Attleboro Vision Care Associates, P.C.

51 Man-Mar Drive Unit 2 Plainville, MA 02762 (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. **Although we primarily treat the area in and around the eye, one's eye is a part of the entire body. Previous health problems and/or medications could have an important interrelationship with your eye's health.**

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

I acknowledge 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 missed appointments or to schedule subsequent appointments after a missed appointment. Fees paid to schedule appointments are refundable if that appointment is kept.

- 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.

Name _____ Today's Date _____

Date of Birth _____ Date of last eye exam if not here _____

MEDICAL HISTORY: *Information related to your health, medications and family history are all relevant to your vision and eye health.*

Your Personal Medical History

Allergies	Yes	No	HIV/AIDS	Yes	No
Alzheimer's Disease	Yes	No	Kidney/Liver Disease	Yes	No
Arthritis	Yes	No	Multiple Sclerosis	Yes	No
Asthma	Yes	No	Pregnant/Nursing	Yes	No
Blood/Bleeding Disorder	Yes	No	Seizures/Epilepsy	Yes	No
Cancer	Yes	No	Stroke	Yes	No
Depression/Anxiety	Yes	No	Cataracts	Yes	No
Diabetes	Yes	No	Color Vision Problems	Yes	No
Diuretic/Fluid pill	Yes	No	Eye/Head Injury	Yes	No
Fainting/Dizziness	Yes	No	Eye Surgery	Yes	No
Frequent Headaches	Yes	No	Eye Turn/Lazy Eye	Yes	No
Hearing Problems	Yes	No	Flashes/Floaters/Spots in Vision	Yes	No
Heart Disease	Yes	No	Glaucoma	Yes	No
Hepatitis A/B/C	Yes	No	Macular Degeneration	Yes	No
High Cholesterol	Yes	No	Vision Loss/Double Vision	Yes	No
High/Low Blood Pressure	Yes	No	Other _____		
			_____		

Your Current Medications

			Related Medication/Notes
Antihistamines	Yes	No	_____
Blood Pressure	Yes	No	_____
Cholesterol	Yes	No	_____
Depression/Anxiety	Yes	No	_____
Diabetes	Yes	No	_____
Diuretic/Fluid pill	Yes	No	_____
Eye Drops	Yes	No	_____
Heart	Yes	No	_____
Oral Contraceptives	Yes	No	_____
Thyroid	Yes	No	_____
Vitamins/Supplements	Yes	No	_____
Other	Yes	No	_____

Family History

	Relationship		Relationship
Blindness	_____	Glaucoma	_____
Cancer	_____	Heart Disease	_____
Cataracts	_____	High Blood Pressure	_____
Color Vision Problems	_____	Lazy/Crossed Eye	_____
Diabetes	_____	Macular Degeneration	_____
		Other	_____

Please list allergies to medications: _____

Please list all injuries, major illnesses and/or hospitalizations: _____

_____

Please list any surgeries you have had: _____

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? Yes No

Do you drink alcohol? Yes No If yes, how much? _____ How many years? _____

Do you smoke? Yes No If yes, how much? _____ How many years? _____

If past smoker, when did you quit? _____

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