

Last Name: _____ **First Name:** _____ **M.I.:** _____

DOB: _____ **Age:** _____ **SSN:** _____ **Sex:** Male Female Undifferentiated Decline to Specify

Address: _____

City: _____ **State:** _____ **Zip:** _____

***Phone Numbers:** Home : _____ Work : _____ Cell : _____

** Check box next to phone number(s) where we may leave a message*

E-mail Address: _____

Employer Name: _____ **Occupation:** _____

How were you referred to NVISION Eye Centers?

Doctor Referral: _____ Family/Friend/Past Patient – Did they have refractive surgery with us? Yes No

** First & Last Name*

** Name & Relationship*

Internet _____ Drive-by _____ Benefits Provider Other: _____

Health/Workplace Event _____ Newspaper/Magazine/Advertisement _____ Radio _____

Which of the following above influenced you the most to schedule an appointment with us? _____

Primary Physician (Full Name): _____ **Phone:** _____ **City:** _____

Optometrist (Full Name): _____ **Office** (Name): _____ **City:** _____

Has your optometrist discussed Laser Vision Correction with you? Yes No

Did they refer you to NVISION? Yes – Which surgeon were you referred to? _____

No – Who were you referred to? _____

Pharmacy: _____ **Phone:** _____ **City:** _____

Primary Insurance: Insurance Co. Name: _____ ID#: _____ Group#: _____

Subscriber Name (if not self): _____ Subscriber's Date of Birth (if not self): _____

Secondary Insurance: Insurance Co. Name: _____ ID#: _____ Group#: _____

Subscriber Name (if not self): _____ Subscriber's Date of Birth (if not self): _____

Vision Insurance: Insurance Co. Name: _____ ID#: _____ Group#: _____

Subscriber Name (if not self): _____ Subscriber's Date of Birth (if not self): _____

Emergency Contact Information/Designated Individuals Release: NVISION Eye Centers may release to, or discuss my personal health information (PHI) (except regarding treatment , payment , and/or administrative operations) with the individuals listed below, verbally or in writing. I understand that NVISION will make best efforts to verify the identity of the designated parties before disclosing PHI. I also understand that I may change any of the Emergency Contact Information/Designated Individuals Release information at any time in writing. **Appointment Reminder Release:** I authorize NVISION may release my name, treatment date, and contact information to a local partnering Optometrist who may prompt me with annual appointment reminder to facilitate follow up care.

Name: _____ Relationship: _____ Ph#: _____

Name: _____ Relationship: _____ Ph#: _____

My signature below indicates that the information provided above is accurate and complete to the best of my ability, and that you acknowledge you were advised of the Notice of Privacy Practices (NPP) for NVISION. Our NPP provides information about how we may use and disclose your protected information. We encourage you to read it in full. Our NPP is subject to change. The notice of Privacy is available on our website at www.nvisioncenters.com and in our office. You may request a copy of the NPP.

Signature of patient (if over 18) or patient's parent or legal guardian

Date

If signed by parent or legal guardian, print name

Relationship

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: Male Female Undifferentiated Decline to Specify

Glasses/Contact Lenses (Please check appropriate boxes below)

Do you currently wear glasses? No Yes If yes, how old are your glasses? _____ Type? _____
 Do you currently wear contact lenses? No Yes If yes, for how long? _____ Type? _____
 Have you ever tried contact lenses? No Yes When did you last wear contacts? _____

Allergies (Meds/Latex/Anesthesia): No Yes If yes, which ones: _____

Current Medical Problems: HTN (High Blood Pressure) Elevated Lipids (High Cholesterol) Diabetes Type I Diabetes Type II Sjogren's
 Rheumatoid Arthritis Other: _____

*If applicable, are you currently or possibly pregnant? No Yes | *If applicable, are you currently breastfeeding? No Yes

Previous Surgeries: _____

Family History (M-Mother, F-Father, S-Sister, B-Brother, MGM/MGF-Maternal Grandmother/Father, PGM/PGF-Paternal Grandmother/Grandfather)

Glaucoma _____ Diabetes _____ Cancer _____ HTN (High Blood Pressure) _____ Keratoconus _____
 Retinal Detachment _____ Color Blindness _____ Macular Degeneration _____ Other _____

Social History (Please check and/or circle appropriate boxes below)

Do you drive? <input type="checkbox"/> No <input type="checkbox"/> Yes	Do you smoke tobacco? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, how often? _____
Do you drink caffeine? <input type="checkbox"/> No <input type="checkbox"/> Yes	Do you currently vape? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, with/without Nicotine? _____
If Yes, type & amount? _____	If Yes, have you ever tried to quit? <input type="checkbox"/> No <input type="checkbox"/> Yes
Do you drink alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes	If Yes, when or how long ago? _____
If Yes, amount & how often? _____	Have you had passive smoke and/or vaping exposure? <input type="checkbox"/> No <input type="checkbox"/> Yes

Current Medications:

*Include over-the-counter No Yes _____

Review of Systems: Do you currently have any of the following symptoms? (Please check the appropriate boxes below)

Environmental Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes	Polydipsia (Excessive Thirst) <input type="checkbox"/> No <input type="checkbox"/> Yes	Rash <input type="checkbox"/> No <input type="checkbox"/> Yes
Food Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes	Polyphagia (Excessive Hunger) <input type="checkbox"/> No <input type="checkbox"/> Yes	Arthralgia (Joint Pain) <input type="checkbox"/> No <input type="checkbox"/> Yes
Chest Pressure <input type="checkbox"/> No <input type="checkbox"/> Yes	Hearing Loss <input type="checkbox"/> No <input type="checkbox"/> Yes	Joint Swelling <input type="checkbox"/> No <input type="checkbox"/> Yes
Chest Discomfort <input type="checkbox"/> No <input type="checkbox"/> Yes	Constipation <input type="checkbox"/> No <input type="checkbox"/> Yes	Muscle Weakness <input type="checkbox"/> No <input type="checkbox"/> Yes
Irregular Heartbeat <input type="checkbox"/> No <input type="checkbox"/> Yes	Diarrhea <input type="checkbox"/> No <input type="checkbox"/> Yes	Dizziness <input type="checkbox"/> No <input type="checkbox"/> Yes
Heart Palpitations <input type="checkbox"/> No <input type="checkbox"/> Yes	Vomiting <input type="checkbox"/> No <input type="checkbox"/> Yes	Gait Disturbances <input type="checkbox"/> No <input type="checkbox"/> Yes
Fatigue <input type="checkbox"/> No <input type="checkbox"/> Yes	Dysuria (Painful Urination) <input type="checkbox"/> No <input type="checkbox"/> Yes	Headache <input type="checkbox"/> No <input type="checkbox"/> Yes
Fever <input type="checkbox"/> No <input type="checkbox"/> Yes	Hematuria (Blood in Urine) <input type="checkbox"/> No <input type="checkbox"/> Yes	Emotional changes <input type="checkbox"/> No <input type="checkbox"/> Yes
Night Sweats <input type="checkbox"/> No <input type="checkbox"/> Yes	Polyuria (Excessive Urination) <input type="checkbox"/> No <input type="checkbox"/> Yes	Cough <input type="checkbox"/> No <input type="checkbox"/> Yes
Cold Intolerance <input type="checkbox"/> No <input type="checkbox"/> Yes	Bruising <input type="checkbox"/> No <input type="checkbox"/> Yes	Wheezing <input type="checkbox"/> No <input type="checkbox"/> Yes
Heat Intolerance <input type="checkbox"/> No <input type="checkbox"/> Yes	Easy Bleeding <input type="checkbox"/> No <input type="checkbox"/> Yes	Other: _____

Eye History: Have you ever had or been told you have: (Please check appropriate boxes below)

<input type="checkbox"/> Cataracts	<input type="checkbox"/> Cataract Surgery	<input type="checkbox"/> Herpes Infection of the Eye	<input type="checkbox"/> Foreign Body Sensation
<input type="checkbox"/> Glaucoma (High Eye Pressure)	<input type="checkbox"/> Laser Eye Surgery	<input type="checkbox"/> Recurrent Corneal Erosion	<input type="checkbox"/> Irritation or Dryness
<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> Pterygium Surgery	<input type="checkbox"/> Blurred or Double Vision	<input type="checkbox"/> Excessive Tearing or Watering
<input type="checkbox"/> Diabetic Retinopathy	<input type="checkbox"/> Corneal Surgery	<input type="checkbox"/> Glare/ Light Sensitivity	<input type="checkbox"/> Mucous Discharge
<input type="checkbox"/> Flashes or Floaters	<input type="checkbox"/> Eyelid Surgery	<input type="checkbox"/> Distorted Vision / Halos	<input type="checkbox"/> Redness
<input type="checkbox"/> Retinal Tear/Detachment	<input type="checkbox"/> Eye Injury	<input type="checkbox"/> Loss of Vision	<input type="checkbox"/> Drooping Eyelids
<input type="checkbox"/> Keratoconus	<input type="checkbox"/> Amblyopia (Crossed/Lazy Eye)	<input type="checkbox"/> Eye Pain or Soreness	<input type="checkbox"/> Other: _____

I understand that dilating eye drops may be used in my examination and may blur my vision, making it unsafe to drive. I will not attempt to drive until I am certain the effect of the medicine has worn off. The effect of the drops may last an hour or longer.

My signature below indicates that the information provided above is accurate and complete to the best of my ability.

Signature of patient (if over 18) or patient's parent or legal guardian _____

Date _____

If signed by parent/legal guardian, print name _____

Relationship _____

ACKNOWLEDGEMENT OF RECEIPT OF THIS NOTICE OF PRIVACY PRACTICES AND PATIENT BILL OF RIGHTS

Patient Name: _____ **Date of Birth:** _____

By signing below, you:

- Acknowledge that you have been informed of the Privacy Practices and Patient Bill of Rights.
- Acknowledge that you have access to a copy of these documents in the center.

Signature of patient

Date

Are you completing this form for someone else?

Check here if you are signing as a personal representative, and complete below. Unless you're the parent of a minor child, please attach documented proof that you are acting on that person's behalf (for example, power of attorney)

Printed name of patient's personal representative

Date

Signature of patient's personal representative

Relationship

References Available on the Internet:

www.hospitalconnect.com/aha/about/pbillofrights.html

www.isrs.org

Other References:

Internal Society for Refractive Surgery Position Paper on Co-Management of Refractive Surgery Pre-operative and Post-operative Care, 2001 available form www.isrs.org

NOTICE TO CONSUMERS

Medical Doctors are licensed and regulated by the:

Medical Board of California www.mbc.ca.gov

Oregon Medical Board www.oregon.gov/OMB

Washington Medical Commission <https://wmc.wa.gov/>

Nevada State Board of Medical Examiners www.medboard.nv.gov

Arizona Medical Board www.azmd.gov

PAYMENT POLICY

Name: _____ **Date of Birth:** _____

BASIC POLICY:

Payment for service is due in full at the time service is provided in our office.

PATIENTS WITH INSURANCE:

LASIK/REFRACTIVE SURGERY IS NOT A COVERED BENEFIT FOR MOST INSURANCE PLANS

Some treatments are billable to insurance, while others are not. NVISION doctors are contracted with Medicare and selective private insurances. If you have OUT-OF-NETWORK benefits and your NVISION provider is not contracted with your carrier, payment is due in full at the time of service. If we are not contracted with your insurance company, you have the ability to submit a claim to your insurance provider and NVISION will supply you with the necessary information to do so. NVISION does not guarantee that your insurance provider will reimburse for services rendered. NVISION is not responsible for denied insurance claims.

For NVISION Eye Institute patients, we will bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. Co-payments and deductibles are due at the time of service. We can only bill for surgeon fees. You must contact the facility where your surgery is performed and inform them to bill facility fees, anesthesia, etc. on your behalf. We cannot guarantee that the facility is in network with your individual insurance company. You must contact the facility prior to your surgery to verify services will be covered. Since your agreement with your insurance is a private one, we do not routinely research why an insurance carrier has not paid or why it has paid less than participated for care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full by you.

NON – COVERED SERVICES:

Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

ASSIGNMENTS OF INSURANCE BENEFITS:

I authorize the release of any medical information necessary to process my insurance claim(s). I authorize and request payment of medical benefits directly to my physicians. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I agree that a photocopy of this form may be used in lieu of the original. I understand I am financially responsible to NVISION for the charges incurred.

Have you met your deductible for the calendar year?

Are you currently employed?

Are your injuries accident related?

Did you sustain an injury at work?

Have you ever served in the military?

Are you covered under an employer or union policy?

Is your spouse or other family member employed?

Do you have a secondary insurance policy?

Are you covered under any other healthcare plan?

- | | | |
|------------------------------|-----------------------------|-----------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Not Sure |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | |

**I have read, understand and agree to the above financial policy for payment of professional fees.
I understand that I am ultimately responsible for all professional fees.**

Signature of patient (if over 18) or patient's parent of legal guardian

Date

If signed by parent of legal guardian, print name

Relationship