Burcham Eyecare Center Patient Information

PERSONAL INFORMATION

LEGAL NAME: _____

NAME YOU GO BY: _____

SOCIAL SECURITY #: _____

MAILING ADDRESS: _____
STREET OR POST OFFICE BOX | CITY | STATE, ZIP

DOB: _____ AGE: _____

MARITAL STATUS: _____ Emergency Cont Name: _____

GENDER: _____ Emergency Contact ph#: _____

PHONE: _____
HOME | WORK | MOBILE / OTHER

E-MAIL: _____
<your email will only be used for communication & info from our office to you>

EMPLOYER: _____ OCCUPATION: _____

PRIMARY CARE DOCTOR: _____
NAME | CITY | PHONE

HOW WERE YOU REFERRED TO US?

Physician | Website | Friend/Relative _____
Radio _____ | Yellow pages | Website _____
Burcham Eyecare Employee _____ | Other _____

INSURANCE INFORMATION

PRIMARY INSURANCE
DOES THIS PLAN COVER ROUTINE EYE CARE?
YES NO

INSURANCE COMPANY NAME _____ ID NUMBER _____ GROUP NUMBER _____

POLICY HOLDER'S NAME _____ RELATIONSHIP _____ DOB / SEX (M OR F) _____

SECOND INSURANCE
DOES THIS PLAN COVER ROUTINE EYE CARE?
YES NO

INSURANCE COMPANY NAME _____ ID NUMBER _____ GROUP NUMBER _____

POLICY HOLDER'S NAME _____ RELATIONSHIP _____ DOB / SEX (M OR F) _____

THIRD INSURANCE
DOES THIS PLAN COVER ROUTINE EYE CARE?
YES NO

INSURANCE COMPANY NAME _____ ID NUMBER _____ GROUP NUMBER _____

POLICY HOLDER'S NAME _____ RELATIONSHIP _____ DOB / SEX (M OR F) _____

PERSON RESPONSIBLE FOR PAYMENT

NAME: _____

ADDRESS: _____
STREET OR POST OFFICE BOX | CITY | STATE, ZIP

PHONE: _____ DOB: _____ SS#: _____

PATIENT FINANCIAL AGREEMENT

I certify that my signature and the given information is correct and complete. I understand it is necessary to bill services in a timely and correct manner. I understand that I am ultimately responsible for co-payment, referrals, co-insurance, and deductible arrangements for each visit. I am responsible for the cost of all collection proceedings. I authorize release of medical records by mail or fax to my insurance for any reason they may state. If self pay, payment is due at the time of service.

Patient or Authorized Signature _____ Date _____

Burcham Eyecare Center

Refraction and Contact Lens Fee and Explanation

- **Refraction Fee: $40:**
  - A Refraction is done to determine the prescription for your glasses so you can achieve the best possible corrected vision. The Refraction Fee is **NOT** a covered Medicare Benefit (this includes Medicare Supplements). **MOST** other medical insurances will cover the refraction. If it is not covered, you will be billed for the $40 Refraction Fee.
  - If you have vision insurance (VSP, EyeMed, Spectera, Superior etc.) this fee is covered.

- **Contact Lens Fee:**
  - Contact lenses are an alternative to glasses which often provide both functional and cosmetic advantages. They are, however, medical devices which can potentially cause eye problems if they are poorly fit or cared for improperly. As a contact lens wearer, we provide your ongoing care to insure the best possible visual results, safety and patient satisfaction.
  - Contact lens fitting, insertion/removal and instruction evaluation fee includes; getting the best contact lens fit for your eye as well as, properly instruct you on how to put the lens in and take the lens out of your eye. Unfortunately medical insurance does **NOT** cover these contact lens related services, but **SOME** vision insurance plans do pay for part of the contact lens fees, what is not covered will be out of pocket due at time of appointment. All follow-up appointments **WITHIN 90 Days** are included, as are any trial lenses that are dispensed. **Contact lens prescriptions are valid for one year by law.** Payment is required at the time your contacts are ordered.
  - **Annual Contact Lens Renewal Fee** (in addition for your annual check-up co-pay).....**$50**
  - **New Contact Lens Wearer Fee** (Spherical Contacts) **$95**
  - **New Contact Lens Wearer Fee** (Toric and Gas Permeable Contacts)...**$145**
  - **New Contact Lens Wearer Fee** (Keratoconus Contacts).....**$200**

I have read and understood the fees regarding refraction and contact lens service fees.

Signature:_____ **Date:**_____

Justin P. Coco, DO
Ophthalmology

James Russell Burcham, MD
Ophthalmology

Razanne Taher, OD
Optometry

Burcham Eyecare Center

Financial Policy of Burcham Eyecare Center

We are committed to providing you with the highest quality care. A good physician/patient relationship begins with good communication. The following information is provided to avoid any misunderstanding or disagreement concerning payment for the professional services you need. This policy is now in effect for **all** patients.

Our office participates with most health plans; however it is your responsibility to make sure we are in-network with yours. It is also your responsibility to:

- Bring your insurance card with you each visit and be prepared to update your current demographic information.
- Be prepared to pay your copay each visit. Payment may be made by cash, check, Visa, MasterCard, American Express, and Discover card.
- Any patient balance from previous services is expected to be paid prior to any additional services. Any need for extended payments must be discussed in advance with our billing office.
- For medical care not covered by your insurance, payment in full is due at the time of service.

We send statements each month reflecting any balance that is not covered by your insurance and/or that has not been collected at the time of service. You are expected to pay this balance upon receipt. If the balance is not paid within 30 days, you will receive a letter and a call from our office. If the balance is not paid within 60 days, your account will go into collections. If your balance is not paid within the allotted time or you have not met the obligations associated with an extended payment plan, we reserve the right to ask you to obtain your eye care from another provider.

Our mission is to maximize the visual experience of all of our patients. We can't do that without a mutual understanding of financial responsibilities. We encourage you to discuss any questions you may have regarding our policies with our billing staff.

Questions about financial arrangements should be made to Kelly Warner-Compton 303-340-4600. Please do not ask the physician to make special arrangements for you.

Please sign that you have read and agree with the financial policy of Burcham Eyecare Center.

_____

Patient Signature Date

_____

Print Name DOB

Burcham Eyecare Center

$50 Fee

For No Shows, Cancellations or Rescheduling With less than a 24 hour Notice

As a medical practice, our goal is to provide you with the best and most current medical and vision care available in a positive and supportive environment. As a small business, we must constantly strive to reduce and minimize our expenses and cost of doing business.

Our schedule for our doctors is now full 1-2 months in advance and we would appreciate your keeping any appointment we have reserved for you. It is very difficult for our receptionists to fill your reserved appointment slot without a 24 hour notice.

Excluding post operative exams, a **$50 fee** will be charged for no shows, cancellations or the rescheduling of appointments with less than a **24 hour notice.** We understand that inclement weather may occur, and the fee will be waived for bad weather.

Thank you for your cooperation and understanding,

Doctors and Staff at Burcham Eyecare Center

I acknowledge the change in office policy to pay a $50 fee per incident to Burcham Eyecare Center for any no shows, cancellations or the rescheduling of appointments with less than a 24 hour notice.

Patient Signature **Date**

Burcham Eyecare Center

HIPAA Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or healthcare operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about your treatment about you for treatment, payment and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Patient understands that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent

Patient Signature/Legal Representative_____

Relationship to Patient (if other than patient):_____

In front of _____ Date: _____

Specific Persons to whom we may disclose Protected Health Information:

Full Name: _____Relationship_____

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Name _____ **Date** _____

Reason for coming in _____

Are you considering laser vision correction? ☐ yes ☐ no Cataracts? ☐ yes ☐ no? ☐ Other?

Do you want a new pair of glasses? ☐ yes ☐ no Are you considering contact lenses? ☐ yes ☐ no

Contact lens wearers:

What kind of lenses do you wear? ☐ soft ☐ extended wear ☐ disposable ☐ toric ☐ gas perm ☐ hard

How long do you usually wear them? ____ hrs / day. How often do you clean them? _____

What do you use to rinse? _____ clean? _____ sterilize? _____

How old are your current lenses? _____

Please check any eye problem you have had or currently have or: ☐ NONE

__ Amblyopia (lazy eye)	__ Eye infections	__ Herpes Simplex/Zoster	__ Muscle imbalance
__ Blind spots	__ Eye surgery	__ Iritis	__ Recurrent Corneal Erosion
__ Cataract	__ Flashing lights	__ Keratoconus	__ Retinal problems
__ Corneal Abrasion	__ Floaters	__ Macular Degeneration	__ Scar
__ Double vision	__ Glaucoma	__ Major injury to eyes	__ Stye
__ Droopy Eyelids	__ Granulated eyelids	__ Major injury to head	__ Trauma/foreign body
__ Dry eyes	__ Headaches	__ Migraines	__ Other _____

Prior Surgeries (eye surgery?) (other?)

Medical History (please circle all that apply) _____ **All Negative, check here**

ASCVD – atherosclerosis	Dementia	Hypothyroidism
Acid reflux disease (GERD)	Depression	Irritable bowel syndrome
Alzheimer's Disease	Diabetes-Type I	Juvenile rheumatoid arthritis
Anemia – chronic	Diabetes-Type II	Kidney problems Leukemia
Arrhythmia/Irregular Heart Beat	Dialysis-hemodialysis	Lupus-systemic
Arthritis-degenerative (DJD)	Diverticulitis	Multiple sclerosis
Arthritis-rheumatoid	Eczema	Myasthenia Gravis
Asthma	Emphysema	Neurofibromatosis
Autoimmune Disease	Epilepsy/Seizures	Obesity
Back pain-chronic	Fibromyalgia	Osteoporosis/Osteopenia
Bipolar Disorder	Gallstones	Pain-chronic
Bleeding Disorder/Anti-Coagulation	Gout	Peptic ulcer disease (PUD)
Brain tumor-benign	Grave's disease	Prostate enlarged (BPH)
COPD-chronic lung disease	HIV / AIDS	Peripheral artery disease
CVA-stroke	Head Injury	Psoriasis
Cancer, type _____	Hearing loss	Rosacea
Cirrhosis	Heart Attack	Sarcoidosis
Collagen vascular disease	Heart disease	Schizophrenia
Congestive heart failure	Hepatitis B or C	Sjogren's disease
Coronary artery disease	Hypercholesterolemia	Sleep apnea
Crohn's disease/Ulcerative Colitis	Hypertension/High Blood Pressure	Tuberculosis
DVT-deep vein thrombosis	Hyperthyroidism	Vertigo

Other _____ _____ _____

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Patient Name _____ Date _____

Current Medications (Include eye medications) ❒ **No Current Medications**

Allergies ❒ **No Known Drug Allergies**

Name of Medication	Type of Reaction

Pharmacy _____ Telephone _____

Review of Systems: Please circle any of the following symptoms or problems that are **currently** afflicting you and require medical attention. **If All Negative, Check Here** ❒

SYSTEM	CIRCLE ANY ISSUES	NONE?
Constitutional Symptoms	Fatigue | Fever |Chills | Night sweats | Weakness | Weight Gain or Loss | Trouble Sleeping	
Ears, Nose, Mouth, Throat (ENT)	Dizziness | Hearing Loss | Hoarseness | Ringing in ears | Sore Throat	
Cardiovascular	Chest Pain | Irregular heart beat | Shortness of breath	
Respiratory	Cough | Trouble breathing | Wheezing	
Gastrointestinal	Abdominal Pain | Indigestion | Nausea/Vomiting Diarrhea/Constipation | Bowel Problems	
Genitourinary	Genital Discharge | Genital Lesions | Painful Urination | Urgency Incontinence | Menstrual issues | Menopause	
Musculoskeletal	Back Pain | Joint Pain | Muscle Aches | Stiffness | Swelling	
Integumentary/Skin	Hair Loss or Changes | Rash | Skin Lesions | Eczema | Itching | Dryness | Color Changes | Nail Changes	
Breasts	Pain | Soreness | Lumps | Discharge | Self-exams | Breast-feeding	
Neurological	Balance Problems | Headache | Numbness | Tingling | Change in smell Change in taste | Seizures | Faints | Speech Problems	
Psychiatric	Anxiety | Depression | Insomnia | Irritability | Nervousness	
Endocrine	Thyroid: Hyper (high)/ Hypo (low) | Hypertension (high blood pressure) | Cold or Heat Intolerance | Excessive Hunger or Thirst | Hypoglycemia | Changes in sexual arousal or libido	
Diabetes	Insulin Dependent | Oral Medication | Diet Controlled Blood sugar _____stable / not stable | Hb A1c_____	

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Hematologic/Lymphatic	Anemia | Bleeding | Bruising | Tender Nodes | Blood Issues	
Allergic/Immunologic	Anaphylaxis | Chronic Runny Nose | Hives | Itching	
Pregnancy	Pregnancy trimester ____ | Number of Pregnancies____	

Patient Name _____ **Date** _____

Family History:

CONDITION	Related How?	CONDITION	Related How?
Amblyopia		**Diabetes**	
Anesthetic Complication		**Glaucoma**	
Astigmatism		**Heart Disease**	
Bleeding Disorder		**High Myopia**	
Blindness		**High Blood Pressure**	
Brain Tumor		**Macular Degeneration**	
Cataracts		**Rheumatoid Arthritis or Lupus**	
Cancer		**Stroke**	
Crossed Eyes		**Thyroid Disease**	

Do you	No	Yes	How Much?	How Often
Smoke				
Drink Alcohol				
Use Recreational Drugs				
Drink Caffeine				