See Clearly Vision / Cornea Consultants
Confidential Patient Registration

Thank you for choosing See Clearly Vision.

We appreciate the confidence you have placed in our practice and we take pride in providing you with the highest quality of care.

Patient Name: _____ **Gender: Male** ☐ **Female** ☐
(Please Print) Last Name First Name Middle Initial

Home Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:**_____

E-mail Address: _____

Date of Birth (mm/dd/yyyy): _____ **Social Security Number:** _____

Race (choose one): ☐ **Asian** ☐ **Black** ☐ **White** ☐ **Native American** ☐ **Pacific Islander** ☐ **2 or more** ☐ **Other**

Ethnicity (choose one): ☐ **Hispanic** ☐ **Not Hispanic**

Employer: _____ **Occupation:** _____

Office Address: _____

City: _____ **State:** _____ **Zip Code:** _____

How did you hear about us? _____

Primary Medical Insurance
Name of Insurance: _____ **ID#:** _____ **Group#:** _____
***Subscriber Information*:**
Name: _____ **SS#:** _____ **Employer:** _____

Date of Birth: _____ **Relationship to Patient:** _____ **Work Phone:** _____

Secondary Medical Insurance (if applicable)
Name of Insurance: _____ **ID#:** _____ **Group#:** _____
***Subscriber Information*:**
Name: _____ **SS#:** _____ **Employer:** _____

Date of Birth: _____ **Relationship to Patient:** _____ **Work Phone:** _____

Vision Insurance Coverage (if applicable)

Name of Insurance: _____ **ID#:** _____

Workers Compensation (if applicable)
Name of Insurance: _____ **Date of Injury:**_____
Insurance Co.
Address: _____**City:** _____ **State:** _____ **Zip Code:** _____
Claims Adjuster: _____ **Phone #:** _____ **Claim #:** _____
Employer (at time of accident): _____
Employer
Address: _____**City:** _____ **State:** _____ **Zip Code:** _____
Employer Contact: _____ **Phone #:** _____

"I request that payment of authorized Medicare benefits be made to either me or on my behalf to Cornea Consultants, PC for any services furnished me by physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its' agents any information needed to determine these benefits or the benefits payable for related services."

"I authorize Cornea Consultants or its billing agents to submit claims on my behalf to my insurance carrier, with payment of insurance benefits being paid to Cornea Consultants. I permit a copy of this authorization to be used in place of my original signature and authorize any holder of medical information about me to release to the Health Care Financing Administration or its agents or other insurance companies any information needed to determine benefits payable as outlines by HIPAA. I will be fully responsible for payment if insurance denies reimbursement. I will further be responsible for payment of fees in the event I have failed to provide my most current insurance information at any visit."

Patient Signature: _____ **Date:** _____

Signature of Patient and/or Guardian (SEAL)

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Patient Name: _____ Date of Birth: _____
(Please Print) Last Name First Name Middle Initial (mm/dd/yyyy)

Please answer the following EYE HISTORY questions about YOURSELF:

Do you have any of the following eye conditions?	Yes	No	If yes, please explain
CATARACTS			
GLAUCOMA			
MACULAR DEGENERATION			
"LAZY EYE" or Strabismus or "Eye Turn"			
RETINAL DETACHMENT			
CORNEAL DISEASE			
DRY EYE			
KERATOCONUS			

Please answer the following MEDICAL HISTORY questions about YOURSELF:

Do you have any of the following medical conditions?	Yes	No	If yes, please explain
NEUROLOGIC CONDITION			
STROKE			
HEADACHES			
ASTHMA OR BREATHING CONDITIONS			
EAR/NOSE/THROAT CONDITIONS			
ENVIRONMENTAL/SEASONAL ALLERGIES			
HEART DISEASE OR HEART CONDITIONS			
HIGH CHOLESTEROL			
BLEEDING DISORDERS			
HIGH BLOOD PRESSURE			
DIABETES			
KIDNEY CONDITIONS			
LIVER CONDITIONS OR HEPATITIS			
URINARY CONDITIONS			
AUTOIMMUNE CONDITIONS			
THYROID CONDITIONS			
HIV			
CANCER			
Are you currently PREGNANT/BREASTFEEDING?			
ANXIETY/DEPRESSION			
PSYCHIATRIC CONDITION			
Have you ever been hospitalized or had surgery?			
Do you smoke or use tobacco?			
Do you consume alcoholic beverages?			drink(s) per week
Are you interested in laser eye surgery or contact lenses?			
Are you interested in BOTOX or Juvéderm?			

Have you ever had eye surgery? YES ☐ NO ☐ If yes, please explain: _____

Do you have any family history of eye conditions (i.e. cataracts, glaucoma, etc)? YES ☐ NO ☐

If yes, please explain_____

Comments or other medical history not listed above: _____

_____

Patient Signature: _____ Date: _____

Signature of Patient and/or Guardian (SEAL)

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Patient Name: _____ Date of Birth: _____
(Please Print) Last Name First Name Middle Initial (mm/dd/yyyy)

Referring Doctor:_____ **Referring Doctor Phone:**_____

Primary Care Physician: _____ **Primary Care Physician Phone:**_____

Pharmacy Name:_____ **Pharmacy Phone:**_____

Pharmacy Address: _____

Do you take any prescriptions, over-the-counter medications, vitamins and minerals, or herbal/dietary nutritional supplements? YES ☐ NO ☐

If yes, please list all medications you are currently taking:

Medication/Supplement	**Dosage** *(i.e. amount, strength)*	**Frequency** *(how often)*	**Route** *(i.e. oral, eye drop, injection, etc.)*

Are you allergic to any medications? YES ☐ NO ☐ If yes, please explain_____
_____

Emergency Contact: _____ **Phone Number:** _____

Please list below any family members/representative(s) that you are authorizing to access your protected health and financial information

Name:_____ **Relationship:**_____ **Phone number:**_____
Name:_____ **Relationship:**_____ **Phone number:**_____
Name:_____ **Relationship:**_____ **Phone number:**_____
Name:_____ **Relationship:**_____ **Phone number:**_____

Patient Signature: _____ **Date:** _____
Signature of Patient and/or Guardian (SEAL)

Patient Name: _____ **Date of Birth:** _____
(Please Print) Last Name First Name Middle Initial (mm/dd/yyyy)

See Clearly Vision Policies & Fees

Appointments: Appointments vary in length, depending on the eye condition being evaluated. Please allow at least 1½ hours for the appointment. Patients are dilated at least once a year and more frequently if necessary. Following dilation, light sensitivity and difficulty reading may be experienced for a few hours so please arrange for a driver if you prefer. Please bring a drivers license/identification, and all applicable insurance cards.

Medical Exams: Patients who are experiencing a medical eye issue, have had previous eye surgery or have a systemic disease (such as, but not limited to: diabetes, multiple sclerosis, Bell's palsy, hypertension, lupus, Graves' disease, etc) will require a medical exam which is billed to medical insurance. Medical exams do not include an eyeglass (refraction) or contact lens prescription.

Routine Vision Eye Exams: Patients who are experiencing no medical eye issues, have not had previous eye surgery, and/or have no systemic disease, would need a routine vision eye exam. Many insurance plans do not cover a routine vision eye exam. Some patients may have a separate insurance for vision. Please note that we are unable to bill a medical insurance and vision insurance on the same day. If the patient requires both services, two separate appointments will be required. Additionally, routine vision eye exams do not include a contact lens prescription.

Refraction: Refraction is a test to generate an eyeglass prescription. It is in addition to the medical exam. If the patient requests an eyeglass prescription, a refraction is required. Most insurance plans do not cover refraction. *The $55.00 refraction fee is collected at the time of service*.

Contact Lens Evaluation: A contact lens evaluation is needed to generate a contact lens prescription; it is in addition to the eye exam and contact lenses. If a patient requests a contact lens prescription, a contact lens evaluation is required. Many insurance plans do not cover a contact lens evaluation. Please ask a member of our staff, or visit seeclearly.com for more details.

Co-payments/Co-insurance/Deductibles: Patients are responsible for all co-payment, co-insurance and deductible amounts at the time of service. We accept cash, check, debit and credit cards. Patient will be responsible for all fees related to a returned check for non sufficient funds.

Collections: All balances beyond 90 days past due will be sent to our collection agency. You will be financially responsible for all collection and legal fees that our office incurs to collect the outstanding delinquent balance.

Primary Care Referrals: Based on the patient's insurance plan, a referral from a primary care physician may be required. Patients who require a referral from the Primary Care Physician and do not have a referral will be required to pay out of pocket at the time of service, or reschedule the appointment.

Cancellations & No-show: We request that patients call and cancel/reschedule their appointment at least 24 hours in advance to allow other patients the opportunity to be seen and to accommodate emergency appointments. *Patients who do not cancel or reschedule their appointment at least 24 hours in advance will be charged a $25.00 fee*.

Records: To be compliant with federal regulations, medical records will be kept for seven years. After seven years, records will be properly disposed of in a manner which protects patient confidentiality. *A patient may request a copy of their records for a nominal fee*. Please allow up to 15 business days for delivery.

Forms/Letters: *Any forms or letters to be completed/dictated by our staff are not covered by insurance and may be subject to a $25.00 administrative fee* (such as, but not limited to: workers compensation, disability, DMV, aviation, military, school forms, etc).

Medication Refills: Please request medication refills during the appointment. *Phone or fax refill requests may be subject to a $25.00 fee.* Please contact the office three days in advance of running out of your medication.

Consulting/Ownership Disclosures: Our doctors and staff are asked by many medical companies for their expert advice as consultants in the development and promotion of healthcare products and to be investigators in clinical trials for new products in the FDA approval process. These companies make lens implants, lasers, instruments, devices, pharmaceuticals, contact lenses, and other products that are used in healthcare. Our doctors and staff have ownership interest in surgical centers, companies, and businesses related to our medical practices and also serve as faculty/instructors or speakers. Patient care is provided without considering financial relationships, and we believe these relationships are advantageous to patient care because they allow access to the newest ideas and technology. Please ask us if you would like more details or have any questions.

Notice of Privacy Practices: Federal law mandates that medical offices provide access to their Notice of Privacy Practices. This notice outlines patient rights and our methods for protecting patient health information. By signing below, the patient (or legal guardian) has acknowledged that they have reviewed the Notice of Privacy Practices on our website (seeclearly.com) or have received a copy at our office. Additional copies are available upon request.

I understand and accept all terms and conditions of my examination and the financial policy.

Patient Signature: _____ **Date:** _____
Signature of Patient and/or Guardian (SEAL)