WELCOME!

Twenty/20 Vision Care
Craig A. Fenimore, O.D.

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we will be glad to help you.

PATIENT INFORMATION: DATE ___________

Name: *(Please give your birth name as your first name)*
First____________________MI._____Last_________________________

How would you like to be addressed? First Name/Mr./Mrs./Miss/Ms./

Other:________________________ Home Ph# (_____)_______-_______

Address____

City______________________________State_______Zip____________

E-Mail Address____

Best time to reach you: (Day)_____________(Evening)_____________

Birth Date_________________Age_________ Sex : ☐ **M** ☐ **F**

☐ Single ☐ Married ☐ Divorced ☐ Widowed

SS#_________-_________-___________(Under HIPAA Federal Privacy Regulations, patient's Identification number will only be used for the filing of medical or vision claims.) → *Protected patient information!*

Employer / (*if minor*) School Status:

Employer/School ____

Work Ph.# (_______)_________-_________ Ext. ____________

Work E-Mail: ____

Occupation (or grade level) __________________________________

If Married:

Spouse's Name____

Spouse's Employer____

Work Ph.# (_______)_________-_________ Ext. ____________

Work E-Mail: ____

Occupation ____
D.O.B. _______________SS#__________________________________

If Minor:

Father's Name ____

Address *(if not same)*_______________________________________

Employer ____

Work Ph.# (_______)_________-_________ Ext. ____________

Work E-Mail: ____

D.O.B. _______________SS#__________________________________

Mother's Name ____

Address *(if not same)*_______________________________________

Employer ____

Work Ph.# (_______)_________-_________ Ext. ____________

Work E-Mail: ____

D.O.B. _______________SS#__________________________________

Information cont'd. If Minor:

If parents are divorced, who is the custodian parent or guardian?

☐ **Mother** ☐ **Father** ☐ **Guardian** _____________________

Our office Policy is that the custodian parent/guardian (or the person who physically brings the minor in for the appointment) is responsible for all fees incurred.

Patient Information:

Who is responsible for your account today?

☐ Self ☐ Parents ☐ Work ☐ Insurance ☐ Other______

Have you been examined by Dr. Fenimore before? Yes No
If yes, when __________________, Reason: Medical Vision Exam
Date of Last Vision Examination______________, Optometrist _________
_______________________________.

Do you wear glasses now? Yes No Always Occasionally Reading Driving TV
Do you wear contacts now? Yes No Always Occasionally Past
Type _________________________Hours/Day_________________
Describe any problems you have with your contacts _______________
____

What is your primary reason for your visit today? ___________________
____

How did you first hear about our office?

Friend Newspaper Practitioner Radio Yellow Pages
Other____

Whom may we thank for referring you? __________________________
____

How will you settle your account today?

☐ Cash ☐ Check ☐ Debit Card/Credit Card-Visa, MC, Disc.

For a special benefit to our patients who pay in full by *CASH or CHECK* the day services are rendered and materials ordered, we will take a 2% savings off your total balance of materials, excluding exam fee.

Our Office Policy:

The fees that are expected to be paid with your appointment today are- co-payment, deductible, and examination fee. If materials such as Glasses and Contacts are to be ordered FULL payment is expected before we can place the order.

We sincerely thank you for respecting our Office Policy.

Our Mission Statement: Twenty/20 Vision Care will provide high quality, comprehensive eye health care to each of our patients throughout their lifetime. We will be courteous, honest, timely and professional in our interactions with our patients. We will attempt to educate each patient about his or her eye health and vision, and make recommendations that will fulfill their visual needs. We will strive to stay at the forefront of eye care education and technology to better serve our patients.

–over-

INSURANCE:

MEDICAL INSURANCE? Yes No

PRIMARY Insurance:

Insurance Company____

Member's name____

Member's Birth Date_______________SS#_____________________

Relationship to patient_____________________________________

SECONDARY Insurance:

Insurance Company____

Member's name____

Member's Birth Date_______________SS#_____________________

Relationship to patient_____________________________________

VISION BENEFITS? Yes No

PRIMARY Insurance:

Insurance Company____

Member's name____

Relationship to patient_____________________________________

SECONDARY Insurance:

Insurance Company____

Member's name____

Relationship to patient_____________________________________

Please present all insurance cards to the receptionist on completion of this form. A copy will remain in your file. In the future if there are any changes to your insurance, please notify us prior to your appointment.

Family Physician:

Name ____

Are you currently under the care of a family physician?

Yes No If yes, for what?

____

Medications:

Are you currently taking any medications? Yes No

If yes, please list below: ***(or we can copy your personal list)***

<u>Name</u> <u>Dosage</u> <u>Frequency</u>

____

____

____

OPTICAL AIDS USED FOR YOUR PERSONAL NEEDS:

Hobbies_______________________________________

Sports____

Occupational Hazards__________________________

Low Vision Aids Used__________________________

Assignment and Authorization to release information for Medical and Vision Benefits:

I, the undersigned, certify that I (or my dependent) have insurance coverage. I authorize Dr. Craig Fenimore to release to my insurance carriers, including Medicare and Medicaid, any information required to file or resubmit my claim. I further authorize my insurance companies to pay Dr. Craig Fenimore directly on my behalf for services rendered. I further authorize all insurances companies including Medicare Supplements (Medigaps) and Medicaid to provide any information to Dr. Craig Fenimore that is required to resubmit any denied or incorrectly paid insurance claims. I understand that I am financially responsible for all charges including the deductibles, coinsurances, non-covered materials, and non-covered medical procedures provided by Dr. Craig Fenimore; whether or not paid by my insurance. Most insurance claims can be filed and handled through our office as long as we will receive the benefit payment in a timely manner. If we have not received a response from your insurance company within 60 days after we file the claim, you will be billed and any further follow up with the insurance company will be your responsibility. (NOTE: This only applies to private insurances <u>NOT MEDICARE and MEDICAID</u>). ***There are network provider benefits that we are unable at this time to file and receive payment from; we will collect the pertinent information required from you to file the claim on your behalf. We require FULL payment on this type of claim.***

I agree that I will pay all attorney fees, collection and court costs incurred by the doctor in the collection of all sums due.

I authorize the use of this signature on all insurance submissions (CMS-1500 claim form, on other approved claim forms or electronically submitted claims) and this authorization remains in effect until withdrawn by me.

_________________________________ _______________

Responsible Party Signature *Date*

Medicare Authorization:

I understand that Dr. Craig Fenimore is a provider assigned to Medicare. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

For any services furnished to me by Dr. Fenimore I request that payment of authorized Medicare benefits be made to Dr. Craig Fenimore on my behalf.

_________________________________ _______________

Signature of Beneficiary *Date*

Authorization to Discuss Your Information with Family or Caregivers:

To comply with the new HIPAA Federal Privacy Regulations, we must receive your written approval to discuss your case with anyone else including your spouse, children, family members, caregivers, friends, etc. By authorizing this, we will be able to, without requiring your presence, discuss your case, answer questions, leave detailed messages, and contact, in the event of an emergency, the person(s) listed below. If you would like us to answer questions or discuss your case to anyone other than yourself, you must include them below. This authorization is optional and can be withdrawn by you at any time.

Name____

Relationship_______________________________

Ph.#_____________________________

Name____

Relationship_______________________________

Ph.#_____________________________

Name____

Relationship_______________________________

Ph.#_____________________________

_________________________________ _______________

Signature ***Date***