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.#**_____

TRICARE

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 un-der TRICARE and that I will not receive the benefit of the TRICARE Hold Harmless Policy (defined below), which otherwise might apply to me. In addition, I acknowledge that if I have obtained services more frequently than authorized by TRICARE policy, I may be responsible for that professional service.

I also understand that if authorization for this care has been denied by TRICARE, or if reimbursement is denied upon submittal of a claim form, I may appeal the written notification of the denial issued by Health Net Federal Services, Inc./MHN Services.

Unless the decision to deny is overturned as the 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.

_____ _____

Sponsor Name (print) **Patient's Name (print)**

_____ _____

Sponsor Social Security Number **Patient Signature**

_____ _____

Sponsor Address **Date**

TRICARE Hold Harmless Policy: A network provider may not require payment from the beneficiary for any excluded or excludable services that the beneficiary received from the network provider (i.e., the beneficiary will be held harmless) unless the beneficiary has been properly informed that the services are excluded or excludable and has agreed in advance in writing to pay for the services.

Privacy Act Statement

In view of the fact that personal information is being requested from you, notice is hereby given as required by the Privacy Act of 1974. The information is requested and maintained under the authority of Chapter 55. Title 10, United States Code, Section 3101, Title 44, United States Code, and 41 Code of Federal Regulations 101-1100 et. Seq. The information is requested to establish or update information to control or process claims for payments. Routinely, the information will be used to determine eligibility for TRICARE benefits, review and approve medical care as TRICARE benefits and to determine reasonable charges/costs of care to be cost-share under TRICARE. Disclosure of the information is voluntary; however, failure to provide the information may result in denial of benefits.

RISK OPTOMETRIC ASSOCIATES, PA

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_____