Welcome To Thomas Eyecare

Here are a few things to help you prepare for your appointment with our office:

- Bring your insurance card, photo ID, specialist co-pay/co-pay (if applicable)
- A list of all your medications, glasses, and contact lens prescriptions and brand(if applicable)
- Plan on your appointment with our office lasting 60-90 minutes for a dilated exam, cataract evaluation, or LASIK consultation
- Complete Patient Registration Forms (on the following pages)
- Our office address is 3619 Park East Dr., Suite 306 Beachwood, OH 44122 phone (216) 292-9150 fax (216) 292-9159. We are located in the South Parkway Medical Building

Medical History Questionnaire

Name:_____Birth Date:_____ Date:_____

Address:_____City,State,Zip:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Employer:_____Employment Status: FT/PT/Retired/Student/Self/None

Occupation:_____ SSN#:_____Email Address:_____

Insurance Company:_____Member ID:_____Group #:_____

Member Name (if other than patient name):_____Member DOB_____

Primary Care Physician:_____PCP phone #_____

List all medications (including oral contraceptives, over-the-counter medications, vitamins & supplements)_____

_____

Are you currently on, or have previously taken Flomax (Tamsulosin) or Proscar (Finasteride)? Y or N

List all known allergies to medicine, food, & the environment: _____

Are you interested in Botox/Latisse? Y or N

Please describe any major illnesses, injuries, or surgeries you have had:_____

_____

Medical History: please note next to the condition if YOU and/or Family Member (mother, father, grandparent, etc.) have been diagnosed or treated for any of the following:

Arthritis _____

Blindness _____

Breathing Problems _____

Cancer (Type) _____

Cataracts _____

Corneal Issues _____

Crossed/Lazy/Turned Eyes_____

Diabetes _____

Diabetic Retinopathy _____

Eye Injury/Surgery _____

Glaucoma _____

Heart Disease _____

High Blood Pressure _____

High Cholesterol _____

Kidney Disease _____

Keratoconus _____

Lupus _____

Macular Degeneration _____

Migraines/Headaches _____

Retinal Detachment _____

Retinal Disease _____

Stroke _____

Thyroid Disease _____

Vertigo/Inner Ear Disorder _____

Other Condition/Disease _____

Thomas Eyecare, LLC

3619 Park East Dr. Suite 306
Beachwood, OH 44122

FINANCIAL POLICY

Thank you for choosing our office as your eye care provider. The following is a statement of our financial policy. Please read carefully prior to any services performed.

NON-INSURED PATIENTS:

We ask that all cash paying patients requiring only services pay in full all charges at the time of services rendered. When purchasing materials such as contact lenses we require full payment be made at the time of the order.

INSURED PATIENTS:

Your insurance policy is a contract between you and your insurance company. We will submit charges to your insurance company if we are a participating provider, and if you have given us all the required information. We must have the most current copy of your insurance information or card. You must notify us immediately of any change in your insurance coverage. Our receptionist will try to gather most of this information when she schedules or confirms your appointment via telephone. Please be aware that some, and perhaps all of the services provided may be considered "non-covered services" according to your policy or your eligibility. You will still be responsible for payment of these services**. If we are a non-participating provider with your insurance company you will be responsible for charges at the time of service.** We reserve the right to determine if your exam will be billed as a medical versus vision exam and how it will billed to your insurance accordingly. We will assist in completion of any forms you have available the day of the appointment.

AUTHORIZATION AND REFERRALS:

At the time of the office visit, you are responsible for all professional fees and materials if referral or authorization is not received. Please check with our receptionist for the current list of insurance companies with which we participate. At the time of service we will collect the co-payment indicated by your insurance. You will be responsible for payment of any deductibles, co-insurance or non-covered services.

MINOR PATIENT (UNDER 18 YEARS)

The parent/guardian/adult accompanying a minor child is responsible for full payment. Please check with your insurance carrier/policy to determine which company is the primary before the appointment. In divorce cases, the parent who brings the child in for services is the responsible party.

PAYMENT OPTIONS:

All co pays, refraction, and contact lens fitting fees are due at the time of services rendered. We accept all major credit cards (Discover, Visa, Master Card), cash and checks. PLEASE NOTE: There will be a $20 charge for any NSF (insufficient funds) checks returned to our office-plus any magistrate fees if further collection proceedings are deemed necessary.

COLLECTION BALANCES:

If you have had a previous collection balance or are presently in collection, it will be required that you pay your previous balance prior to being seen again or ordering any new materials.

I have read the outlined financial policy. I understand and agree to this financial policy

_____ **INTIAL**

INSURANCE SIGNATURE ON FILE

I certify that the information given to me in applying for Insurance and/or Medicare benefits is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I request that payment of these benefits be made either to me or on my behalf to Thomas Eyecare, LLC, for any services and materials furnished. I authorize any holder of medical information about me to release it to the office for Medicare Services and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the HCFA1500 claim form or electronically submitted claim) my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

_____ **INTIAL**

ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I have received a copy of Thomas Eyecare, LLC's Notice of Privacy Practices and have had sufficient time to read and understand its contents.

_____ **INTIAL**

HIPAA AUTHORIZATION

Please list the family members or other persons, if any, whom may be informed about your general medical condition and your diagnosis (including treatment, payment, and health care operations.)

_____

_____

SIGNATURE FOR ABOVE POLICIES

I HAVE READ AND UNDERSTOOD ALL AREAS ABOVE. MY SIGNATURE BELOW INDICATES THAT I UNDERSTAND AND AGREE TO ALL POLICIES.

_____ _____

Signature of Patient Date
(or Parent/Guardian if Patient is under 18)

_____

Printed Name

THOMAS EYECARE

CANCELLATION / NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore, requested that if you must cancel your appointment you provide 24 hours notice. Office appointments which are cancelled with less than 24 hours notification may be subject to a $25.00 cancellation fee.

Patients who do not show up for their appointment will be considered as a NO SHOW and will be charged a $25.00 fee.

The Cancellation and No show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no show fees should be directed to our office at 216-292-9150.

Please sign that you have read, understand, and agree to the Cancellation and No show Policy.

_____

Patient Name (Please Print)

_____

Signature of Patient or Patient Representative

_____

Date

For insurance purpose:

Preferred Contact: (please circle)
Phone/email/Postal

Race: White, American Indian, Asian, African American or Black Hispanic, Native Hawaiian or Other Pacific Island