PATIENT DEMOGRAPHICS INFORMATION

PATIENT NAME:_____ **TODAY'S DATE:**_____

SSN:_____ DOB:_____ SEX: _____ CAREGIVER NAME (if applicable) _____

ADDRESS:_____**CITY:**_____**ST:**_____**ZIP:**_____

CELL PHONE:_____**HOME PHONE:**_____**MAY WE LEAVE A MESSAGE?** YES NO

EMAIL:_____ HOW DID YOU HEAR ABOUT US?_____

PRIMARY CARE DOCTOR: _____ **ANY OTHER DOCTORS?** _____

_____

PHARMACY: _____ **PHARMACY CITY & STREET:** _____

PRIMARY MEDICAL INSURANCE NAME: _____

SECONDARY MEDICAL INSURANCE NAME (if applicable): _____

VISION INSURANCE NAME (if applicable): _____

PATIENT ACKNOWLEDGEMENT

PRIVACY NOTICE-"I have read and understand the Notice of Privacy Practices for Medical Vision Institute, PSC and would like the following person(s) to have access to my account information: _____ (optional). I understand that I can rescind this permission at any time with written notice to Medical Vision Institute."

INSURANCE PATIENTS-"I authorize my health insurance company to utilize my medical information as reasonably necessary for the proper administration of the health plan. I hereby assign MVI any payments of medical benefits for services rendered to myself or dependents." Copayments: MVI is required by your insurance to collect your copayment. Your copayment is due at the time of service. If you do not have your copayment, your appointment may be rescheduled. "I have read and understand that I am responsible for paying the annual deductible, copayment, coinsurance and any charges for non-covered services as determined by my insurance."

REFRACTION/CONTACT LENS FITTING FEE: "I have read the MVI fee schedule for refraction and contact lens fitting and understand these services may not be covered by my insurance plan. I understand if they are covered services, it would be under my vision plan, not medical insurance."

ACCEPTANCE OF FINANCIAL RESPONSIBILITY: "I acknowledge full financial responsibility for services rendered by MVI, regardless of insurance coverage and whether or not there was an accident with another party at fault. "

OUTSTANDING BALANCES- "Any patients having an outstanding balance with a collection agency will not be able to make an appointment until the balance is paid in full. Any third-party costs associated with collecting past due accounts will be added to the patient's account. MVI will charge 2% interest on any balances over 90 days old. I AGREE TO THE TERMS AND CONDITIONS ABOVE."

E-PRESCRIBING- "I have read the Medical Vision Institute (MVI) e-Prescribing consent form in its entirety and would like to enroll in the e-Prescribing program. I agree that Medical Vision Institute may request and use my prescription medication history from other healthcare providers
or pharmacies for treatment purposes."

Responsible Party Signature: _____ **(required)**

For more information regarding MVI policies and procedures, please visit our website at www.medicalvision.com

MEDICAL VISION INSTITUTE OCULAR/MEDICAL HISTORY FORM

PATIENT NAME: DATE OF BIRTH:

OCULAR HISTORY:(CIRCLE ALL THAT APPLY)	**MEDICAL HISTORY:(CIRCLE ALL THAT APPLY)**
PAST EYE INJURIES? NO / Details:	**DIABETES (IF YES, LAST A1C _____)** THYROID DISORDER HEART DISORDER ARTHRITIS ASTHMA ANGINA COPD HYPERTENSION SLEEP APNEA
PAST EYE SURGERY? NO / Details:	
USED EYE DROPS? NO / Details:	**HAVE YOU EXPERIENCED ANY OF THE FOLLOWING IN THE LAST YEAR? (CIRCLE)** Headache Chest pain Anxiety/Depression Cancer Allergies Change in bowel habit Shortness of breath Weight loss/gain Uncontrolled blood sugar Dry mouth
DO YOU WEAR GLASSES? NONE/ BIFOCALS/ DISTANCE ONLY/ PRESCRIPTION READING/ OVER THE COUNTER READING/ COMPUTER/ CONTACT LENSES	
HAVE YOU HAD ANY MEDICAL TESTS RECENTLY? IF SO, WHAT FOR?	**PLEASE LIST ANY OTHER MEDICAL CONDITIONS:**
HOW WOULD YOU DESCRIBE YOUR TOBACCO USE? Never Smoker Former Smoker Current Smoker	**DOES ANYONE IN YOUR FAMILY HAVE A HISTORY OF EYE DISEASE?** e.g. glaucoma, macular degeneration
MEDICATIONS (PLEASE LIST)—and/or attach sheet 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____	**ALLERGIES (CIRCLE & DESCRIBE REACTION)** LATEX _____ IODINE _____ ADHESIVE _____ NSAIDS _____ ANESTHESIA _____ EYE DROPS _____ OTHER (Please list): _____ _____ _____ _____

MEDICAL VISION INSTITUTE OCULAR/MEDICAL HISTORY FORM

PATIENT NAME: DATE OF BIRTH:

WHAT IS YOUR PROFESSION?	**PLEASE LIST A FEW OF YOUR HOBBIES/PASTIMES:**

Please indicate if you are experiencing the following symptoms:

Circle the number that corresponds to your answer.

	Always	**Usually**	**Often**	**Seldom**	**Never**
1. Eyes that are sensitive to light?	**4**	**3**	**2**	**1**	**0**
2. Eyes that feel gritty?	**4**	**3**	**2**	**1**	**0**
3. Painful or sore eyes?	**4**	**3**	**2**	**1**	**0**
4. Blurred vision?	**4**	**3**	**2**	**1**	**0**
5. Excess tearing?	**4**	**3**	**2**	**1**	**0**
6. Reduced side vision?	**4**	**3**	**2**	**1**	**0**
7. Double vision?	**4**	**3**	**2**	**1**	**0**
8. Glare/halos around lights?	**4**	**3**	**2**	**1**	**0**

Have problems with your eyes limited you in performing any of the following during the last week?

Circle the number that corresponds to your answer.

	Always	**Usually**	**Often**	**Seldom**	**Never**
1. Reading?	**4**	**3**	**2**	**1**	**0**
2. Driving at night?	**4**	**3**	**2**	**1**	**0**
3. Working on a computer?	**4**	**3**	**2**	**1**	**0**
4. Watching TV?	**4**	**3**	**2**	**1**	**0**
5. Seeing at night or in dim conditions?	**4**	**3**	**2**	**1**	**0**

Are there any other concerns that you would like to address at this visit?

_____

_____

_____

MEDICAL VISION INSTITUTE FINANCIAL AGREEMENT

PAYMENT POLICY

As a courtesy, MVI verifies your benefits with your insurance company. A quote of benefits is not a guarantee of benefits or payment.

It is the policy of MVI that payment is due at the time of service unless other financial arrangements are made in advance. At the conclusion of your visits with us, you may be billed for any outstanding balances.

Please provide your insurance information to the front office staff, and we will verify your coverage as a courtesy. Accepting your insurance does not place all financial responsibilities onto this practice, and you will be held accountable for any unpaid balances by your plan.

Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Please remember that you are 100 percent responsible for all charges incurred: your physician's referral and our verification of your insurance benefits are not a guarantee of payment.

We highly recommend you also contact your insurance carrier and check into your coverage.

Initial _____

NO SHOW/CANCELLATION POLICY

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, MVI reserves the right to charge a fee of $50.00 for all missed appointments ("no shows") and appointments which, absent a compelling reason, are not cancelled with a 24-hour notice. (*Procedures* must give 5+ days cancellation notice or may be subject to a $150.00 fee.)

"No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. More than 3 "no shows" in any 6-month period may result in practice termination.

Initial _____

ARRIVAL POLICY

All established patients must arrive early or on-time for appointments. Established patients who are 10 or more minutes late for appointments will be asked to reschedule unless approved by a supervisor.

All new patients must arrive at least 15 minutes early for appointments or may need to be rescheduled.

Initial _____

By signing below, you acknowledge that you have received this notice and understand the above policies:

_____ _____

Printed Name Date

_____

Signature