COKINGTIN EYE CENTER PA

WHAT YOU MAY EXPECT THE DAY OF YOUR EXAMINATION

We would like your visit to *Cokingtin Eye Center, PA* to be very enjoyable. So that you will know what to expect on the day of your examination, we have outlined the process below. Our staff is highly trained to complete all necessary testing, so please feel free to ask questions along the way. While we will make every effort to complete your examination as quickly as possible, please expect to spend approximately one and half hours to two hours with us.

On the day of your examination please bring the following:

- Your current insurance cards.
- Your Driver's License with current address
- Your current eye glasses, glasses prescriptions, and/or contact lens prescriptions.
- The forms that you were mailed. If there was not enough time for you to complete your paperwork you will be asked to complete it the day of your appointment. Please arrive 15 minutes prior to your examination to complete the paperwork.
- We will need information on all medications you are taking, including the names, dosages, and frequency.

After checking in at our front desk:

- While your chart is being processed you may help yourself to coffee and be seated.
- A qualified technician will begin your examination. A complete history and preliminary testing will be done at this time:
    - Your current eye glass prescription will be evaluated.
    - Your eyes will be tested to verify your best corrected vision.
    - Your eyes will be dilated to allow a complete evaluation by your Doctor.
    - Topography, a test to map corneal astigmatism, will be done if your examination or prescription warrants it.

Examination with your Doctor:

- A comprehensive diagnostic examination is performed at this time.
- Special testing may be ordered by your Doctor at this time.
- All testing may be done at this examination or may require a return visit.

If you will be scheduling surgery:

- You will speak with a surgical counselor to discuss the specific procedure and answer any remaining questions you may have.
- A financial counselor will be available to verify insurance coverage and assist in payment options.

Thank you for choosing *Cokingtin Eye Center, PA* for your eye care.

COKINGTIN EYE CENTER PA

PATIENT INFORMATION

DEMOGRAPHICS

LEGAL NAME Last First Mi			Date	Email address			
Street Address			Social Security #				
City			Special Needs ☐ Wheel Chair ☐ Walker ☐ Other_____ ☐ Hearing Impaired ☐ Translator Language _____				
State	County	Zip Code	Birthdate	Age	Race	Sex	
Home Phone ( )	Work Phone ( )		Maritial Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed				
Employer Name / Address			Position / Department				
Spouse			Work Phone ( )				
Emergency Contact			Emergency Phone ( )				

BILLING

Guarantor (Financially Responsible Person) Name			Relationship To Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other_____	
Street Address			Phone ( )	
City			State	Zip Code
Primary Insurance	Policy Holder	Policy ID #	Social Security #	Insured's B/D
Secondary Insurance	Policy Holder	Policy ID #	Social Security #	Insured's B/D
Send Workers Compensation To			Authorized By/Position	Date of Incident
Are you under the care of a skilled nursing facility? Yes No			If yes, please list name and address and phone number.	

REFFERAL

Whom may we thank for telling you about our practice?	☐ Friend / Family ☐ Patient ☐ Prologue ☐ Newspaper _____ ☐ Sign ☐ Radio ☐ Yellow Pages ☐ Screening ☐ Other _____ ☐ MD /OD _____ ☐ Optometrist _____		
Primary Care Doctor Name		Phone ( )	
Street Address	City	State	Zip Code
Family Optometrist Name		Phone ( )	
Street Address	City	State	Zip Code

COKINGTIN EYE CENTER PA

PATIENT HEALTH HISTORY

Name: _____ D.O.B. _____ Date _____

Medical Doctor: _____ Eye Doctor: _____

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING

MEDICATION	DOSAGE	HOW OFTEN

PLEASE LIST ANY DIAGNOSED EYE PROBLEMS

_____

_____

_____

PLEASE CIRCLE ALL THAT APPLY

Auto-Immune	Myasthenia Gravis, Lupus, Rheumatoid arthritis, Sjogrens Syndrome, Addisons Disease, HIV, Hay Fever
Cardiovascular	Heart, Coronary Artery Disease, Pace Maker, Defibrillator
Circulatory	High Blood Pressure, High Cholesterol, TIA (transient ischemic attack)
Endocrine	Diabetes, Graves Disease, Thyroid
Gastrointestinal	Stomach, Intestines, Irritable Bowel Syndrome (IBS), Gastric Esophageal Reflux (GERD)
Genitourinary	Urinary frequency, History of kidney stones, Female problems (reproductive), Male Problems (prostate)
Hematological	Blood, Lymph Nodes, Leukemia, Anemia, Hepatitis
Musculoskeletal	Chronic fatigue syndrome, Post Stroke Paralysis, Osteo-arthritis,
Neurological	Alzheimer's, Epilepsy, Multiple Sclerosis (MS), Muscular Dystrophies (MD)
Psychiatric	Psychosis, Depression, Bi-polar (manic-depression), ADD (attention deficit disorder), ADHD (attention deficit hyperactive disorder)
Respiratory	COPD, Asthma, Emphysema, Chronic Bronchitis, Lung Disease
Other Problems	_____

USE BACK OF FORM IF MORE SPACE IS NEEDED

Name: _____ D.O.B. _____ Date _____

LIST ANY KNOWN DRUG ALLERGIES

_____

_____

_____

Do you have an allergic reaction to tape or band aids? Y N Latex products? Y N

SOCIAL HISTORY

Do you drink?	Y	N	How often _____
Do you smoke?	Y	N	How often _____
Do you use any Illegal substances?	Y	N	How often _____

FAMILY MEDICAL HISTORY

Relation codes: F-Father, M-Mother, GF-Grandfather, GM-Grandmother, S-Sister, B-Brother, U-Uncle, A-Aunt, C-Cousin, (P)-Paternal, (M)-Maternal

Does any member of your family suffer from any of these conditions?

Condition	Yes	No	Relation	Condition	Yes	No	Relation
Blindness	____	____	_____	Heart	____	____	_____
Cataracts	____	____	_____	Stroke	____	____	_____
Glaucoma	____	____	_____	High Blood Pressure	____	____	_____
Macular Degeneration	____	____	_____	Kidney	____	____	_____
Retinal Detachment	____	____	_____	Lupus	____	____	_____
Diabetes	____	____	_____	Sjogrens	____	____	_____
Thyroid	____	____	_____	Arthritis	____	____	_____
Cancer	____	____	_____	Other	____	____	_____

SURGICAL HISTORY

Please list any eye surgeries you have had.

SURGERY	DATE	DOCTOR

Please list all other surgeries.

SURGERY	DATE	SURGERY	DATE

USE BACK OF FORM IF MORE SPACE IS NEEDED

COKINGTIN
EYE CENTER PA

5520 College Blvd., Suite 201
Overland Park, KS 66211
Phone: 913-491-3737

Patients Name _____

Date of Birth _____

PHARMACY INFORMATION

Pharmacy Name _____

Pharmacy Address _____

City _____

State _____

Zip _____

Phone _____

Fax _____

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Agreement of Responsibility

I understand that professional services are rendered to the patient and the patient is responsible for charges incurred for these services. Payment for annual deductibles and co-insurance may be collected at the time of service. I understand that I am financially responsible for charges not covered by my insurance company.

Consent to Treat

I voluntarily consent to such care and treatment as prescribed by the physicians as is necessary in his/her judgement.

Release of Information/Assignment of Benefits

I authorize use of this form on all my insurance submissions and authorize release of information needed to process a claim to all my insurance companies. I permit a copy of this authorization to be used in place of the original. I authorize the provider to act as my agent in helping me obtain payment from my insurance companies. I understand the provider does not accept responsibility for collecting my insurance claims. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand I will receive a monthly statement for any balance due by me.

Medicare Authorization

I request payment of authorized Medicare benefits be made on my behalf to Cokingtin Eye Center, PA for services furnished to me by that physician/supplier. I authorize the holder of medical information about me to release to Medicare 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 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 to the agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and the uncovered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Medigap Authorization

The following is to be filled out if you have a Medigap insurance policy for which you wish to assign benefits. A Medigap or Medical Supplemental policy is a health insurance policy or other health plan offered by a private company to those entitled to Medicare benefits. It is designed to pay certain costs that Medicare does not pay. By law, this excludes a policy or plan offered by an employer to employees or former employees, as well as a policy or plan offered by a labor organization to members or former members.

This agreement is in effect until revoked in writing by the patient.

Signature:_____Date:_____

Printed Name:_____

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COKINGTIN EYE CENTER, PA • MIDWEST EYE CONSULTANTS

FINANCIAL POLICY

Thank you for choosing our office to assist you with your eye care needs. We strive to provide you with the highest quality care possible, and in return, we ask that you assist us not only in monitoring your eye health care, but also by paying for our services in a responsible and timely manner.

The following is a statement of our financial policy. Our office requires that each patient read and sign a copy of this policy before we provide any treatment. Therefore, please read through this statement and feel free to ask us any questions you may have relating to our policy. Then sign the statement at the bottom of this form.

Acceptable Payment Methods:

We accept cash, checks, Visa, MasterCard and American Express. Under certain circumstances, with prior credit approval, we do offer extended payment plans. If you need additional information on that, please talk to our billing staff.

- **Insurance:** Our office accepts assignment of benefits from many insurance companies, HMO and PPO programs. However, we do not accept all benefit programs. Therefore, please inquire (call them to be sure) as to whether or not your insurance company is accepted by this office.

- **Affordable Care Act Insurance:** Our Office accepts assignment of benefits from the Affordable Care Act with participating plans. Please inquire (call them to be sure) as to whether or not your physician accepts your insurance plan and alert our staff if you are receiving benefits from the Affordable Care Act. The Affordable Care Act does not provide full coverage and it will be patient responsibility to pay their share of the bill.

- **We do require that your co-payment, deductible and any non-covered services, such as refractions and contact lens related charges, be made at the time of service.** In the event that we do not accept assignment of benefits from a particular insurance company, we require you to pay your bill in full at the time of each visit or be pre-approved on our extended payment plan.

- **Your bill is your responsibility**: If your insurance company or other benefit program doesn't cover the entire bill, it's your responsibility to pay the balance. Unless you are on an extended payment plan, we expect payment in full within 60 days of being notified of any balance due. It is our policy to mail out 3 billing statements. Failure to pay the balance in full or contact our office regarding a payment plan after 60 days will result in your account being sent to collections.

I certify that I have read and understand the "Financial Policy" and agree to all terms and conditions stated above. I understand it is my sole responsibility to verify my medical coverage with the insurance company, HMO or PPO, Medicare, Medicaid, Affordable Care Act or other benefit program and that I am ultimately responsible for payment in full for any outstanding balances incurred.

Signature:_____ **Date:**_____

Print Name:_____