Meadows Eye
Physicians & Surgeons

Patient Registration Form

PATIENT INFORMATION			
NAME			EMERGENCY CONTACT NAME / RELATIONSHIP TO PATIENT
STREET ADDRESS			EMERGENCY CONTACT NUMBER
CITY	STATE	ZIP	PREFERRED PHARMACY
PHONE	DOB		PRIMARY CARE PHYSICIAN
E-MAIL			OPHTHALMOLOGIST/OPTOMETRIST

MEDICAL HISTORY - PLEASE LIST ANY MEDICAL CONDITIONS YOU HAVE	
1	5
2	6
3	7
4	8

EYE HISTORY - PLEASE LIST ANY EYE CONDITIONS YOU HAVE	
1	3
2	4

SURGICAL HISTORY - PLEASE LIST PRIOR SURGERIES AND YEAR			
1	YEAR	4	YEAR
2	YEAR	5	YEAR
3	YEAR	6	YEAR

CURRENT MEDICATIONS - PLEASE INCLUDE EYE DROPS	
1	5
2	6
3	7
4	8

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DO YOU SMOKE?	ARE YOU ALLERGIC TO LATEX?
☐ YES ☐ NO, I QUIT SMOKING IN _____ (YEAR) ☐ NO, I HAVE NEVER SMOKED	☐ YES ☐ NO

DO YOU HAVE MEDICATION ALLERGIES?	DO ANY MEDICAL PROBLEMS RUN IN YOUR FAMILY?
☐ YES ☐ NO IF YES, PLEASE LIST BELOW:	☐ YES ☐ NO IF YES, PLEASE LIST BELOW:
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____

FINANCIAL INFORMATION

PRIMARY INSURANCE	PRIMARY INSURANCE POLICY NUMBER
NAME OF INSURED (IF OTHER THAN PATIENT)	RELATIONSHIP TO PATIENT
SECONDARY INSURANCE	SECONDARY INSURANCE POLICY NUMBER
NAME OF INSURED (IF OTHER THAN PATIENT)	RELATIONSHIP TO PATIENT
OCCUPATION/EMPLOYER	SSN (IF SELF PAY OR REQUIRED FOR INSURANCE)

INFORMATION REGARDING DILATING DROPS

Dilating drops will be used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye. Dilating drops frequently blur vision for a length of time which varies from person to person and make make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself. Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention. My signature below additionally authorizes Meadows Eye and any designated care giver to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

NOTICE OF PRIVACY PRACTICES

I have had the opportunity to review the Meadows Eye Notice of Privacy Practices available in hard copy and online at www.meadowseye.com/new-patient-forms/

SIGNATURE AUTHORIZATION

SIGNATURE:	DATE
PRINTED NAME:	TIME

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FINANCIAL POLICY

This document is intended to inform our patients about our financial policies and procedures. We are aware that the complexity of health insurance makes it difficult to know when you will have to pay anything out of pocket. For patients with traditional Medicare or Medicaid plans these answers are straightforward, easy to obtain and reliable. For patients with commercial insurances or Medicare Replacement plans the answers can be convoluted, difficult to obtain and subject to the insurance company's interpretation of the treatment we provide. Generally speaking insurances will pay for a service if it is a covered benefit, provided by an in network physician and the patient has met their applicable copay/deductible/coinsurance responsibility.

In our practice non-covered services most often applies to people who want premium cataract surgery (multi-focal lens implantation, etc). Insurance companies treat these services as elective and not covered because if the patient was willing to wear glasses they would be unnecessary. Occasionally some patients have very limited health insurance coverage that only pays for the Office Visit but not for any imaging, labs, medications or treatments. In these cases, the issue of services not being covered does come into question. The second reason insurances may not pay for services is if the service is deemed a "patient responsibility" by your plan. Insurances use many terms for these including copays, deductible and co-insurance. Often people are not aware of the true limits of their insurance. The most important number to know about your insurance is the Out Of Pocket Max. After you have reached your out of pocket max for the plan year the insurance will pay for all covered services. Some insurances require you to receive a prior authorization for a service to be covered, this however does not mean that the insurance will pay for the service if it is deemed within a patient responsibility category.

NO CALL / NO SHOW

In an effort to provide effective and efficient treatment to all of our patients, it is the policy of this office that all appointment cancellations are made at least 24 hours prior to your scheduled appointment time.

If an appointment is not canceled or patient fails to show up for appointment, Meadows Eye reserves the right to charge the patient a $25 fee per occurrence. As this fee is not billable to any insurance company, patient accepts full responsibility to pay this fee.

If you have any questions about this form, please talk to us before signing.

I have read and agree to the financial policy outlined above.

SIGNATURE AUTHORIZATION

PRINTED NAME: _____ DATE: _____

SIGNATURE: _____ TIME: _____

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

REQUEST TO RECEIVE RECORDS

I date of birth authorize

to release all medical records and **previous testing (HVF, OCT, photos,etc.)** which might affect ongoing treatment of eye disease to:

Meadows Eye
2749 Sunridge Heights Pkwy
Henderson, NV 89052
(702) 358-0472 phone
(702) 425-9955 fax
info@meadowseye.com

I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed. I have the right to withdraw permission for the release of my information. I can revoke that authorization at any time athought this revocation must be made in writing and will not affect information that has already been used or disclosed. I have the right to receive a copy of this authorization. I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization. I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

REQUEST TO SEND RECORDS

I date of birth hereby authorize Meadows Eye to release all records to:

Name

Address

City, State , Zip

Phone/Fax

I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed. I have the right to withdraw permission for the release of my information. I can revoke that authorization at any time athought this revocation must be made in writing and will not affect information that has already been used or disclosed. I have the right to receive a copy of this authorization. I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization. I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

SIGNATURE AUTHORIZATION

SIGNATURE:	DATE
PRINTED NAME:	TIME

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Medical Information Release Form
(HIPAA Release Form)

Patient Name: _____ DOB: _____

I understand that Meadows Eye maintains my personal records, medical history, symptoms, examinations, and test results as a part of my healthcare. This information is not to be given to any other person without my permission. Therefore, this is a written consent to authorize release of my medical information.

RELEASE OF INFORMATION

[ ] I authorize the release of information including the diagnosis, records, laboratory results, prescribed medications, treatment plan, examination rendered and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] Information is **NOT** to be released to anyone

[ ] Check if okay to leave detailed health information on voicemail

[ ] Check if ok to email records to the following email address:
_____

_____ _____
Patient (or person authorized to sign for patient) Date