Attleboro Vision Care Associates, P.C.

550 North Main Street Attleboro, MA 02703 (508) 222-9912

Dear New Patient:

Welcome to Attleboro Vision Care Associates, P.C.

Please complete the enclosed Patient Information Sheet and Medical Questionnaire using black or blue ink, and bring them with you to your first appointment. This will speed up the registration process for you.

Please remember to bring a complete list of all medications you are currently taking.

If this is your first visit with us, please bring your glasses and/or contact lens boxes if possible, or your last written prescription. For existing contact lens wearers, please wear your contacts to your appointment.

Please note that Medicare and most major insurance carriers require physicians to obtain this medical information and retain it in their patients' medical records. These documents will become part of your record.

Some insurance carriers only allow a routine eye exam every 24 months. **Please note that you are responsible for checking with your insurance carrier to insure that you are eligible for your visit.** This will help prevent delays at your appointment and insure you do not unexpectedly receive a bill for your visit. Also, authorization of insurance is not a guarantee of payment.

If you belong to a health plan that requires a **referral** for an eye exam, please contact your primary care physician to obtain one. **Please note that the patient is responsible for obtaining a referral.**

Again, we welcome you to Attleboro Vision Care Associates, P.C., and we look forward to meeting you and your family's vision care needs.

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Welcome To Our Office

Today's Date: _____

Patient Information:

Name: _____
Last First Middle
Address: _____ City_____ State_____ Zip_____

Date of Birth:_____ Sex:____ M____F Married____ Single_____ SS#: _____

Cell Phone: (_____)_____ Home Phone: (_____)_____ Email:_____

Occupation: _____ Employer Name: _____

Employer Address: _____ Business Phone: (_____)_____

Primary Care Physician: _____Location: _____ Phone: (_____)_____

Emergency Contact Person/Phone Number _____

Responsible Party: (Complete if patient is under 18 years of age)

Name: _____
Last First Middle
Address: _____ City: _____ State: _____ Zip:_____

Home Phone: (_____)_____ Cell Phone: (_____)_____ Email: _____

Business Phone:(_____)_____Date of Birth: _____ Relationship to Patient: _____

Insurance Information:

Primary Medical Insurance: _____ Subscriber ID:_____

Secondary Medical Insurance: _____ Subscriber ID:_____

Vision Insurance Plan: _____ Subscriber ID: _____

Subscriber's Name: _____ Relationship to Patient: _____

Subscriber's Address: _____
(Complete if different from patient's address)
Subscriber's Date of Birth:_____Subscriber's SS#: _____

Subscriber's Employer: _____Subscriber's Phone: (_____)_____

Referral Information:

How were you referred to our practice?
____Friend/Relative ____Physician ____Optometrist ____Insurance Listing ____ Eye Screening

Name of Referral Source: _____

When was your last eye exam?_____

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Written Financial Policy

Thank you for choosing Attleboro Vision Care where our mission is to deliver the best and most comprehensive care available while making the cost of optimal care as easy and manageable for our patients as possible.

Payment Options:

-Cash, Check, all major credit cards or CareCredit healthcare credit card. (CareCredit is a healthcare credit card with special financing and payment options* for medical expenses.) **Note: There is a $25 fee on all returned checks.**

Please Note: A refraction is a measurement of the lens power necessary to prescribe glasses or other corrective lenses. Most medical insurance plans, including Medicare, do not cover routine refractions or routine eye exams (when no medical eye problem is known or suspected). Medicare, and most other insurance plans, insists that we charge separately for that portion of the examination, since it is not a covered service. You will receive an explanation of benefits from them itemizing your responsibilities.

It is customary to pay for professional services when rendered. However, if you have a medical problem then we will bill your insurance on your behalf.** You are authorizing your insurance carrier to make payment directly to Attleboro Vision Care for any medical benefits due for services rendered and this is a direct assignment of your rights and benefits under this policy. You will be responsible for any co-payments, deductibles and/or non-covered services as determined by your insurance company. If you have a separate plan that covers routine examinations and/or glasses, please let us know. Your vision plan may assist you with your eye care needs that are not covered by your medical plan. We will bill your vision plan as above.** In accordance with our contract and with your insurance provider, we are responsible for collecting, and you are responsible for paying, co-payments at the time of service.

AUTHORIZATION OF INSURANCE IS NOT A GUARANTEE OF PAYMENT.

Please initial the following:

____ I authorize Attleboro Vision Care to release information to my insurance carrier to determine my benefits and I recognize and accept responsibility for any balance remaining after payment of such benefits.

____I understand that Attleboro Vision Care requires payment prior to products received/services rendered.

____I understand that I may be responsible for a contact lens exam fee $50-$150, dependent upon insurance.

____I am aware that I may be assessed a fee of $25 for canceling more than 3 times in a calendar year without a 24 hour notice.

____I understand that Attleboro Vision Care does not allow returns on prescription eye wear as they are made to order.

HMO Referral Waiver:

____I understand that it is my responsibility to obtain a referral from my primary care physician and that any charges incurred as a result of failing to do so are my responsibility.

For Medicare patients:

____I understand that I may be responsible for a refraction fee of $45, dependent upon supplemental insurance.

If you have any questions, please do not hesitate to ask.

_____ _____

Patient, Parent or Guardian Signature Date

*Subject to credit approval **However, if we do not receive payment from your insurance carrier within 30 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

MEDICAL HISTORY QUESTIONNAIRE

Name_____ **Date**_____

Date of Birth _____ Date of **last eye exam** _____

Please list all medications you currently take (Prescription and over-the-counter): _____

_____

Do you have **allergies** to any medications? **YES NO**
If YES, list the medications:_____

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or **injuries** (concussion, etc.):

_____

List any **surgeries** you have had (cataract, appendectomy): _____

Do you ***currently*** have any problems in the following areas? If YES, please provide additional information.

	YES	NO	Details
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL / CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, **KIDNEY**, **BLADDER** (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
FEMALES Are you pregnant? Nursing?			
MUSCLES, **BONES, JOINTS** (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			

FAMILY HISTORY (Mother, Father, Grandparent, Sibling)

Has any member of your family had these diseases (circle all that apply) ? **YES NO UNKNOWN**

Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis

Other heritable disease:

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? **YES NO**

Have you ever had a blood transfusion?..... **YES NO**

Do you drink alcohol? ..... **YES NO** If YES, how much? _____

Do you smoke?..... **YES NO** If YES, how much? _____ How many years? _____

Physician's Signature _____ *Date* _____

ATTLEBORO VISION CARE ASSOCIATES, P.C.
RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

- I have received a copy of **Attleboro Vision Care Associates, P.C.'s** "Notice of Privacy Practices".

- I understand that **Attleboro Vision Care Associates, P.C.** owns and maintains my **Attleboro Vision Care Associates, P.C.** medical records and, in its "Notice or Privacy Practices" has assured me that **Attleboro Vision Care Associates, P.C.** keeps information about me confidential as required by state and federal laws. I know that if I want to have access to my **Attleboro Vision Care Associates, P.C.** medical records or copies of any information in that record, I should ask anyone at **Attleboro Vision Care Associates, P.C.** for assistance.

_____ _____

Signature of Patient **Date**

_____

Signature of Legal Guardian

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Name:_____**Date**:_____**Occupation**:_____

This questionnaire was designed to assist your eye care professional in helping you select the perfect lenses, frames and/or contacts to suit your visual needs. Please take a moment to answer the following questions.

1. Which of the following visual demands do you encounter on a regular basis?
   __ Artificial Lighting __ Computer Work __ Potential Eye Hazards
   __ Board Work __ Sun Exposure __ Reading
   __ Close-up Work __ Phone/Tablet Use __ Other:_____

2. Which of the following hobbies or activities do you participate in?
   __ Reading __ Musical Instruments __ Biking
   __ Golf __ Snow Sports __ Hunting/Shooting
   __ Driving __ Jogging/Running __ Landscape/Gardening
   __ TV/Video Games __ Competitive Sports __ Fishing/Water Sports
   __ Computer __ Sewing/Arts/Crafts __ Other:_____

3. Do your eyes seem bothered by glare from any of the following situations?
   __ Night Driving __ Fluorescent Lights
   __ Sunshine __ PC/Phone/Tablet Screen __ Other:_____

4. A. If you wear contacts, do you have:
   Current pair of prescription glasses Yes / No
   Sunglasses Yes / No
   Issues with allergies Yes / No
   Issues with vision shifting while lying down Yes / No
   B. If you do not wear contacts:
   Would you be interested in full time use Yes / No
   Would you be interested in occasional use Yes / No

5. Do you wish you had more comfort when working long hours on the computer? Yes / No

6. Lately, do you find yourself holding objects farther away to read? Yes / No

7. What do you like/dislike about your current glasses and/or contacts (comfort, style, fit, etc)?
   _____
   _____
   _____
   _____

Doctor recommendations

__ AR __ Transitions __ Polarized __ Occupational/Computer

Other_____