# BRILLIANT EYECARE WELCOMES YOU

**DEMOGRAPHICS:** (**PLEASE PRINT**)

LEGAL NAME:_____ DATE OF BIRTH: _____

STREET: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ DAYTIME PHONE: _____

CELL PHONE: _____ EMAIL ADDRESS: _____

S.S. #: _____ - _____ - _____ APROXIMATE DATE OF LAST EXAM: _____

PRIMARY CARE DOCTOR: _____ CITY: _____ PHONE: _____

**RACE**: _____ AMERICA INDIAN / ALASKA NATIVE _____ ASIAN _____ BLACK / AFRICAN AMERICAN _____ HISPANIC
_____ NATIVE HAWAIIAN / PACIFIC ISLAND _____ WHITE

**ETHNICITY**: _____ HISPANIC / LATINO _____ NATIVE HAWAIIAN / PACIFIC ISLAND _____ NOT HISPANIC / LATINO

**PREFERRED LANGUAGE**: _____ ENGLISH _____ SPANISH

**REASON FOR VISIT**: _____ ROUTINE EXAM _____ MEDICAL _____ LASIK CONSULTATION _____ GLASSES
_____ CONTACT LENSES (NEW WEARER / CURRENT WEARER)

**(CONTACT LENS EVALUATION MAY RESULT IN ANOTHER APPOINTMENT & ADDITIONAL CHARGES)**

**VISION INSURANCE INFORMATION**:

INSURANCE NAME: _____ MEMBERSHIP #: _____

POLICY HOLDERS NAME: _____ D.O.B OF POLICY HOLDER: _____ S.S. #: _____ - _____ - _____

**HEALTH INSURANCE INFORMATION**:

INSURANCE NAME: _____ MEMBERSHIP #: _____

POLICY HOLDERS NAME: _____ D.O.B OF POLICY HOLDER: _____ S.S. #: _____ - _____ - _____

**PATIENT MEDICAL HISTORY**

| | | |
|---|---|---|
| ALLERGIES (SEASONAL) | NO | YES |
| RETINAL DETACHMENT | NO | YES |
| MACULAR DEGEN. | NO | YES |
| EYE INJURIES | NO | YES |
| LAZY EYE | NO | YES |
| CATARACTS | NO | YES |
| GLAUCOMA | NO | YES |
| ASTHMA | NO | YES |
| ARTHRITIS | NO | YES |
| CANCER | NO | YES |
| DIABETES | NO | YES |
| HEART DISEASE | NO | YES |
| HIGH BLOOD PRESSURE | NO | YES |
| RHEUMATOID ARTHRITIS | NO | YES |
| THYROID DISEASE | NO | YES |
| LUPUS | NO | YES |
| HIGH CHOLESTEROL | NO | YES |

OTHER: _____

PHARMACY: _____

**PATIENT SOCIAL HISTORY**

| | | |
|---|---|---|
| TOBACCO USE | NO | YES |
| ALCOHOL USE | NO | YES |
| DRUG USE (RECREATIONAL) | NO | YES |

**VITALS:** ESTIMATED HEIGHT: _____' _____" WEIGHT: _____

**FAMILY MEDICAL HISTORY**: RELATIONSHIP

| | | | |
|---|---|---|---|
| BLINDNESS | NO | YES | _____ |
| CATARACTS | NO | YES | _____ |
| GLAUCOMA | NO | YES | _____ |
| DIABETES | NO | YES | _____ |
| MACULAR DEGEN. | NO | YES | _____ |
| RETINAL DETACHMENT | NO | YES | _____ |
| OTHER: _____ | | | _____ |

**PATIENTS MEDICATION (RX OR OVER THE COUNTER):**

EYE DROPS NO YES _____

MEDICATIONS _____

_____

ALLERGIES TO MEDICINE: _____

_____

LOCATION & PHONE#: _____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY CLAIM AND REQUEST BENEFITS TO BE PAID TO BRILLIANT EYECARE. I UNDERSTAND THAT SOME INSURANCE REQUIRE REFERRALS AND ASSUME THE RESPONSIBILITY TO OBTAIN ONE, PRIOR TO MY APPOINTMENT. **INSURANCE ELIGIBILITY AND BENEFITS HAVE BEEN CHECKED TO THE EXTENT POSSIBLE AND DOES NOT GUARANTEE COVERAGE**; I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ANY CHARGES NOT COVERED BY MY INSURANCE. **ANY CANCELLATIONS LESS THAN 24 HOURS MAY BE CHARGED A $45 MISSED APPOINTMENT FEE.**

SIGNATURE: _____ DATE: _____

# FINANCIAL POLICY

THANK YOU FOR CHOOSING BRILLIANT EYECARE AS YOUR MEDICAL EYE CARE AND VISION CARE PROVIDER. WE ARE COMMITTED TO PROVIDING YOU AND YOU'RE FAMILY WITH THE BEST AVAILABLE MEDICAL AND VISION CARE. IN OUR ONGOING PROCESS TO MAKE SURE THAT ALL OF YOUR MEDICAL NEEDS ARE MET, OUR BILLING DEPARTMENT WILL BE AVAILABLE TO DISCUSS OUR FEES AND THIS POLICY WITH YOU. WE ASK THAT ALL RESPONSIBLE PARTIES READ AND SIGN OUR FINANCIAL POLICY AS WELL AS COMPLETE THE PATIENT FORMS PRIOR TO SEEING THE DOCTOR. PAYMENTS FOR ALL SERVICES WILL BE DUE AT THE TIME SERVICES ARE RENDERED. IN ORDER TO SERVE YOU BETTER, WE ACCEPT CASH, CHECK, VISA, MASTERCARD, AMEX, DISCOVER, CARE CREDIT, FLEX SPENDING. AS A COURTESY TO YOU, IT IS THE POLICY OF BRILLIANT EYECARE TO BILL YOUR INSURANCE CARRIER, ALTHOUGH YOU ARE ULTIMATELY RESPONSIBLE FOR THE ENTIRE BILL.

**(PLEASE INITIAL THE FOLLOWING)**

1. YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU, YOUR EMPLOYER, AND THE INSURANCE COMPANY. WE ARE NOT A PARTY TO THAT CONTRACT. OUR RELATIONSHIP IS WITH YOU, NOT YOUR INSURANCE COMPANY. WE WILL NOT BECOME INVOLVED IN DISPUTES BETWEEN YOU AND YOUR INSURER REGARDING DEDUCTIBLES, CO-PAYMENTS, COVERED CHARGES, AND SECONDARY INSURANCE CHARGES. AS YOUR MEDICAL PROVIDER, WE WILL ONLY SUPPLY FACTUAL INFORMATION TO FACILITATE CLAIM PROCESSING.
2. FEES FOR SERVICES, WHICH INCLUDE UNPAID BALANCES, DEDUCTIBLES AND CO-PAYMENTS, ARE DUE AT THE TIME OF SERVICE. RETURNED CHECKS AND UNPAID BALANCES MAY BE SUBJECT TO COLLECTION PLACEMENT AND/OR SERVICE FEES.
3. ALL CHARGES ARE YOUR RESPONSIBILITY WHETHER YOU'RE INSURANCE COMPANY PAYS OR DOES NOT PAY. IF YOUR INSURANCE CARRIER DOES NOT REMIT PAYMENT WITHIN 60 DAYS, THE BALANCE WILL BE DUE IN FULL FROM YOU. IF ANY PAYMENT IS MADE DIRECTLY TO YOU FOR SERVICES BILLED BY BRILLIANT EYECARE, YOU RECOGNIZE AN OBLIGATION TO PROMPTLY REMIT PAYMENT TO BRILLIANT EYECARE.
4. I UNDERSTAND AND AGREE THAT IF I FAIL TO MAKE ANY OF THE PAYMENTS FOR WHICH I AM RESPONSIBLE IN A TIMELY MANNER, AFTER SUCH DEFAULT AND UPON REFERRAL TO A COLLECTION AGENCY OR ATTORNEY BY BRILLIANT EYECARE, I WILL BE RESPONSIBLE FOR ALL COST OF COLLECTING MONIES OWED, INCLUDING COURT COST, COLLECTION AGENCY FEES, AND ATTORNEY FEES.
5. I UNDERSTAND THAT IF I DO NOT SHOW FOR A SCHEDULED APPOINTMENT WITHOUT GIVING A 24 HOUR NOTICE I AM SUBJECT TO A $45 NO SHOW FEE.

# PATIENT HIPAA CONSENT FORM

I UNDERSTAND THAT I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION. THESE RIGHTS ARE GIVEN TO ME UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA). I UNDERSTAND THAT BY SIGNING THIS CONSENT I AUTHORIZE YOU TO USE AND DISCLOSE MY PROTECTED HEALTH INFORMATION TO CARRY OUT:

- TREATMENT (INCLUDING DIRECT OR INDIRECT TREATMENT BY OTHER HEALTHCARE PROVIDERS INVOLVED IN MY TREATMENT);
- OBTAINING PAYMENT FROM THIRD PARTY PAYERS (E.G. MY INSURANCE COMPANY);
- THE DAY-TO-DAY HEALTHCARE OPERATIONS OF YOUR PRACTICE.

I HAVE ALSO BEEN INFORMED OF AND GIVEN THE RIGHT TO REVIEW AND SECURE A COPY OF YOUR *NOTICE OF PRIVACY PRACTICES*, WHICH CONTAINS A MORE COMPLETE DESCRIPTION OF THE USES AND DISCLOSURES OF MY PROTECTED HEALTH INFORMATION AND MY RIGHTS UNDER HIPAA. I UNDERSTAND THAT YOU RESERVE THE RIGHT TO CHANGE THE TERMS OF THIS NOTICE FROM TIME TO TIME AND THAT I MAY CONTACT YOU AT ANY TIME TO OBTAIN THE MOST CURRENT COPY OF THIS NOTICE.

I UNDERSTAND THAT I HAVE THE RIGHT TO REQUEST RESTRICTIONS ON HOW MY PROTECTED HEALTH INFORMATION IS USED AND DISCLOSED TO CARRY OUT TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS, BUT THAT YOU ARE NOT REQUIRED TO AGREE TO THESE REQUESTED RESTRICTIONS. HOWEVER, IF YOU DO AGREE, YOU ARE THEN BOUND TO COMPLY WITH THIS RESTRICTION.

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT, IN WRITING, AT ANY TIME. HOWEVER, ANY USE OR DISCLOSURE THAT OCCURRED PRIOR TO THE DATE I REVOKE THIS CONSENT IS NOT AFFECTED.

SIGNATURE: _____ DATE: _____