Children's Eye Institute
PATIENT INFORMATION

DATE:

Patient Name ______________________________
Last First Middle Initial

Date of Birth: **Age** **Sex:** ☐ Male ☐ Female

Mailing Address: ______________________ **Home Phone #:** ______________________
City __________ **State** ______ **Zip** ______ **Soc. Sec#:** ______________________
Employer ______________________ **Drivers License:** ______________________
Business Address ______________________ **Occupation** ______________________
City __________ **State** ______ **Zip** ______ **Business Phone#:** ______________________

SPOUSE OR PARENT INFORMATION (Required for all patients under age 18)

Name of Father or Spouse ______________________ **Date of Birth** ______________________
Address ______________________ **Home Phone#:** ______________________
City __________ **State** ______ **Zip** ______ **Soc. Sec#:** ______________________
Employer ______________________ **Drivers License:** ______________________
Business Address ______________________ **Occupation** ______________________
City __________ **State** ______ **Zip** ______ **Business Phone#:** ______________________
Work Phone #: ______________________ **Cell Phone #:** ______________________
E-mail: ______________________

Name of Mother ______________________ **Date of Birth** ______________________
Address ______________________ **Home Phone#:** ______________________
City __________ **State** ______ **Zip** ______ **Soc. Sec#:** ______________________
Employer ______________________ **Drivers License:** ______________________
Business Address ______________________ **Occupation** ______________________
City __________ **State** ______ **Zip** ______ **Business Phone#:** ______________________
Work Phone #: ______________________ **Cell Phone #:** ______________________
E-mail: ______________________

INSURANCE INFORMATION (Please Check)

MEDICARE ☐ **MEDI-CAL** ☐ **HMO** ☐ **PPO** ☐ **CCS** ☐ **CASH** ☐

Name of Insurance Co. ______________________ **Name of Insurance .** ______________________
I.D. # ______________________ **I.D. #** ______________________
Insurance Member ______________________ **Insurance Member** ______________________

EMERGENCY CONTACT (Not at same Address)

Name ______________________ **Relationship** ______________________
Address ______________________ **Phone #** ______________________
City __________ **State** ______ **Zip** ______

Name of Referring Doctor ______________________ **Name of Pediatrician** ______________________
Address ______________________ **Address** ______________________
City __________ **State** ______ **Zip** ______ **City** __________ **State** ______ **Zip** ______
Phone # ______________________ **Phone #:** ______________________

1246 E. Arrow Hwy., Ste. A
Upland, CA 91786
Office (909) 931-9675

7710 Limonite Ave., Ste. 101
Jurupa, CA 92509
Fax (909) 931-3239

14075 Hesperia Rd., Ste 101
Victorville, CA 92395
Toll Free (866) 516-8069

www.strabismus.net

FINANCIAL POLICY

Patient Name: **Date of Birth:**

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve the goals, we need your assistance, and your understanding of our payment policy.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, MasterCard, Visa or American Express.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You must, however, realize that:

1. Your insurance is a contract between you, your employer and the insurance company.
2. Our fees are generally considered to fall within the acceptable range by most insurance companies, and therefore are covered up to the maximum allowance determined by each carrier. If this is not the case, the patient is still liable for the remaining balance.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. For example, most insurance policies will not cover routine eye exams and refractions, thereby making the patient completely responsible for the charge.

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. All charges are your responsibility from the date the services are rendered, unless the contract between our office and the insurance company states otherwise. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help.

Signature: ____Date_________________

1246 E. Arrow Hwy., Ste. A
Upland, CA 91786
Office (909) 931-9675

7710 Limonite Ave., Ste. 101
Jurupa, CA 92509
Fax (909) 931-3239

14075 Hesperia Rd., Ste 101
Victorville, CA 92395
Toll Free (866) 516-8069

www.strabismus.net

Authorization to Release Medical Information to My Health Plan

Name: ______________________________________ D.O.B: __________________

I request that payment of authorized insurance benefits be made on my behalf to **Children's Eye Institute, INC.** I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand that my signature requests that payment be made and authorizes the release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA 1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the release of the information to the insurer or agency shown.

I realize I am responsible for the deductible, co-deductible, co-insurance and non covered services.

____ ________________________

Signature **Date**

1246 E. Arrow Hwy., Ste. A
Upland, CA 91786
Office (909) 931-9675

7710 Limonite Ave., Ste. 101
Jurupa, CA 92509
Fax (909) 931-3239

14075 Hesperia Rd., Ste 101
Victorville, CA 92395
Toll Free (866) 516-8069

www.strabismus.net

Patient Acknowledgement to the Use and Disclosure of Health Information
For Treatment, Payment, or Healthcare Operations

I acknowledge that as part of health care, Children's Eye Institute INC., originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I acknowledge that this information serves as:

a. A basis for planning my care and treatment.
b. A means of communication among the many health professionals who contribute to my care.
c. A source of information for applying my diagnosis and surgical information to my bill.
d. A means by which a third-party payer can verify that services billed were actually provided.
e. A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I acknowledge and have been provided with Notice of Information Practices that provides a more complete description of information uses and disclosures. I acknowledge that I have the following rights and privileges:

a. The right to review the notice prior to signing the consent.
b. The right to object to the use of my health information for directory purposes.
c. The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I acknowledge the Children's Eye Institute is not required to agree to the restrictions requested. I acknowledge that I may revoke this form in writing to the extent that the organization has already taken action in reliance thereon. I also acknowledge that by refusing to sign this form or by revoking this form, this organization may refuse to treat me as permitted by Section 164.506 of the code of Federal Regulations.

I further acknowledge that Children's Eye Institute reserves the right to change their notices and practices prior to implementation, in accordance with Section 164.520 of the Code of federal Regulations. If Children's Eye Institute changes their notice, I may obtain a revised copy by contacting their office.

I wish to have the following restrictions to the use or disclosure of my health information:

____
____
____

I acknowledge that, as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, included disclosures via fax.

I fully acknowledge the terms above.

____ ________________________
Patient or Patient's Representative's Signature Date

A copy of the full Notice of Patient Privacy Act is available upon request.
________ I acknowledge that I have received a copy of the Notice of Patient Privacy Act.
(Initials)

FOR OFFICE USE ONLY
[ ] Acknowledgement received by _________________________________
[ ] Acknowledgement added to patient's medical record on _____________

1246 E. Arrow Hwy., Ste. A
Upland, CA 91786
Office (909) 931-9675

7710 Limonite Ave., Ste. 101
Jurupa, CA 92509
Fax (909) 931-3239
www.strabismus.net

14075 Hesperia Rd., Ste 101
Victorville, CA 92395
Toll Free (866) 516-8069

AUTHORIZATION FOR DISCLOSURE OF INFORMATION

Section A: Must be completed for all authorizations

I hereby authorize the release of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the release may no longer be protected by federal privacy regulations.

Patient Name: **DOB:**

Persons/Organization providing information:
____
____

Persons/Organizations using or receiving information:
____
____

Specific description of information (including date(s), if relevant),
____
____

Revocation: This authorization is also subject to written revocation by the undersigned at anytime between now and the disclosure of information by the disclosing party. Written revocation will be effective upon receipt, but will not be effective to the extent that the requestor or others have acted in reliance upon the authorization.
If I revoke this authorization I understand that it will not affect any actions Children's Eye Institute took before it received the revocation.

Section B: Must be completed if health care provider or health plan requested the authorization is used for research.

1. Health care provider or health plan must complete the following:
   a. Will provider or health plan receive financial or in-kind compensation in exchange for using or disclosing the health information described above?

      YES____________ NO______X_______
2. Patient must complete the following:
   a. I understand that I may see and copy the information described on this form if I ask for it,, and that I receive a copy of this form after I sign it.

      Initials______________________
   b. I understand that, in most situations, my health care provider will treat regardless of whether I sign this authorization. If the purpose of the authorization is to allow research-related treatment, I understand I will not be able to get treatment without signing this form.

      Initials______________________
   c. I understand that a health plan may condition enrollment or eligibility for benefits on my signing an authorization releasing requested medical records other than psychotherapy notes prior to my enrollment in the plan. However, once I am enrolled, the plan may not refuse to pay for my care, adjust my eligibility for benefits or remove me from the plan if I refuse to sign an authorization.

      Initials______________________

______________________________________ ____________________________
Signature of Patient or Representative Date

Printed name of Patient or Patient's Representative ____

Relationship to Patient ____

____
Witness Date

1246 E. Arrow Hwy., Ste. A
Upland, CA 91786
Office (909) 931-9675

7710 Limonite Ave., Ste. 101
Jurupa, CA 92509
Fax (909) 931-3239

14075 Hesperia Rd., Ste 101
Victorville, CA 92395
Toll Free (866) 516-8069

www.strabismus.net

Office Policy

Date:
Patient Name:
Date of Birth:

PLEASE NOTE: THIS IS A SUMMARY OF THE OFFICE POLICIES OF CHILDREN'S EYE INSTITUTE, BY SIGNING BELOW YOU HEREBY AGREE TO THE TERMS OF THIS CONTRACT. IF YOU DONOT WISH TO ACCEPT THESE POLICIES, PLEASE NOTIFY OUR STAFF SO APPROPRIATE MEDICAL CARE MAY BE PROVIDED FOR THE PATIENT.

1. We believe all patients deserve our special attention, many of our patients have extreme medical problems, no shows, and dilations, patient co-operation, emergencies, and severity of eye conditions greatly affect our inability to schedule effectively. The wait in this office can be 4 hours. Please make sure you have toys/snacks/activities/bottles for your child.
2. Please NOTE: Some plans do not allow collecting payments for no shows. However, Federal law (Medicare) and CMS require all patients be treated the same in an office. **We have a $75 no show policy**. You **are not** required to be seen in this office by your health plan. By accepting a visit in our office **you agree** to our policy. Regardless of your health plans state, federal, or insurance policy guidelines. Thus, if you miss an appointment that you scheduled and do not notify us within 24hrs of the visit you will be billed $75 for the missed appointment and rescheduling. If you feel you have a valid reason for missing the appointment and did not notify us. You must present to the office a written reason for your missed appointment to have the exam rescheduled and the fee possibly waived. While we try to call everyone to remind them prior to their appointment, if we cannot or do not reach you, you are still responsible for the missed fee if you "no show". Thus, it is imperative that you keep all contact information current with our office. NO SHOW FOR A **SCHEDULED SURGERY WITHOUT VALID REASON FOR CANCELLATION WILL RESULT IN A $200 CANCELLATION FEE.**
3. It is your responsibility to have current contact information on file. You must have a valid ID on file and a copy of current insurance cards with you to be seen. Likewise a working phone number and current address must be provided at each visit as well as at least one emergency contact not living with you.
4. Patients with HMO insurance must have a valid authorization, and be eligible with our accepted codes to be seen in our office. While our office will try to obtain this; it is ultimately the patients (or parents) responsibility to assure this is done. Patients found to be ineligible or without current insurance cards or with no insurance must pay **at the time of visit**.
5. While we will try to bill your insurance for the services performed, please note the giving of glasses prescriptions (code 92015 refraction) is not covered by many plans in our office. If your insurance denies payment for this or any other service as not a covered you will be financially responsible for that service, regardless if it was covered at another facility. Please note we now bill $70 for refraction (CPT code 92015) we will discount the fee to $35 if paid prior to check out. If the bill is not paid prior, we will try to recover the cost from your insurance; if the insurance denies payment then the cost is $70 which includes our administrative fees. If you wish to get your glasses prescription elsewhere please notify our office and your plan, so your plan can arrange such care. Note we not are responsible for blindness or permanent vision loss that may occur by glasses prescription being given by an outside facility.

1246 E. Arrow Hwy., Ste. A
Upland, CA 91786
Office (909) 931-9675

7710 Limonite Ave., Ste. 101
Jurupa, CA 92509
Fax (909) 931-3239

14075 Hesperia Rd., Ste 101
Victorville, CA 92395
Toll Free (866) 516-8069

www.strabismus.net

I understand, agree to, and accept the following terms and conditions above:

____   ____________________

Signature of Patient or Guardian   **Date**

____   ____________________

Witness   **Date**

____ I do not agree to the above terms and conditions

[For office use only]

____ Patient seen on a one time emergency basis, family informed of need to find non emergent care elsewhere.

____ Patients condition deemed non urgent/ emergent and sent/ referred to another provider.

____Other____

____

____

____

____

____

PATIENT NAME:

Date of Birth:

Children’s Eye Institute

Health History

Patient Name: ____ **Date**: ______________

Date of Birth: _______________________ **Age**: _____________

Primary Doctor/Pediatrician: _______________
Address: _______________________________
____
____
Phone: ________________________________

Referring/Consulting Doctor: _______________
Address: _______________________________
____
____
Phone: ________________________________

Eye History

Reason for visit/current eye problem:

Circle those symptoms below which you are or your child is currently experiencing, and then describe which eye, the frequency, severity, and duration.

1. Loss of vision/ Blurred Vision/ Double Vision ____
2. Dryness/ Redness/ Discharge/ Itching/ Burning/ Tearing/ Sandy-Gritty Feeling _______________
3. Foreign Body Sensation/ Eye Pain/ Photosensitivity/ Swelling/ Glare ______________________
4. Infection/ Eye or Lid Lesion/ Face Pain/ Headaches ____________________________________
5. Crossed Eyes/ Droopy Eyes/ Bulging Eyes/ Abnormal Eye Movements _____________________

Please list all previous eye surgeries and dates:

1. 2. 3.

Is there any history of eye trauma or injuries? (Yes ☐ No ☐) If yes, when and what? _________________
Do you wear glasses currently? (Yes ☐ No ☐) If yes, when did you start wearing glasses? ___________ How often do you wear the glasses? _________ When was the last change in glasses prescription or refraction? ___________
Have you ever had to do patching? (Yes☐ No ☐) If yes, which eye? ________ When and for how long? ________

Past and Family Ocular History

Please check those problems which apply:

	Patient	Family Member	
Cataracts	☐	☐	Whom _____________________
Glaucoma	☐	☐	Whom _____________________
Retinal Problems	☐	☐	Whom _____________________
Inflammation/Uveitis	☐	☐	Whom _____________________
Blindness	☐	☐	Whom _____________________
Strabismus (crossed eyes)	☐	☐	Whom _____________________
Lazy or Weak Eye	☐	☐	Whom _____________________
Glasses	☐	☐	Whom _______What Age? ___

Other: ____

Last: First: MI:

Birth History (for all patients under 18 years old)

Birth Weight lbs oz Was child born early? (Yes No) If yes, how many weeks? ______
Was the baby on oxygen? (Yes☐ No☐) If yes, how long? ____________________
Were there any problems at birth: (circle those that apply?)

Seizures/ Bleeds in the brain/ Infection/ Intestinal Problems/ Birth Trauma/ Other:

Did mother have any problems with the pregnancy? (Yes☐ No☐) If yes, what? ____________________________
Was there any history of substance abuse in the mother during pregnancy? (Yes☐ No☐) If yes, what? __________
Are mother and father blood related? (Yes☐ No☐) If yes, how? ____

Past Medical History

MEDICATIONS (all oral and eye drops):

1. 2. 3. 4. 5. 6.
7. 8. 9. 10. 11. 12.

Do you take Aspirin, Ibuprofen or Coumadin? (Yes☐ No☐)
Do you have ALLERGIES to any medications? (Yes☐ No☐) If yes, what? _______________________________
Are you allergic to Iodine? (Yes ☐ No ☐) Adhesive Tape? (Yes ☐ No☐) LATEX? (Yes☐ No ☐)

General Medical Problems: (Circle or list those that apply)
Seizures/ Migraine/ High Blood Pressure/ Heart Disease/ Asthma/ Thyroid/ Diabetes/ Arthritis/ Cancer/ Other

____

Please list any other general operations or surgeries and dates:
1. 2. 3.
Is there a history of bleeding problems or reactions to anesthesia? (Yes☐ No☐) Any family members? (Yes No)
If yes, explain: ____
Please list all hospitalization dates and reasons:
1. 2. 3.

Family Medical History (circle or list those that apply and in whom)

Seizures/ Migraine/ High Blood Pressure/ Heart Disease/ Asthma/ Thyroid/ Diabetes/ Arthritis/ Cancer/ Other

____

Social History

Occupation: ____
Do you drink alcohol? (Yes☐ No ☐) If yes, how much? ____
Do you or anyone living in your house smoke? (Yes☐ No ☐) If yes, how many packs per day? _________________
Do you or have you used any illicit drugs? (Yes ☐ No ☐) If yes, when and what? ___________________________

Review of Systems (Check all those conditions that are currently having problems and describe)

General: Fever/ Weight Loss	☐	_________________
Neurologic: Seizure/ Stroke	☐	_________________
Migraine/ Headaches	☐	_________________
Cardiovascular: Pacemaker/ Vascular	☐	_________________
Heart Disease/ High Blood Pressure	☐	_________________
Respiratory: Asthma/ Tuberculosis	☐	_________________
Endocrine: Thyroid/ Diabetes	☐	_________________
Nose/ Throat: Allergies/ Sinus	☐	_________________
Urinary/ Kidney	☐	_________________
Gastrointestinal: Hepatitis/ Jaundice	☐	_________________
Musculoskeletal/ Arthritis	☐	_________________
Psychiatric	☐	_________________
NONE	☐	_________________

Patient Name: ____ ____

AUTHORIZED SIGNATURE FOR TREATMENT
Parent or guardian must sign if patient is under 18 yo

(For Office Use Only)

Date: Health History Reviewed: