PATIENT HISTORY QUESTIONAIRE

(Must be updated at each visit)

Last Name: ______________________ First Name: ______________________ MI:_____

Address: ______________________ City: ______________________ Zip: __________

Date of Birth: ______________ SSN: ______________________ Marital Status: M W D S

Telephone: (Cell) ______________ Other Phone: ______________________ Home Work

Email: ______________________ Last Eye Exam (if elsewhere) ____________ Dilated: Y / N

Occupation: ______________________ Employer: ______________________________

Emergency Contact: ______________________________ Phone: ______________________

MEDICAL INFORMATION

Are you Diabetic? Y / N **Type:** 1 or 2 Date of diagnosis: ____________ **Headaches?** Y / N

Do you have problems with any of these categories?

Allergic/Immunologic	Y / N	Genitourinary	Y / N	Mental Health/Anxiety/Other	Y / N
Anemia/Blood/Lymph	Y / N	Heart Disease	Y / N	Migraines	Y / N
Ears/Nose/Throat	Y / N	High Blood Pressure	Y / N	Musculoskeletal	Y / N
Endocrine (glands)	Y / N	High Cholesterol	Y / N	Neurological	Y / N
Eyes	Y / N	Integumentary (skin)	Y / N	Respiratory/Asthma	Y / N

Other (Please Explain): ____

Please answer all that apply:

Medication Allergy Y / N To what? ______________ What happens? ______________

Other Allergies? Y / N To what? ______________ What happens? ______________

Current medication(s) and/or eye drops? ______________________________________

____

Have you had any operations? Y / N What kind(s) and when? ______________________

____

Currently use cigarettes/tobacco? Y / N Previous cigarette/tobacco use? Y / N How long ago? __________

Alcohol? Y / N Other substance(s)? Y / N

Are you pregnant? Y / N If yes, how many weeks? ______ Are you nursing? Y / N

Primary Care Doctor: ______________ Location: ______________ Last Visit? ______________

FAMILY HISTORY

High blood pressure? Y / N Relation__________ Macular degeneration Y / N Relation__________

Diabetes? Y / N Relation______________ Retinal detachment Y / N Relation__________

Glaucoma? Y / N Relation______________ Cataracts Y / N Relation______________

Other eye conditions (describe) ____

____

PERSONAL EYE INFORMATION

Eye Operations? LASIK PRK Cataracts Other (Type): ______________________ Date: __________

Eye Injury? Y / N Kind: ______________________________________ Date: __________

Do you have Glaucoma? Y / N Cataracts? Y / N Dry Eyes? Y / N Macular Degeneration? Y / N

Other eye problems? Y / N Please explain: ______________________________________

Do wear glasses? Y / N Contact Lenses? Y / N Type: ______________________________

Updated:

Signature on File / Assignment of Benefits / Financial Agreement

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Voss Eyecare, LLC, for services furnished to me by Voss Eyecare. I authorize any holder of medical information about me be released to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Voss Eyecare accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and deductibles are based upon the charges determined by the Medicare Carrier.

2. **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment or authorized secondary insurance benefits be made on my behalf to Voss Eyecare, if possible, or otherwise to me.

3. **RELEASE OF INFORMATION:** Voss Eyecare, LLC may disclose all or any part of my medical record and/or financial ledger, to any person or corporation (1) which is or may be liable or under contract with Voss Eyecare for reimbursement for services rendered, and (2) any health care provider for continued patient care. Criteria for all releases of information will be based upon the Health Insurance Portabiity and Accountability Act of 1996 (HIPAA). Voss Eyecare may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical date or pursuant to State of Federal law, statute or regulation. I expect no financial reimbursment for release of my data. A copy of this authorization may be used in place of the original.

4. **OTHER INSURANCE:** I understand that Voss EyeCare, LLC maintains a list of health care service plans with which it contracts. A list of such plans is available by request. Voss Eyecare has no contract, expressed or implied, with any plan that does not appear on the list. Voss Eyecare reserves the right to revise the list of health care service plans at any time without notification. The undersigned or my responsible party agrees that I am obigated to pay the full charges of all services rendered to me by Voss Eyecare if I belong to a plan that does not appear on the above mentioned list.

5. **DOCUMENTATION:** I understand that I am responsible to provide documentation at the time of services. Voss Eyecare may request proof of identity, insurance cards, Medicare cards, and any other documents relevant to provide services and collect payments on my behalf. I will be responsible for any charges for services provided by Voss Eyecare if they cannot process my insurance.

6. **NON-COVERED SERVICES:** I understand the contracts with health care service plans (i.e. HMOs, PPOs) in which Voss Eyecare, LLC participates relate only to items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnished to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Voss Eyecare to obtain necessary health care service plan authorizations prior to services being rendered.

7. **FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by Voss EyeCare, LLC, I will pay my account at the time service is rendered or the balance upon receipt of materials. If an account is sent to collections, I agree to pay collection expenses and any reasonable associated fees. I understand and agree that if my account is delinquent, I will be charged interest fees on the balance. In addition, I understand any courtesy discounts will also be waived. A 20% restocking fee will be charged on any returns or unpaid orders. Any benefits or any type under any policy of insurance insuring the patient, and any other party liable to the patient, is hereby assigned to Voss Eyecare. Returned merchandise, for any reason in which insurance was used for all or part of payment, will not be accepted by Voss Eyecare. Returns on prescription lenses or used frames will not be accepted. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Voss Eyecare. Voss Eyecare reserves the right to make reasonalbe changes to this agreement without notification or additional approval by the undersigned. It is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill under all circumstances.**

****By signing, I understand the financial and insurance information described above****

______________________________ ______________

Signature of Patient/Authorized Party/Parent or Guardian   Date

PATIENT HISTORY QUESTIONAIRE

(Must be updated at each visit)

Apellido: ______________________ Primer Nombre: ______________________

Direccion: ______________________ Ciudad: ________________ Zip: __________

Fecha de Nacimiento: ______________ SSN: ______________ Matrimonial: M W D S

Numero de Telefono: (Cell) ______________________

Email: ______________________ Ultimo Examen de la Vista: ____________ Dilated: Y / N

Ocupacion: ____________________ Empleador: ______________________

Contacto de Emergencia: ______________________ Telefono: ______________________

INFORMACION MEDICA

Are you Diabetic? Y / N **Type:** 1 / 2 Date of diagnosis: __________ **Dolores de Cabeza?** Y / N

Do you have problems with any of these categories?

Alergias	Y / N	Genitourinaria	Y / N	Salud Mental	Y / N
Sangre	Y / N	Corazon Enfermedad	Y / N	Migranas	Y / N
Orejas/Nariz/ Garganta	Y / N	Hipertension	Y / N	Musculoesqueletico	Y / N
Glandulas	Y / N	Cholesterol Alto	Y / N	Neurologica	Y / N
Ojos	Y / N	Piel	Y / N	Asma	Y / N

Problems de Salud: ____

Please answer all that apply:

Alergias a Medicamentos Y / N To what? ______________ What happens? ______________

Otras Alergias? Y / N To what? ______________ What happens? ______________

Medicamentos y/o gotas para los ojos? ____

____

Operaciones? Y / N What kind(s) and when? ____

____

Currently use cigarillos/tabaco? Y / N Previous cigarette/tobacco use? Y / N How long ago? __________

Alcohol? Y / N Other substance(s)? Y / N

Embarazada? Y / N If yes, how many weeks? _______ Enfermeria? Y / N

Primary Care Doctor: ______________ Location: ______________ Last Visit? ______________

FAMILY HISTORY

High blood pressure? Y / N Relation____________ Macular degeneration Y / N Relation____________

Diabetes? Y / N Relation____________ Retinal detachment Y / N Relation____________

Glaucoma? Y / N Relation____________ Cataracts Y / N Relation____________

Other eye conditions (describe) ____

____

PERSONAL EYE INFORMATION

Eye Operations? LASIK PRK Cataracts Other (Type): ______________________ Date: __________

Eye Injury? Y / N Kind: ______________________________ Date: __________

Do you have Glaucoma? Y / N Cataratas? Y / N Ojos Secos? Y / N Degeneracion Macular? Y / N

Other eye problems? Y / N Please explain: ______________________________

Anteojos? Y / N Lentes de Contacto? Y / N Type: ______________________

Updated:

(Fecha y Firma la Parte de Atras.)

Signature on File / Assignment of Benefits / Financial Agreement

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Voss Eyecare, LLC, for services furnished to me by Voss Eyecare. I authorize any holder of medical information about me be released to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Voss Eyecare accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and deductibles are based upon the charges determined by the Medicare Carrier.

2. **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment or authorized secondary insurance benefits be made on my behalf to Voss Eyecare, if possible, or otherwise to me.

3. **RELEASE OF INFORMATION:** Voss Eyecare, LLC may disclose all or any part of my medical record and/or financial ledger, to any person or corporation (1) which is or may be liable or under contract with Voss Eyecare for reimbursement for services rendered, and (2) any health care provider for continued patient care. Criteria for all releases of information will be based upon the Health Insurance Portabiity and Accountability Act of 1996 (HIPAA). Voss Eyecare may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical date or pursuant to State of Federal law, statute or regulation. I expect no financial reimbursment for release of my data. A copy of this authorization may be used in place of the original.

4. **OTHER INSURANCE:** I understand that Voss EyeCare, LLC maintains a list of health care service plans with which it contracts. A list of such plans is available by request. Voss Eyecare has no contract, expressed or implied, with any plan that does not appear on the list. Voss Eyecare reserves the right to revise the list of health care service plans at any time without notification. The undersigned or my responsible party agrees that I am obigated to pay the full charges of all services rendered to me by Voss Eyecare if I belong to a plan that does not appear on the above mentioned list.

5. **DOCUMENTATION:** I understand that I am responsible to provide documentation at the time of services. Voss Eyecare may request proof of identity, insurance cards, Medicare cards, and any other documents relevant to provide services and collect payments on my behalf. I will be responsible for any charges for services provided by Voss Eyecare if they cannot process my insurance.

6. **NON-COVERED SERVICES:** I understand the contracts with health care service plans (i.e. HMOs, PPOs) in which Voss Eyecare, LLC participates relate only to items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnished to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Voss Eyecare to obtain necessary health care service plan authorizations prior to services being rendered.

7. **ACUERDO FINANCIERO: Acepto que a cambio de los servicios brindados al paciente por Voss Eyecare, LLC, pagare mi cuenta en el momento en que se preste el servicio o el saldo al recibir los materiales. Si una cuenta se envia a cobranza, acepto pagar los gastos de cobranza y cualquier tarifa asociada razonalbe. Entiendo y acepto que si mi cuenta esta en mora, se me cobraran intereses sobre el saldo. Ademas, entiendo que tampoco se aplicaran descuentos de cortesia. Se cobrara una tarifa de reposicion del 20% en cualquier devolucion o pedido impago. Cualquier beneficio o cualquier tipo bajo cualquier poliza de seguro que asegure al paciente, y cualquier otra parte responsable ante el paciente, se asigna a o parte del pago, para obrener credito de ningun plan de servicos de atencion medica. No se aceptaran devoluciones de lentes recetados o monturas usadas. Si mi compania de seguro o plan de salud designa copados y/o deducibles, acepto pagarlos a Voss Eyecare. Voss Eyecare se reserva el derechos de realizar cambios razonables a este acucerdo sin notificacion ni aprobacion adicional por parte del abajo firmante. Se entiende que el abajo firmente y/o el paciente son los principales responsables del pago de mi factura en toda las circunstancias.**

Al firmar entiendo la informacion financiera y de seguro descrita anteriormente.

____
Signature of Patient/Authorized Party/Parent or Guardian

____
Date