MASON FAMILY VISION

PATIENT INFORMATION

Patient Name _____ **Gender** ☐ Male ☐ Femaie
Last First Middle

Preferred First Name _____ **Marital Status** ☐ Minor ☐ Single ☐ Married ☐ Widowed

Patient Home Address _____
Street Apt City State Zip

Phone Home_____ Work _____ Cell _____

Texting OK ☐ Yes ☐ No

Email_____

Patient DOB _____/_____/_____ **Age**_____ **Patient SSN** _____-_____-_____

Patient's Employer _____ **Occupation** _____

Emergency Contact _____
Name Relationship Phone

How did you hear of us? ☐ Physician Referral, if yes name of Physician _____

☐ Mail ☐ Internet ☐ Yellow Pages _____ Friend/Family Member _____ Other

In accordance with health care reform, please help our office report meaningful use measures:

Pref Language ☐ English ☐ Spanish **Communication Preference** ☐ Phone ☐ Postal ☐ Email

Race ☐ Asian ☐ Black/African American ☐ Hispanic ☐ Native Hawaiian/Other Pacific Islander ☐ White

Height _____ **Weight** _____

ADVANCE BENEFICIARY NOTICE: I understand that Medicaid does not pay for Retinal Imaging and Vision Therapy and Medicare does not pay for the refraction fee and both Medicaid and Medicare do not pay for contact lens evaluation fee.

INSURANCE INFORMATION

Do you have vision insurance?

☐ Yes ☐ No

Insurance Co _____
Policyholder Name _____DOB_____
ID#_____SSN_____

Do you have medical insurance?

☐ Yes ☐ No

Primary Insurance Co _____
Policyholder Name _____DOB_____
ID#_____SSN_____

Secondary Insurance Co _____
Policyholder Name _____DOB_____
ID#_____SSN_____

RESPONSIBLE PARTY

☐ Self ☐ Spouse ☐ Parent ☐ Guardian ☐ Other _____

☐ Name/Address same as above
Name _____DOB _____
Address _____
Phone _____SSN_____

ASSIGNMENT AND RELEASE

I hereby state the information given is true and complete. I hereby authorize and request the payment of services from Medicare, Medicaid, and/or other insurance plans or payers be made on my behalf to Mason Family Vision, PC.

I hereby assign to Mason Family Vision, PC all payments for treatment services. I understand and agree that I am responsible for paying any amount not covered by Medicare, Medicaid, and/or other insurance plans or payers.

SIGNATURE _____ **DATE**___/_____/____

Patient's Name: _____ Date: _____

Primary Care Physician: _____ Phone Number: ( ) -

MEDICAL INFORMATION (PLEASE CHECK ALL THAT APPLY)

DO YOU CURRENTLY WEAR:

GLASSES? **YES NO** (***IF YES)*** WHAT ARE THE AGE OF YOUR **CURRENT** GLASSES? _____

CONTACT LENSES? **YES NO** (***IF YES)*** WHAT BRAND OF CONTACTS? _____

HAVE YOU HAD:

CATARACT SURGERY	**YES NO**	EYE MUSCLE SURGERY	**YES NO**	LASIK/PRK SURGERY	**YES NO**
RETINAL SURGERY	**YES NO**	TRAUMATIC EYE INJURY	**YES NO**	OTHER SURGERY	**YES NO**

VISION HISTORY

Do you or anyone in your immediate family have:

			RELATION
Amblyopia/Lazy Eye	YES	NO	_____
Blindness	YES	NO	_____
Cataracts	YES	NO	_____
Crossed/Turned Eyes	YES	NO	_____
Diabetic Retinopathy	YES	NO	_____
Double Vision	YES	NO	_____
Flashes/Floaters	YES	NO	_____
Glaucoma	YES	NO	_____
Macular Degeneration	YES	NO	_____
Retinal Detachment	YES	NO	_____
Other _____	YES	NO	_____

SOCIAL HISTORY

DO YOU SMOKE YES NO, _____ PACK PER DAY

ALCOHOL USE YES NO, _____ DRINKS PER WEEK

BLOOD TRANSFUSION YES NO, **(IF YES)** YEAR:_____

FEMALES: ARE YOU

PREGNANT: YES NO, _____ WEEKS NURSING: YES NO

ALLERGENS:

Animal Dander **YES NO**

Environmental **YES NO**

DRUG ALLERGIES: YES NO. list below

LIST ALL CURRENT MEDICATIONS (Rx/OTC/Vitamins)

YOUR CURRENT MEDICAL HISTORY: Circle all that apply.

CARDIOVASCULAR			**IMMUNOLOGIC**		
Elevated Cholesterol	YES	NO	Herpes Simplex	YES	NO
Heart Disease	YES	NO	Herpes Zoster	YES	NO
High Blood Pressure	YES	NO	HIV Positive	YES	NO
CONSTITUTION			Sarcoidosis	YES	NO
Significant weight			**INTEGUMENTARY**		
Gain or Loss	YES	NO	Rosacea	YES	NO
EAR, NOSE, THROAT			Lupus	YES	NO
Sinuses	YES	NO	**MUSCULOSKELETAL**		
ENDOCRINE			Rheumatoid Arthritis	YES	NO
Diabetes ***(I or II)***	YES	NO **(if yes) A1c:_____**	Osteoporosis	YES	NO
Thyroid Disorder	YES	NO	**NEUROLOGICAL**		
GASTRONITESTINAL			Headache	YES	NO
Acid-Reflux	YES	NO	Migraines	YES	NO
Crohn's Disease	YES	NO	Seizures	YES	NO
Hepatitis	YES	NO	**PSYCHIATRIC**		
GENITOURINARY			ADD	YES	NO
Kidney Stones	YES	NO	Anxiety Disorder	YES	NO
Genitals/Kidney/Bladder	YES	NO	Depression/Bipolar	YES	NO
Sexually Trans. Disease	YES	NO	**RESPIRATORY**		
HEMATOLOGIC/LYMPHATIC			Asthma	YES	NO
Anemia	YES	NO	COPD	YES	NO
Leukemia	YES	NO	Sleep Apnea	YES	NO
Sickle Cell Trait	YES	NO	**HISTORY OF CANCER:**		
Sickle Cell Disease	YES	NO	Family	YES	NO, Type:_____
OTHER: _____			You	YES	NO, Type:_____

MASON FAMILY VISION
Financial Policy Agreement

THANK YOU *for choosing Mason Family Vision for your eye care needs. We appreciate your trust in us and we look forward to providing you with quality and affordable eye care. Our financial policy is intended to facilitate excellent service to you while minimizing our administrative costs. Please read, sign and date this agreement.*

√ **PATIENT PAYMENTS**
Full payment is due **at the time of service**. We accept cash, credit card, debit card, and CareCredit. In cases of financial hardship, and prior to receiving services, you may apply for the CareCredit healthcare credit card and establish an account to make monthly payments. Apply online at www.carecredit.com or call (800) 677-0718. We reserve the right to charge interest and/or apply late fees on a past due balance. Accounts with balances 90 days past due will be referred to an outside collection agency.

√ **INSURANCE COVERAGE**
We make no claim to know what services your insurance covers. While we make a good faith attempt to verify coverage, we are not able to guarantee that the information given to us by your insurance is correct. It is your responsibility to supply us with the correct insurance information at the time of your visit. **If your insurance plan requires a referral from a primary care physician and you do not present one, you will be financially responsible for payment of these services.** We encourage you to refer to your benefits manual if you have any questions about covered services. Be aware that some or all of the services provided may be not be covered by your insurance. You will be responsible for payment of all non-covered services at the time they are rendered.

√ **INSURANCE PAYMENTS**
As your vision care provider, our relationship is with you, our patient, not with your insurance company. We require certain co-payments, deductibles or prepayment amounts depending on the type of insurance and insurance carrier. **Be assured our office works diligently to obtain payment from your insurance company.** However**,** if we file your insurance, and the claim has not been paid for any reason within 90 days, we require that you pay the balance using one of the approved payment methods. In the event that your insurance pays us after that time, you will be reimbursed.

√ **THIRD PARTY PAYORS**
Our office does not bill third party payors such as PIP (Personal Injury Protection), worker's compensation carriers or attorneys.

√ **MISSED / LATE CANCELLED APPOINTMENTS**
Please give us at least 24 working hours notification if you cannot keep an appointment. This courtesy will allow others to be seen. If you fail to notify us you will be billed a $50.00 fee. We realize that emergencies arise; however, habitual late cancels or no-shows, may cause our relationship to be terminated.

√ **PRODUCT RETURNS**
All prescription optical materials are customized and fabricated specifically for each individual patient. Fees for these materials are non-refundable, and once ordered, become the financial responsibility of the patient. All materials not picked up after 90 days become property of Mason Family Vision.

√ **CONTACT LENS EVALUATION FEES**
If you are a contact lens wearer, the doctor needs to evaluate the comfort, fitting characteristics, and vision obtained with a particular contact lens. A separate contact lens evaluation is required to determine the contact lens prescription. Contact lens evaluation fees are due at the time of service.

We welcome the opportunity to discuss any aspects of this agreement. Please let us know if you have any questions, comments, or concerns. We thank you for your support, and look forward to serving you.

I have read, understand, and agree to abide by the terms stipulated above.

Patient Signature (or Parent of minor/Legal Guardian): _____Date: _____

Mason Family Vision - 141 Wildewood Park Drive

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgement"

I, _____ have been informed of this office's Notice of Privacy Practices.

_____
Print Name

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____
_____
_____

DIGITAL RETINAL PHOTOGRAPHY

At Mason Family Vision, we continue to offer you the most advanced technology to maintain good ocular health. We consider the Digital Retinal Imaging Camera an important part of your eye examination today.

Dr. Mason is concerned about retinal problems including Macular Degeneration and Glaucoma, as well as systemic diseases such as Diabetes, Stroke and High Blood Pressure. These conditions can lead to partial vision loss or blindness, and often can develop without warning and can progress without symptoms. The digital retinal photograph provides:

- A detailed view of the retina
- The ability to view your digital image during your examination
- An annual, permanent record for your medical file, which gives Dr. Mason baseline pictures for comparisons and for tracking and diagnosing potential eye diseases in the future.

Digital Retinal Photography is painless and non-invasive. Retinal photography is especially important for both adults and children with a personal or family history of Glaucoma, Diabetes, High Blood Pressure, Retinal problems or a high prescription.

The fee is $25 and is not covered by insurance.

☐ Yes, I **elect** to have digital retinal photography and understand the fee is my responsibility.

☐ I have read and understand the above information and **decline** to have digital retinal photography. I understand that Dr. Mason may recommend baseline photographs based on the results of my examination.

_____ ____/____/____

Patient / Guardian Signature Date