ADVANCED EYECARE ASSOCIATES

Kyle D McMurray, O.D., Douglas J Kimball, O.D., Jody L Fink, O.D.,
Jennipher Harper, O.D., Tel Todd, O.D.

New Patient Packet

Welcome to Advanced Eyecare,

We are so excited to have you as a new patient! To make your check in quick and easy we ask that you fill out the following forms in full and email them back to our office at least 24hrs before your scheduled appointment.

We look forward to meeting you!

4265 Fallon Street, Suite B, Bozeman, MT 59718 Phone: 406.587.0668 Fax: 406.587.0396

91 West Madison Ave, Belgrade, MT 59714 Phone: 406.388.1988 Fax: 406.388.2488

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New ____ Updated_____ **Today's Date_____**

Legal First name _____ **MI** ___ **Last** _____

Soc Sec # ___-__-____ Date of Birth ____/_____/_____Marital Status _____ Sex _____

Mailing Address _____ City _____ State ____

Zip _____ Phone _____ Email address: _____

Employer Name: _____ Phone: _____

Guardian/Spouse Information

Parent 1/Spouse Legal First Name: _____ Last: _____

Date of Birth: __/____/_____ Soc. Sec # _____-____-_____ Phone:

Mailing Address: _____ City: _____State____ Zip _____

Employer Name: _____ Phone _____

Parent 2/Spouse Legal First Name: _____ Last: _____

Date of Birth: __/____/_____ Soc. Sec # _____-____-_____ Phone: _____

Mailing Address: _____ City: _____State____ Zip _____

Do you have insurance? Yes ____ No ____ **If yes, Name of Carrier** _____

Insurance Card Holder Name: _____ Soc. Sec # of Card Holder_____

ID Number _____ Group Number _____ Effective Date _____

Secondary insurance? Yes ____ No ____ If yes, Name of Carrier _____

Insurance Card Holder Name: _____ Soc. Sec # of Card Holder_____

ID Number _____ Group Number _____ Effective Date _____

WORKMANS COMPENSATION? Yes ____ No ____ If yes, Work Comp Insurance _____

Claim # _____ Injury Date: _____ Employer's Name _____

Phone number _____ Supervisor or HR Name _____

*** **IS LEGAL ACTION OR LITIGATION PENDING FOR THIS INJURY? YES _____ NO _____**

PAYMENT IS EXPECTED AT TIME OF SERVICE UNLESS PRIOR ARRANGMENTS ARE MADE. ALL APPOINTMENTS CANCELLED WITHIN 24 HOURS OR NO SHOWS ARE SUBJECT TO A $50.00 FEE

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Patient Name: _____ **Gender:** _____ **Date of Birth:** _____

Primary Language: _____

Race/Ethnicity:

☐ Caucasian ☐ African American ☐ Native American or Alaska Native ☐ Other/Declined
☐ Asian ☐ Hispanic or Latino ☐ Hawaiian or Pacific Islander

CHECK THE FOLLOWING CONDITIONS THAT APPLY TO YOU:

Constitution:
- Developmental Disabilities ☐
- Cancer ☐
- Headache ☐
- Other ☐

Ear/Nose/Throat:
- Hearing Loss ☐
- Sinus Condition ☐
- Dry Mouth ☐
- Laryngitis ☐
- Other ☐

Neurological:
- Multiple Sclerosis ☐
- Epilepsy ☐
- Cerebral Palsy ☐
- Tumor ☐
- Stroke/CVA ☐
- Migraines ☐
- Autism Spectrum Disorder ☐
- Other ☐

Psychological:
- Depression ☐
- ADD/ADHD ☐
- Anxiety ☐
- Bipolar Disorder ☐
- Other ☐

Cardiovascular:
- High Blood Pressure ☐
- Stroke/CVA ☐
- Heart Disease ☐
- Vascular Disease ☐
- Congestive Heart Failure ☐
- Other ☐

Respiratory:
- Cigarette Smoker ☐
- Asthma ☐
- Bronchitis ☐
- Emphysema ☐
- Chronic Obstruction ☐
- Sleep Apnea ☐
- Other ☐

Gastrointestinal:
- Crohn's Disease ☐
- Colitis ☐
- Ulcer ☐
- Acid Reflux ☐
- Celiac Disease ☐
- Other ☐

Gastrourinary:
- Kidney Disease ☐
- Prostate Disease/ Cancer ☐
- STD ☐
- Benign Prostate ☐
- Pregnant ☐
- Nursing ☐
- Herpes ☐
- Chlamydia ☐
- Other ☐

Musculoskeletal:
- Arthritis ☐
- Osteoarthritis ☐
- Fibromyalgia ☐
- Muscular Dystrophy ☐
- Ankylosing Spondylitis ☐
- Osteoporosis ☐
- Gout ☐
- Other ☐

Integumentary:
- Eczema ☐
- Rosacea ☐
- Psoriasis ☐
- Cold Sores (simplex) ☐
- Shingles (zoster) ☐
- Other ☐

Endocrinology:
- Type 2 Diabetes ☐
- Type 1 Diabetes ☐
- Thyroid Condition ☐
- Hormone Disorder ☐
- Other ☐

Hem/Lymph:
- Anemia ☐
- Large Volume Blood Loss ☐
- Ulcer ☐
- High Cholesterol ☐
- Other ☐

Allergic/Immunologic Conditions:
- Drug Allergies ☐
- Environmental Allergies ☐
- Rheumatoid Arthritis ☐
- Lupus ☐
- Sjogren's syndrome ☐
- Other ☐

Primary Medical Doctor: _____

Other Medical Conditions: _____

NAME AND DOSAGE OF CURRENT MEDICATIONS:

_____

_____

DRUG OR OTHER KNOWN ALLERGIES: _____

LATEX SENSITIVITY? _____ **CURRENT EYEDROPS:** _____

Do you have or have you previously had any of the following eye conditions?

☐ Cataract ☐ Glaucoma ☐Macular Degeneration ☐ Lazy Eye ☐ Retinal Detachment ☐ Eye Surgery

Other conditions or concerns: _____

Does a member of your family have or have they had any of the following conditions?

(Please mark **M** for mother; **F** for father; **B** for brother; **Si** for sister; **D** for daughter; **So** for son)

Cancer_____ Diabetes_____ High Blood Pressure_____

Cataract_____ Macular Degeneration_____ Glaucoma_____

Do you drink alcohol? YES ☐ NO ☐ Do you smoke? YES ☐ NO ☐

Former Smoker? YES ☐ NO ☐ Use smokeless tobacco? YES ☐ NO ☐

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CONSENT TO ASSIGNMENT OF BENEFITS AND PROMISE TO PAY

Benefits to Physician:

I hereby assign all my rights to insurance benefits and instruct my insurance company to make payments directly to **Advanced Eyecare LLC** and/or its physicians for the benefits provided.

Promise to Pay:

I understand and agree that I am responsible for paying for all services provided to me by **Advanced Eyecare LLC.** and its staff. In the event of non-payment of any balance, I agree that I will be responsible for services rendered or have a signed agreed payment arrangement. I agree that I will be responsible for all the costs of collection, including but not limited to interest at the rate of one and a half percent (1.5%) per month or eighteen percent (18%) per year, court cost and fees, attorney fees, and a collection fee of thirty five percent (35%) of the unpaid balance assigned for collection.

_____ _____

Date Patient Signature

_____ _____

Signature of patient Representative Relationship

(Required if the patient is a minor or an adult unable to sign)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received a Notice of Privacy Practices for **ADVANCED EYECARE LLC.** I understand that my Protected Healthcare Information (PHI) may be used and disclosed for the purpose of TREATMENT, PAYMENT, and HEALTH OPERATION of the practice.

_____ _____

Date Patient Signature

_____ _____

Signature of patient Representative Relationship

(Required if the patient is a minor or an adult unable to sign)

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WRITTEN AUTHORIZATION FOR RELEASE OF PHI

I hereby authorize ADVANCE EYECARE LLC. To discuss my (PHI) Protected Health Information with the following person(s). Should I wish to revoke this authorization, I understand **I must do so in writing.**

Name: _____ Phone: _____

Relationship: _____ Expiration Date: _____

Name: _____ Phone: _____

Relationship: _____ Expiration Date: _____

Name: _____ Phone: _____

Relationship: _____ Expiration Date: _____

_____ _____

Signature Today's Date

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ADVANCED EYECARE ASSOCIATES

Contact lens Examination

A contact lens examination requires additional testing and assessment by your doctor that are not preformed during an annual comprehensive eye examination. Although contact lenses are considered medical devices, they are not considered medically necessary (with some exceptions). For this reason, service and fitting fees associated with contacts are often not a covered benefit under most insurance policies. The contact lens service and fitting cost will be the responsibility of the patient if insurance does not include that benefit. Patients can expect the service and fitting fee for contact lens to vary between 50.00-120.00 dollars.

The additional assessment and follow up care (commonly referred to as the contact lens "fitting") provided for successful contact lens wearers includes:

Tear Film Analysis:

Your tear ducts and your body's ability to produce tears are evaluated in order to determine whether you will be able to comfortably wear contact lens. Additionally, the amount of tears you produce may determine which of the new contact lens materials will work most effectively on you.

Corneal Assessment:

Using a keratomer or a corneal topographer, your doctor will measure the curvature of your cornea (the clear front surface of your eye) to access the proper base curve of your contact lens. Additionally, the doctor will provide a more comprehensive assessment of the surface of the cornea with a biomicroscope, in order to assure that surface integrity can support contact lens wear.

Pupil and Iris Measurements:

Both pupil and iris (the colored part of your eye) size determination can be very important in ascertaining the best contact lens design for you.

Follow Up Visits:

In most cases you will leave our office with a free trial of contact lens and if you are new to contacts we will provide education on how to properly insert and remove contact lens as well as comprehensive lens care and eye health guidelines. Follow up visits are needed within the first two months to ensure your best vision and wearing comfort. These follow ups will be included with your original contact lens examination charge.

- I have read and understand the contact lens examination information
- I consent to obtaining electronic delivery of RX by patient portal

Signature: _____ Date: _____

ADVANCED EYECARE ASSOCIATES

Cancelation / "No Show" Policy

At Advanced Eyecare Associates our goal is to provide exceptional eyecare to our patients in a timely matter. We have enabled a "no show" and cancellation policy that helps us to better utilize available appointments for our patients who are seeking eyecare. The following policy is for patients who fail to keep their scheduled appointment with our office.

We ask our patients to please be courteous and call Advanced Eyecare Associates if you are no longer able to make your scheduled appointment. This time will be reallocated to someone who is in urgent need of eyecare. Available appointments are in high demand and your early cancellation will give another patient sooner possible access to eyecare.

- Patients who fail to show up for their scheduled appointment or who do not notify the office about needing to cancel or reschedule their appointment 24 hrs prior will be subject to a 50.00 "no show/cancellation fee". In the event of an actual emergency where prior notice could not have been given, consideration will be given, and a one-time exception may be granted.
- These fees are not covered by insurance and are therefore the sole responsibility of the patient.

- I have read and understand the policy stated above and will except any charges given to me as the result of a "no show" or late cancellation.

Signature:_____ Date: _____