Patient Information

(PLEASE PRINT LEGIBLY AND FILL OUT BOTH SIDES)

Who can we thank for bring you to our office today?

☐ Referred by: ____________________________ ☐ Friend/Family member: __________________________

☐ Another patient: _________________________________ ☐ Newspaper:__________________________

☐ Radio ☐ Yellow pages ☐ Internet ☐ Facebook ☐ Insurance company

☐ Study: ___________________ ☐ Emergency: ____________________ ☐ Other: ___________________

Patient's Last Name:	First Name:	MI:

Previous Name:	Street:	Apartment Number:
City:	State:	Zip:
Home Phone:	Cell Phone:	Work phone/ext.

*Patient's E-mail:	May we send you a text reminding you of your appointment? ☐ yes ☐ No

Preferred language ☐ English ☐ Spanish ☐ Other:	Preferred time to call ☐ Morning ☐ Afternoon ☐ Evening	Date of Birth:	Gender:

Marital Status:	Spouse's name:	Patient's SS#:

If under 18, Mother's Name, phone &e-mail:	If under 18, Father's Name, phone &e-mail:

Responsible Party:

☐ Self, If marked, you may continue to back of form.

☐ Another patient of Dr. Affleck, fill in only last and first name and continue to back of form.

☐ Other: please complete the following section.

Last Name:	First Name:	MI:

Date of Birth:	SS#:	Phone:

E-mail:	Gender:	Relationship:

Address, complete if different than the patient's street:	Apartment Number:	City/State/Zip:

Employer Name:	Phone:

Employer's Full Address:

Emergency Contact (complete if different than responsible party) Name & Address:		
Relationship:	Home phone:	Work phone:

We must have a copy of your insurance card(s) to bill your insurance and all the following information must be complete.

☐ No insurance

Primary Insurance company:	Secondary Insurance company:
Primary Insured's Name:	Secondary Insured's Name:
Primary Insured's SS#:	Secondary Insured's SS#:
Relationship to patient:	Relationship to patient:

May we leave messages at? ☐ Home ☐ Cell ☐ Work	Is the patient living in a Nursing home at this time? ☐ Yes ☐ No	
Race: ☐ White ☐ Hispanic ☐ American Indian or Alaska Native ☐ Black or African American ☐ Asian ☐ Native Hawaiian ☐ Refused to report ☐ other race :		Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Refused to report
Patient's Employment Status:	Patient's Employer	Are you a student?
Patient's Employer Full Address:		

Pharmacy name
Pharmacy street name/city:

**** Needed so you can access your health file on a secure web portal. Ask a staff member to tell you more!***

Thank you

PATIENT CONDITIONS OF TREATMENT

Thank you for choosing Affleck, MD Eye Care for your care. We will provide medical and surgical services to you provided that you understand and comply with the following policies of our practice. If you have any questions about the following, please ask to speak with one of our or office manager.

CONSENT FOR TREATMENT: *I (or the patient's authorized representative) consent to health care, including but limited to examinations, test, procedures, diagnosis, medical management, and/or surgical treatment by Dr. Affleck or his staff. I understand that health care is not an exact science; it may have a risk of injury which will be explained to me. I acknowledge there is no guarantee of my diagnosis(s), examination(s) or treatment(s) results.*

INSURANCE APPLICATION AND ASSIGNMENT OF BENEFITS: I authorize Affleck, MD Eye Care or companies contracted with Affleck, MD Eye Care to apply, on my behalf (or my child/dependent behalf) to medical insurance carrier (the term medical insurance carrier is defined as Medicaid, Medicare, responsible payer, any health care insurance and etc.) for payment of Affleck, MD Eye Care's health care services, unless other arrangements have been made. I authorize the use of the below signature on all insurance carrier submissions whether manual or electronic. I understand and authorize payment be made directly to Affleck, MD Eye Care. I agree to re-pay Affleck, MD Eye Care any money I receive from my medical insurance carrier for services provided to me for which I have not paid to Affleck, MD Eye Care. I (or the patient's authorized representative) agree to be financially responsible for charges that are not covered by medical insurance carrier, and that I am responsible for satisfying any conditions necessary for insurance or health benefits. I agree I am solely responsible to understand my medical insurance carrier's restriction, requirements and coverage details. I agree to provide Affleck, MD Eye Care with the most accurate insurance cards, information or proof of eligibility at time of service and/or when requested.

RELASE OF INFORMATION: I authorize Affleck, MD Eye Care to release any information, including the diagnosis and the records of any treatment or exam rendered to my dependent or me to individuals such as third party payers and/ or heath providers. This includes, but is not limited to, to myself, and to people or companies responsible to pay Affleck, MD Eye Care for my care, such as worker's compensation carrier, welfare funds or my employer.

FINANCIAL AGREEMENT: Insurances require all co-payments, co-insurance, deductible and/or non-covered services to be paid at the time service is rendered. I acknowledge that insurance is considered only a method of reimbursement to Aaron J. Affleck, M.D. for services I have received. If there are any questions regarding the payment or insurance filing policies, I will notify one of the office staff as soon as possible to make any necessary arrangements. Regardless of custody arrangements or divorcee decrees, I agree the person bringing a dependent in for services is responsible for all copayments, etc., and is expected to pay at the time service is rendered.

I agree it is my responsibility for obtaining a referral if one is required by my medical insurance carrier. I agree that if payment from medical insurance carrier is not received within 45 days of the file date, the balance due will become the obligation of the guarantor on the account and must be paid within 30 days. If I do not have insurance payment is expected the day services are rendered.

AGREEMENT TO PAY: I accept the fee(s) charged as a lawful debt and promises to pay said fee including all costs of collection, attorney fees, and court costs, if such be necessary, waiving now and forever the right to claim exemption under the constitution and laws of the State of Idaho or any other state. All unpaid balances will be charged a 1.5 percent rebilling fee monthly. All returned items will be assessed a $25.00 fee.

CANCELATION, NO SHOW APPOINTMENTS, AND LATE ARRIVAL: I acknowledge a 24 business hour notice of canceling an appointment is required (unless unforeseen factors are involved). I understand Affleck, MD Eye Care may charge a $25.00 fee for cancelations without advance notice and/or no show to appointments. I agree this charge is my responsibility for payment and it will not be billed to my insurance. I also understand that if I am more than 15 minutes late to an appointment my appointment maybe rescheduled.

PATIENT'S RIGHTS: I acknowledge that Affleck, MD Eye Care has a "Privacy Practice Notice" also known as HIPAA. I understand I have the right to review this agreement prior to signing this document. I may request a written copy at any time and can also view the agreement on Affleck, MD Eye Care website www.LOVE*healthy*EYES.com under the tab "Your Visit." Click the link signing paperwork and then go to the tab labeled: "Privacy Practice Notice."

INFORMATION REGARDING DILATING EYE DROPS: Dilating drops are used to dilate or enlarge the pupils of the eye to allow Dr. Affleck to get a better view of the inside of your eye. Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself. Please wear your sunglasses when leaving the office until the effects of the dilation wear off. Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

CONSENT FOR DILATION: *By signing the signature page at the end of this document, I hereby authorize Dr. Affleck and/or such assistants as may be designated by him to administer dilating eye drops. The eye drops are necessary to diagnose my condition.*

PATIENT FINANCIAL POLICY:

YOUR HEALTH INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR HEALTH INSURANCE PLAN. You are responsible for understanding and following your health plan's required procedures and policies. It is your responsibility to provide us with accurate and up-to-date insurance information, so that we can file an insurance claim on your behalf for services rendered. Policies and coverage determinations may vary from year to year.

IS DR. AFFLECK AN "IN NETWORK OR CONTRACTED PROVIDER"? As a patient, it is in your best interest to know if your plan is contracted with Affleck, MD Eye Care or Aaron J. Affleck, M.D., and if you are having surgery please make sure that both Aaron J. Affleck, M.D. and the surgical facility are listed as a contracted provider by your insurance company. It is possible that only Aaron J. Affleck, M.D. or only the surgical facility is contracted with your insurance plan. If Aaron J. Affleck, M.D. and/or the surgical facility are not listed as a contracted provider and/or are not in your insurance company's network, we are still happy to accept your insurance and provide you with services. If your policy has out-of-network benefits, your insurance plan may still cover the services provided to you with Aaron J. Affleck, M.D. However, you may be responsible to pay a higher amount out-of-pocket than if you receive services from an in-network provider. Your insurance company's customer service representative can help verify your benefits and out-of-pocket costs. Should you require additional assistance regarding your out-of-pocket cost, we can provide you with financial assistance options with Care Credit.

PRIOR TO SERVICE REFERRALS AND/OR PRIOR AUTHORIZATIONS: If your insurance requires referrals/pre-authorization for full benefits to be paid, it is your responsibility to verify that the referrals/pre-authorizations are in place prior to your care. Failure to have a valid referral authorization may result in your care being rescheduled until a valid referral is obtained. FAILURE TO NOTIFY AFFLECK, MD EYE CARE OF THE NEED FOR A REFERRAL PRIOR TO YOUR CARE MAY RESULT IN YOU BEING RESPONSIBLE FOR PAYMENT OF THE BALANCE IN FULL. If you request to be seen without a valid referral, you will be responsible for payment of services rendered and will need to complete additional paperwork that will allow us to bill you for services rendered.

IF YOUR HEALTH PLAN REQUIRES SURGERY PRE-AUTHORIZATION, PLEASE NOTIFY AFFLECK, MD EYE CARE OF THIS PROVISION. Our billing office will assist you in pre-authorization of your surgery. During the pre-authorization process, your health plan and your employer may be contacted to verify plan enrollment. Pre-authorization does not guarantee payment of your surgery costs. FAILURE TO HAVE YOUR SURGERY PRE-AUTHORIZED IF REQUIRED BY YOUR HEALTH PLAN MAY RESULT IN DENIAL OF MEDICAL PAYMENT FOR SERVICES RENDERED. IF PAYMENT IS DENIED, YOU MAY BE RESPONSIBLE FOR PAYMENT OF THE BALANCE IN FULL. If you have any questions about your benefits or what services are covered under your health plan, it is your responsibility to contact your health plan prior to your surgery.

OUT OF POCKET COSTS: Not all services are covered in all insurance contracts. If your insurance plan benefits do not cover a service or procedure, you can be held personally responsible for payment of these charges. To find out what your insurance plan benefit covers and what your financial obligation may be, call the customer service or member services department of your insurance company (the phone numbers are on your insurance card). Your employer's human resources department may also be a source of information and assistance. Ask about your responsibility for any deductibles, co-insurance, or co-payment amounts prior to any care. You may have different deductibles, co-insurance, or co-payment amounts, depending on the contracted status of your insurance company. If your health plan requires a co-payment, we are required to collect it at the time of your care. We cannot waive co-payments, deductibles or co-insurance amounts, which are the patient's responsibility. Non-covered services are collectable at the time of your care. If you cannot make the required payment, your appointment/treatment may be rescheduled. If you do not have health insurance coverage or request a service that is not covered by your health plan (i.e., cosmetic in nature), we require that payment be made in full at the time that services are rendered. For your convenience, we accept cash, personal or cashier's checks, VISA, MasterCard or Discover Card payments.

With surgery treatment you may possibly receive up to three bills for the treatment. You will receive charges from Aaron J. Affleck, M.D., the surgical facility, and anesthesia. Understand your out of pocket costs from all health care resources. We are not responsible for any charges or billing practices from the surgical facility, anesthesiologist or healthcare personnel that are not part of Affleck, MD Eye Care. Aaron J. Affleck, M.D is a participating provider for Medicare. This means that Affleck, MD Eye Care must accept Medicare's allowed charge for the services rendered. Medicare will pay 80% of the approved amount. The patient is responsible for the remaining 20% plus any out-of-pocket deductibles. We will adjust/write off the difference between what we charge and what Medicare approves. If you have secondary insurance, we will submit the claim for the remaining balance after Medicare has paid. Please remember that although we accept assignment for Medicare, the patient by federal law, must be held responsible for any portion of the approved amount not paid by Medicare or a secondary insurance company.

COSMETIC SURGERY: Most insurance will not cover cosmetic surgery. If you are scheduled for surgery that is cosmetic in nature and not covered by your health plan, we require that payment be made in full prior to surgery. For your convenience, we accept cash, personal or cashier's checks, flex plans, VISA, MasterCard, Discover Card or Care Credit financing payments. If you request co-management of post-operative care by your optometrist prepayment is also required, however, this payment is separate billing. You will pay them directly and be informed of their payment policies from their practice. We are not responsible for any charges or billing practices from your optometrist.

MISSING, INACCURATE OR INCOMPLETE BILLING INFORMATION: You are responsible for notifying our office of any health plan or billing information changes. Failure to notify us of changes may result in your being responsible for any remaining balance on your account. Our practice will not be responsible for any billing errors, lack of coverage or payment due as a result of missing, inaccurate of incomplete information that you have provided us, including inaccurate information on secondary or third party payment coverage.

AUTHORIZATION/SIGNATURE PAGE: By signing, I indicate I have read and understand both the PATIENT CONDITIONS OF TREATMENT and the PATIENT FINANCIAL POLICY for Affleck, MD Eye Care and accept all the terms, conditions and/or consent as stated above. I have received EITHER a paper copy of this policy or agreed to an electronic copy found of Affleck, MD Eye Care website at www.Lovehealthyeyes.com. I am either the patient, guarantor, the patient's legal representative and I am authorized to sign this agreement and accept these terms

Print Patient's Full Name Date of birth Today's date

Signature of Patient or Signature of Minor patient's parent or legal guardian

AFFLECK MD EYE CARE
MEDICAL & SURGICAL
763 S. Woodruff Ave, Idaho Falls, ID 83406

Medical History: *Questionnaire*

Aaron J. Affleck, M.D. 208-523-6868 www.LOVEhealthyEYES.com

Please fill out the following Medical history by filling in the corresponding square to the appropriate answer. PLEASE FILL OUT FRONT AND BACK!

Name________________________ Date of Birth ______________ Today's Date ______________

Current Medication: *Add a separate page if needed.*

Medication Name	Dosage	Start Date

Past Medical/Ocular History:

I have been in good general health most of my life ☐ Yes ☐ No

Has anyone diagnosed you with these conditions?

☐ AIDS/ HIV	☐ Amblyopia(lazy eye)	☐ Astigmatism
☐ Cataracts	☐ Crossing eyes	☐ Diabetes
☐ Diabetic retinopathy	☐ Dry eyes	☐ Glaucoma
☐ Graves disease	☐ Heart disease	☐ Herpes
☐ Hyperopia (far sighted)	☐ Hypertension	☐ Hypothyroidism
☐ Iritis	☐ Keratoconus	☐ Lupus
☐ Macular degeneration	☐ Multiple Sclerosis	☐ Myopia (near sighted)
☐ Optic neuritis	☐ Retinal Detachment	☐ Rheumatoid arthritis
☐ Sjogrens	☐ Steroid Use	
☐ Stroke	☐ Thyroid disease	☐ **NONE**

Allergies: Do you have allergies to any eye drops or other medications? ☐ Yes ☐ No

If YES, list the medications:

____

____

Name______________________ Date of Birth________

Ocular Surgeries: Mark any that apply

☐	**No prior ocular surgery**	☐	Blepharoplasty	☐	Cataract surgery
☐	Corneal transplant	☐	LASIK/PRK	☐	Retinal laser surgery
☐	Radial Keratotomy	☐	Strabismus surgery	☐	Tear duct surgery
☐	Trabeculectomy	☐	Vitrectomy		

Hospitalization

List any hospitalization dates and reason (*PLEASE PRINT*). ☐ **No Hospitalizations**

MONTH & YEAR:	REASON:

Family History: *Mark any that apply*

	Arthritis	Blindness	Cancer	Cataract	Diabetes	Glaucoma	Heart disease	Hypertension	Lazy eye	Macular Degeneration	Migraine	Retinal detachment	Stroke	Thyroid disease	None	UnKnown
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Children	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Siblings	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Number of: Brothers _____ Sisters _____ Sons _____ Daughters _____

Name____________________ Date of Birth________

Social History:

Smoking: ☐ **Never smoked**

☐ **Current smoker;** How often do you smoke? ☐ Every Day ☐ Some Days, but not every day.

How many cigarettes a day do you smoke? ☐ 5 or less ☐ 6-10 ☐ 11-20 ☐ 21-30 ☐ 30 or more

How soon after you wake up do you smoke your first cigarette (in minutes)? ☐ within 5 ☐ 6-30 ☐ 31-60 ☐ after 60 Are you interested in quitting? ☐ Ready to quit ☐ Thinking about quitting ☐ Not ready to quit

☐ **Former smoker;** How long has it been since you last smoked? ☐ less than 1 month ☐ 1-3 months ☐ 3-6 months ☐ 6-12 months ☐ 1-5 years ☐ 5-10 years ☐ 10 years or more

Do you wear any corrective lenses? ☐ Yes ☐ No, If **Yes**, what? (Mark all that apply)

☐ Glasses ☐ Hard contact lenses
☐ Reading glasses ☐ Soft contact lenses

Do you currently have any problems in the following areas?

Light Sensitivity? ☐ **Yes** ☐ **No**

Do you experience: Glare ☐ **Yes** ☐ **No**

When: ☐ Always ☐ When driving ☐ At night

Loss of vision? ☐ **Yes** ☐ **No**

When: ☐ Sudden ☐ Gradual ☐ Temporary ☐ Permanent

Do you drive? ☐ **Yes** ☐ **No**

Do you have visual difficulty when driving? ☐ **Yes** ☐ **No**

Does your vision limit any activities of daily living? ☐ **Yes** ☐ **No**

If **Yes**, when? ☐ Reading ☐ Sports ☐ Work ☐ Other

With whom do you live? ☐ Self ☐ Family ☐ Guardian ☐ Assisted Living

How often did you have a drink containing alcohol in the past year?

☐ never ☐ monthly or less ☐ 2- 4 times a month ☐ 2 - 3 times a week ☐ 4 or more times a week

Name____________________ Date of Birth________

Review of System: Mark any problems/situations you have TODAY.

EYES:

- ☐ double vision
- ☐ dryness
- ☐ eye pain
- ☐ eye redness
- ☐ flashers/floater
- ☐ gritty feeling
- ☐ infection of eyelashes, or styes
- ☐ itching, burning or discharge
- ☐ loss of side vision
- ☐ tearing
- ☐ None

GENERAL:

- ☐ sudden weight change
- ☐ fever
- ☐ Other:

ALLERGIC/IMMUNOLOGIC:

- ☐ cough/wheeze
- ☐ seasonal allergies
- ☐ Other:

CANCER:

- ☐ skin
- ☐ Other:

CARDIOVASCULAR:

- ☐ high blood pressure
- ☐ cholesterol treatment
- ☐ Other:

DERMATOLOGIC:

- ☐ rash
- ☐ ocular rosacea
- Other:

EARS, NOSE, THROAT:

- ☐ hearing loss
- ☐ sinus infection
- ☐ Other:

ENDOCRINE:

- ☐ increased thirst
- ☐ Addison's disease
- ☐ Other:

FEMALES:

- ☐ I am pregnant or trying to be pregnant.
- ☐ I am nursing

GASTROINTESTINAL:

- ☐ Heartburn
- ☐ nausea/diarrhea
- ☐ Other:

HEMATOLOGY:

- ☐ blood disease
- ☐ Other:

MUSCULOSKELETAL:

- ☐ Arthritis
- ☐ Other:

NEUROLOGICAL:

- ☐ Alzheimer's
- ☐ Dementia
- ☐ Parkinson's
- ☐ Other:

PSYCHIATRIC:

- ☐ anxiety/stress
- ☐ depression
- ☐ Other:

RESPIRATORY:

- ☐ shortness of breath
- ☐ Asthma

UROLOGY:

- ☐ blood in urine
- ☐ Other:

Height: ______________ Weight: ______________