RISK OPTOMETRIC ASSOCIATES, PA

PATIENT HISTORY

Are you here for: **Glasses exam** _____ **Contacts** ____ **Other Reason** _____

Name_____ **Male** _____ **Female** _____

Address_____ **Date of Birth** _____

City_____ **State** _____ **Zip** _____

List ALL insurances _____ **How much is your co-pay?** _____

Are you the Primary Insured or are you a family member? ____ **Primary** ____ **Family member (spouse / child)**

Home Phone: _____

Cell Phone: _____

Email:_____

We're **online**! **Confirm** your appointments via text or email! Your **email** is the only way we will send you a yearly reminder (not for soliciting)

Which of our offices was your last appointment?

Skibo / Hope Mills / Raeford / Ramsey / Yopp

Marine / Hendersonville / Ft. Bragg / Other

Office Name: _____

I know my HIPAA rights: ____ Yes

Personal Medical **Race**:_____

Family Doctor _____(_____Never _____ Don't remember) **Last Visit:** _____

Last Eye Doctor _____(_____Don't have one) **Last Eye Exam**_____

What problems are you having today (check all that apply):

Are these problems noticed with your glasses / contact on or off? _____**On** ____ **Off** _____**Both**

What	Location	Duration	Timing	Context	Severity
____Blur at distance	____Both eyes	____Minutes	____Constant	____While driving	____Mild
____Blur at near	____Right eye	____Hours	____Intermittent	____School board	____Moderate
____Blur everywhere	____Left eye	____Days		____Reading book	____Severe
____Diabetic Ret.		____Months		____Computer	
____Glaucoma		____Years		____Other	
____Macular Degen		____All my life			
____Cataract					
____Dry					
____Itch					
____Pain					

Does anything make it better? **No** ___ **Yes, what?** _____

Other information you wish to provide:

_____

_____

_____

_____

Review Of Systems (If we are filing insurance for you, your insurance company requires a complete history to be filled out. Please do not leave any question blank.) This Section Applies to YOU and YOUR Family Members

NO (X)		Yes (X)	Who	Explain
_____	Diabetes	_____	_____	_____
_____	Heart	_____	_____	_____
_____	Ear /Noses	_____	_____	_____
_____	Lungs	_____	_____	_____
_____	Stomach	_____	_____	_____
_____	Urinary	_____	_____	_____
_____	Skin	_____	_____	_____
_____	Nervous	_____	_____	_____
_____	Psychiatric	_____	_____	_____
_____	Weakness	_____	_____	_____
_____	Blood	_____	_____	_____
_____	Allergies	_____	_____	_____
_____	Other	_____	_____	_____
_____	**Pregnant**	_____	ME	How far along are you?_____
	Eye Diseases			
_____	Glaucoma	_____	_____	_____
_____	Cataract	_____	_____	_____
_____	Macular Deg	_____	_____	_____
_____	Eye Injury	_____	_____	_____
_____	Retina	_____	_____	_____
_____	Blindness	_____	_____	_____
_____	Turned eye	_____	_____	_____
_____	Lazy eye	_____	_____	_____

Anything Else?_____

Social History (Gives us an idea of your visual needs and is required by most insurance companies)

Do you smoke?_____ **PPD**?_____**Years**?_____ **Recreational Drugs**?_____

How much Alcohol do you consume?_____ **What is your OCCUPATION**?_____

What are your HOBBIES?_____

Have you had any major surgeries? When?_____

MEDICATIONS:_____

ALLERGIES:_____

Please Note: Insurance may cover part of your charges, or may be payable directly to you. Please give any forms to the receptionist. If your insurance company does not pay as expected, you are ultimately responsible for the charges.

I have read my privacy rights. I understand I may request a copy. I authorize the release and payment of any medical or other information necessary to process claims filed pertaining to services rendered at this office. **I understand and agree that the professional services provided to me are nonrefundable. Method of payment today must be in cash or credit card. We no longer accept checks.**
A service charge of 1 ½ % per month, 18% APR will be added to overdue accounts. Also liable for legal and collection fees.

Signature _____ **Date**_____

Insurance Sponsor's Name _____ **I.D.#**_____

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INSURANCE INFORMATION

In order to process your claim to the insurance provided, additional information may be needed. Please fill out this form to the best of your ability so your claim can be processed properly.

Patient's Name_____

Plan Name_____

Sponsor's / Primary's Name:_____

Sponsor's / Primary's Date of Birth_____

Sponsor's / Primary's SS#_____

Sponsor's / Primary's Gender: _____**Male**

_____**Female**

Sponsor's / Primary's Employer_____

RISK OPTOMETRIC ASSOCIATES, PA

REQUEST FOR NON-COVERED SERVICES

I am hereby requesting that the following services be provided to me by _____

(Provider Name)

Services (list all)	Frequency Limitations	Proposed Date(s) of Service	Estimated Cost of Service

In making this request, I acknowledge that these services are not a benefit of my health coverage with _____. In addition I acknowledge that if I obtained service(s) more frequently than authorized by my insurance policy, I may be responsible for that professional service(s).

I also understand that if my insurance company has denied authorization for this care, or if reimbursement is denied upon submittal of a claim form. I may appeal the written notification of the denial issued by my insurance company.

Unless the decision to deny is overturned as a result of an appeal or dispute, I agree that I will be personally responsible for the payment **In Full** of the billed charges for these services.

Patient's Name (please print)_____

Patient Signature_____

Date_____

RISK OPTOMETRIC ASSOCIATES, PA

(A) Notifier(s): **Risk Optometric Associates, PA**

(B) Patient Name: _____

(C) Identification Number: _____

ADVANCED BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for (D) Services below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the (D) Services below.

(D) Services	(E) Reason Medicare May Not Pay:	(F) Estimated Costs

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive (D) Services listed above.
  Note: If you choose Option 1 or 2, we may help you use any other insurance that you might have but Medicare cannot require us to do this.

(G) OPTIONS: Check only one box. We cannot choose a box for you.

_____ **OPTION 1.** I want the (D) Services listed above. You may to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

_____ **OPTION 2.** I want the (D) Services listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

_____ **OPTION 3.** I don't want the (D) Services listed above. I understand with this choice I am **not** responsible for payment and I **cannot appeal to see if Medicare would pay.**

(H) Additional Information:

This notice gives our opinion not an official Medicare decision. If you have any other questions on this notice of Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

(I) Signature	(J) Date