procedure being allowed once in a lifetime (e.g. pachymetry), not being a separately reimbursable supply (e.g. punctal plugs), or not deemed medically necessary (e.g. cosmetic).**
- A refraction (the measurement of your eyes for a glasses prescription by either the doctor or one of the ophthalmic technicians) is typically *not a covered benefit of your insurance plan.* In the course of your examination, when it is necessary to perform a refraction, it is with the understanding that you will be held financially responsible for this charge.
- This office accepts assignment for Medicare patients. However, each patient is responsible for payment of all non-covered costs. Examples of non-covered Medicare services include the refraction for a glasses prescription that is part of almost every comprehensive eye examination, the annual Medicare deductible, and any remaining balance of Medicare allowable fees not covered by a supplemental insurance plan. It is important to understand that when a participating physician accepts assignment from Medicare, it does not mean that whatever Medicare pays is to be considered payment in full. Medicare has never paid 100% of any charge. Many other insurance companies follow this same basic philosophy. The Stark II legislation, recently passed by the United States Congress, prohibits this office from extending courtesy discounts and/or professional write-offs.
- Payment on all accounts billed is expected within 30 days. If payment is not received within 30 days, a monthly administrative fee may be added to your account to partially defray postage and other office costs generated by multiple billings.
- By signing below, I agree to the above terms and I agree to pay any collection costs and/or reasonable attorney's fees, if a delinquent balance is placed with a collection agency and/or attorney for collection or suit.

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to the Stingl Eye Clinic. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges, whether or not these charges are paid by my medical insurance. I hereby authorize the Stingl Eye Clinic to release any and all information necessary to secure payment.

Signed _____ Date _____

FOR OUR MEDICARE PATIENTS:

After you are seen by the doctor, the Stingl Eye Clinic will submit a completed insurance form to Medicare. Their guidelines permit us to obtain a one-time signature that is valid for this and future visits to our office. By signing below, the notation "SIGNATURE ON FILE" will appear in lieu of your signature on Medicare forms submitted for you by our office.

Signed _____ Date _____

STINGL EYE CLINIC CANCELLATION/NO-SHOW POLICY

1.**Cancellation/ No Show Policy for Doctor Appointment**

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. If an appointment is not cancelled at least 24 hours in advance, you will be charged a twenty-five dollar **($25) fee**; this will not be covered by your insurance company.

2. **Cancellation/ No Show Policy for Surgery**

Due to the large block of time needed for surgery, last-minute cancellations can cause problems and added expenses for the office. Unless there is a medical reason for your surgery cancellation, if surgery is not cancelled at least 7 days in advance, you will be charged a seventy-five dollar **($75) fee**; this is will not be covered by your insurance company.

3. **Account balances**

We will require that patients with self-pay balances do pay their account balances to zero (0) prior to receiving further services by our practice. Patients who have questions about their bills or who would like to discuss a payment plan option may ask to speak to a billing representative with whom they can review their account and concerns. Self-pay patients with balances over $100 must make payment arrangements prior to future appointments being made.

_____ _____ _____

Print Name Patient | Signature Patient/Guardian | Date

Updated 2/1/2017

SEC# _____
(OFFICE USE ONLY)

NOTICE OF PRIVACY PRACTICE

Patient Name: _____

DOB: _____/_____/_____ SSN: _____-_____-_____

We are required by law to provide you with a copy of our Notice of Privacy Practices. As this office uses electronic medical records (EMR), and wishes to reduce paper usage, you are asked to sign a laminated copy of this form which will then be scanned into the computer. If you prefer, a paper copy (hard copy) of this form can be used and retained by you after scanning. To ensure accuracy and compliance with the law, please sign this form and return it to our receptionist to acknowledge that you have been provided with a copy of our Notice.

_____ _____

Signature of Patient or Legal Representative Date of Request (of exception and/or restriction)

☐ Exception for Disclosure (Individuals or means whereby P.H.I. may be released)

I authorize the following people to be involved in my care (i.e., "OK to talk to them about you and your care"). This consent for disclosure includes both health and financial information as it relates to my care.

Individual's Name (Please Print) *Relationship to Patient*

_____

_____

_____

☐ Restriction of Disclosure (Individuals or means whereby P.H.I. cannot be disclosed.)

I DO NOT want these people involved in my care (i.e., "NOT OK to talk to them about you and your care"). This request for nondisclosure includes both health and financial information related to my care. Please be specific:

Individual's Name (Please Print) *Relationship to Patient*

_____

_____

_____

_____ _____

Signature of Patient or Legal Representative Date of Request (of exception and/or restriction)

For Practice Use ONLY:

_____ _____

Signature of Employee receiving request Date Received

Request for exception/restriction has been (circle one): Approved Denied

Reason for denial:

_____

_____

Signature of Privacy Officer _____ Date _____

Updated 2/1/2017