MAPLE GROVE EYE CARE

8955 W. Hackamore Dr. Boise, ID 83709
PHONE: 208-344-7944 FAX**:** 208-343-4676 WWW.MGEYECARE.COM

PATIENT REGISTRATION

Patient Name (**as shown on insurance card)** _____
First MI Last

Address: _____
Street or P.O. Box City State Zip

Primary Phone :(___) _____Secondary Phone: (___) _____ Email: _____

Sex: ☐ **M** ☐ **F** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Birthdate: _____ Age: _____ Social Security #_____

Patient's Occupation: _____ Employer: _____ Work# :(___) _____

How did you hear about us? _____ Primary Care Physician: _____

Emergency Contact: _____ Relationship: _____ Contact# :(___) _____

If you are NOT the policy holder please provide their information below:

Name	**Birthdate**	**Address**	**SSN#**

If you do not feel comfortable providing the full social security number for the policy holder please provide the last four digits. They are often needed to verify insurance

HIPPA (Health Insurance Portability and Accountability Act)

The Privacy of your health information will remain confidential, and will not be released without your written consent. We need this authorization to release your information.
I authorize the following to have access to my health information:

Name	Relationship to Patient	Phone

Signature: _____ Date: _____

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PATIENT QUESTIONNAIRE

Welcome! We are looking forward to your visit. In order to make the most of your time with us, please fill out this questionnaire. In doing so, you will help us to better understand your vision, health, and lifestyle.

NAME:_____ **DOB:**_____**DATE:**_____

Have you had any eye surgeries or eye injuries? (Please Circle) Yes No
If yes, please list:_____

☐ Poor vision ☐ Red Eye(s) ☐ Double Vision
☐ Blurred Vision ☐ Flashing Lights ☐ Dry Eye
☐ Floaters ☐ Watering, Itching, Burning ☐ Glare
☐ Any other eye concerns that you have?_____

Tell us about your vision:

☐ I do not wear glasses ☐ I have been wearing glasses since age: _____ ☐ Age of current glasses: _____
☐ I currently wear contacts: If yes, what brand of contacts: _____

My last eye exam was:_____ by Dr._____

Do you have trouble seeing when you drive at night? (Please Circle) Yes No

Eye Drops:

List the eye drops you take, how often, and in which eye:_____

Health:

Do you use alcohol? (Please Circle) Yes No Do you use tobacco (Please Circle) Yes No

List any other known medical problems that aren't listed below and previous surgeries:_____
_____
_____

Please list all medications that you are currently taking (including vitamins, and any over the counter medications)

Daily Medications:_____

_____

_____

Medication Allergies
List any allergies to medications:_____

_____

Personal History/ Family History

Check the following conditions present in your family, if any:

☐ Glaucoma ☐ Diabetes ☐ Macular Degeneration ☐ Retinal Degeneration ☐ Cancer

☐ Cataracts ☐ Strabismus ☐ High Blood Pressure ☐ Heart Disease ☐ Thyroid

☐ Other_____

Head to Toe Review
Have you ever had or have any of the following conditions:

General:	☐ Fever	☐Weight change	☐ Cancer	
Eyes:	☐ Glare	☐ Pain	☐ Redness	☐ Blur
Head:	☐ Depression	☐ Anxiety	☐ Stroke	☐ Headache
Heart:	☐ Heart Attack	☐ Cholesterol	☐ Blood Pressure	
Lungs:	☐ Asthma	☐ COPD	☐ Current Smoker	☐ Former Smoker
Stomach:	☐ Chronic	☐ Diarrhea		
Urinary:	☐ Ever used Flomax (tamsulosin), doxazosin, or other urinary meds			
Joint/Muscles:	☐ Fibromyalgia	☐ Rheumatoid		
Skin:	☐ Rosacea	☐ Lupus	☐ Psoriasis	☐ Allergies
Endocrine:	☐ Thyroid	☐Diabetes ---Type?_____	A1C:_____	
Blood:	☐Clotting	☐ Bruising	☐ Bleeding	

☐ **Communicable Diseases** (including HIV and AIDS)

☐ **Any others that we need to be aware of?** _____

Thanks! We appreciate the time you spend filling out this questionnaire, and we look forward to your visit!

Maple Grove Eye Care
Financial Policy and Agreement

Thank you for choosing Maple Grove Eye Care as your eye care provider. We are committed to providing excellent patient care. The following is an explanation of our Financial Policy and Agreement, which you must read and sign prior to your visit.

1. Each Patient is responsible for his/her own bill. Payment of all insurance co-payments, co-insurances and deductibles are required at the time services are rendered, unless prior payment arrangements have been made with the billing department.

2. Patients who have no insurance are required to pay 100% of the services rendered at each visit unless prior payment arrangements have been made with the billing department. For your convenience we accept cash, checks and all major credit cards. We also accept Care Credit.

3. Your insurance policy is a contract between you and your insurance company. Whether we are a contracted or non-contracted provider with your medical insurance, as a courtesy, we will submit claims to your insurance carrier. In order to facilitate claims processing, you must provide all insurance policy information and changes to our office along with a copy of your card(s). It is the patient's responsibility to know their coverage and benefits. Your bill is your responsibility whether or not your insurance company makes payment. At times, you may need to contact your insurance carrier regarding slow or non-payment of your insurance claim(s).

4. Maple Grove Eye Care's rates for services reflect the usual and customary amounts for this area. A refraction is done to determine your current eyeglass and/or contact lens prescription. Most insurance companies do not cover this $39.00 refraction charge. We will submit this as a courtesy to your insurance company. If your insurance company determines that this is non-covered, it will be your responsibility. A contact lens fitting fee will be billed by the doctor at the time of your exam for all contact wearers.

5. Lenses purchased at Maple Grove Eye Care's Optical Department are guaranteed for 60 days. After 60 days, replacement lenses will be at the expense of the patient. Frames and opened boxes of contact lenses are non-refundable.

6. Monthly payments are required on all accounts with outstanding balances. We do not charge any interest. By signing below, you acknowledge receipt of this Financial Policy and Agreement; and you agree to pay collection costs and/or reasonable attorney fees if any delinquent balance is referred to an agency or Attorney for collection or suit. If your account is turned over to a collection agency for collection, there will be a $10.00 billing fee charged to your account.

7. A $35.00 fee will be charged on all returned checks, per Idaho code 28-22-105.

8. Please contact our office if you need to cancel or reschedule your appointment within 24 hours of your appointment time. Failure to attend your appointment or give a 24 hour notice may result in a $50.00 fee.

I hereby authorize Maple Grove Eye Care to release all information concerning my medical treatment to my insurance carriers or referring physicians (if applicable).

I further authorize and direct said agency, attorney or insurance company to pay, from the proceeds or benefits of any recovery or insurance payments in my case, directly to Maple Grove Eye Care for their professional services rendered. I understand this in no way relieves me of my personal responsibility for paying my physician when a statement is rendered. It is understood that the signing of this form does not prohibit customary monthly billings.

_____ _____

Signature of Patient or Responsible Party Date

MAPLE GROVE

EYE CARE

As part of our ongoing progression, Maple Grove Eye Care offers Optomap imaging of the back of your eye (retina). This photo takes less than one minute. This imaging may, or may not require dilation and allows us to easily check for macular degeneration, glaucoma, diabetic retinopathy, retinal detachments and even tumors.

You will be able to see and review the retinal images with Dr. McAdams. These photos will also be stored in your chart for later comparison should retinal disease develop in the future.

There is an additional charge of $35 which may not be covered by your insurance.

___ I have read and understand the above, and **agree** to the Optomap Imaging

____I have read and understand the above and **decline** the Optomap Imaging

Patient/ Parent Signature_____

OPTICAL AGREEMENT

I understand that, within 30 days of receiving my glasses, I can do a one-time satisfaction exchange to alter anything I wish to change about either frames or lenses.

I understand that I have 90 days after the date I receive my glasses to do an RX change, if the RX has changed in that time.

I understand that most optical frames and lenses have a two-year warranty. Meaning I get a one-time replacement if there are scratches in the lenses, breaks in the frame, etc.

I understand that, after the time frames listed above, there will be no exchanges, returns, or refunds. If the RX changes outside of the 90-day period, I will pay the full price for the new lenses.

I understand that, if purchasing optical materials, payment is expected before the order will be processed by the optician. If payment is not able to be given, the order will be held for two weeks (or until an agreed upon date).

I understand that any costs given by the optician for glasses will be considered a quote/estimate and are subject to approval by insurance. Any discrepancies will be billed to me on a statement and I will work with Maple Grove Eye Care to pay off the balance.

I understand that glasses frames are delicate and breakages can happen. If I choose to use my own frame, I understand that those working with it will be as careful as possible. If a breakage should happen, I understand that I am responsible for the cost of replacing the frame.

Name:_____ Date:_____

Signature:_____