**Demographic Information**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
| Last | First |  MI | Preferred Name |
|  |  |  |  |
| Mailing Address | City | State | Zip Code |
|  |  | Sex |  |
| Date of Birth | SSN |  □ M □ F | Preferred Pronouns |

**Contact Info**

Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Preference:

Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Home □ Cell

Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May we leave a voicemail?

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Yes □ No

**Specific Disclosure Consent**

I agree that Bonnie M Gauer OD MS LLC and Umpqua Optical Lab may disclose my health information to the specified individual(s) listed. This consent may be revoked at any time with written statement from you. I voluntarily consent to disclosure of health information to specified individual(s) to act on my behalf:

Name of Recipient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Marital Status:**

□ Single □ Married □ \_\_\_\_\_\_\_\_\_\_\_\_

**Employment and Occupation**

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 what grade? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**✰ Federal Health Care Equality Initiative Questionnaire** (required by law)

Please circle your answer or opt to decline. □ decline

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Race: | White | Black/African American | Asian | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Ethnicity: | Hispanic | Not Hispanic |  |  |
| Primary Language: | English | Spanish | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |
| --- |
| By signing below, I agree that I have reviewed and understand the information on the following page and that I have been offered a copy of the **Notice of Privacy Practices** and **Office Policy**. |
| Patient or Responsible Party Signature Date |

**Acknowledgement and Consent: Notice of Privacy Practices**

• I understand that Bonnie M. Gauer OD MS LLC (aka This Practice) will use and disclose health information about me; health information may include both created and received by This Practice, may be in form of written or electronic records, or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

• I understand and agree that this practice may use and disclose my health information in order to: (1) make decisions about, and plan for my care and treatment, (2) refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment, (3) determine my eligibility for health plan or insurance coverage, and submit bills, claims, and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and (4) perform various office, administrative, and business functions that support my physician’s efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

• I also understand that I have a right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information. I understand that the Notices of Privacy Practices may be revised from time to time, and I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a summary of the most current version of This Practice’s Notice of Privacy Practices in effect will be available in the reception area.

• I understand that I have a right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

**Authorization to Release Information:** I hereby authorize **Bonnie M Gauer OD MS LLC** and **Umpqua Optical Lab** to furnish insured’s insurance company all information, which said insurance company might request concerning my present claim. A “Notice of Privacy” has been presented regarding HIPAA compliance with patient privacy and release of health information.

**Assignment of Insurance Benefits:** I hereby authorize and assign **Bonnie M Gauer OD MS LLC** and **Umpqua Optical Lab** all monies to which I am entitled for expense relative to the services performed from time to time, but not to exceed by indebtedness to said doctor. It is understood that any money received from the named insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand I am financially responsible to said doctor for charges.

**Office Policy**

• As a service to our patients, we would like to outline our policy toward the payment for services rendered.

Professional fees are paid in full. Prompt pay discounts may apply to self-pay patients in addition to balance payments on accounts.

As a courtesy, your PRIMARY insurance will be billed, provided the necessary ID, group numbers, and billing address are provided at the time of visit, unless other arrangements have been made prior. After 45 days, the balance of the bill becomes your responsibility.

• As noted, some insurance companies will assist with **Coordination of Benefits** with automatic transfer to a known Secondary insurance (e.g. traditional Medicare to Secondary or Primary & Secondary insurance are with same insurance carrier). We are happy to assist you with secondary claim submission information; however this office does NOT bill Secondary Insurances separately.

• Any services or materials considered to be a ‘non-covered benefit’ by your insurance company will be your responsibility.

Insurance copays are required at time of service visit; known unmet medical deductibles shall be required at time of medical service visit.

• Optical lab orders, frames, and contact lens orders must be paid in full – minus insurance benefit – prior to placing order, unless it is understood insurance benefit will cover said amount; any non-covered optical services/products are patient responsibility. The balance is due prior to hardware/contact lens release.

• We realize that many families are in a state of change. Divorces, separations, single parents, and blended families are now common. In many of those families, the question of who is responsible for the children’s care is uncertain. **Our policy is that the parent who requests treatment for the child is responsible for all fees incurred.** If there is a court order in place, please present copy to front desk for patient responsibility party payor.

• When billing insurances, the refraction (and contact lens fitting, if applicable) part of the eye examination determining a need for vision correction with glasses and/or contact lenses, will be billed separately from the MEDICAL portion of the examination. Typically, insurance plans, including Medicare, will NOT pay for refraction service unless specifically stated in coverage benefits. This is your responsibility.

• In the event to your account has to be referred to a collection agency for collections, **you will be charged $50.00 at the time** the account is assigned to said agency, in addition to any and all reasonable attorney fees, filing fees, and court cost(s) will be charged to you.

• **Non-sufficient funds charges on checks is $25.**

• We encourage you to contact our billing department if questions about your account arise. If you are having difficulty making payments, in most cases, we are happy to set up a payment plan. Once a payment plan has been established, failures to pay will consequent in your account being turned over to collections.

• I hereby authorize the **Bonnie M Gauer OD MS LLC / Dr. Gauer** to furnish the insured’ insurance company all the information which said insurance company may request concerning my claims for service.

• **I understand that prior to release of any prescriptions or medical records, my financial account shall be paid in full.**

• **I understand that I am financially responsible for charges NOT covered by my insurance company.**

• A **missed appointment fee of $25** applies if notice was not given ahead of a cancelled/missed appointment.

**Demographic Information**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
| Last | First |  MI | DOB |
|  |  |  |  |
| Height | Weight | Pharmacy |  |

**Ocular History**

|  |  |
| --- | --- |
| **When was your last eye exam?** |  |
| **Who did you see?** |  |
| **Where do you have trouble seeing?** |  □ distance □ reading □ driving □ night time |

**Primary eye correction:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| □ None | □ Contacts | □ OTC readers | □ Single Vision | □ Bifocals | □ Trifocals | □ Progressives |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  How many hours are you on the computer per day? | □ None | □ 1-2 hours | □ 3-6 hours | □ 7+ hours |
|  How long do you use your phone/tablet? | □ None | □ 1-2 hours | □ 3-6 hours | □ 7+ hours |

**Do you have computer glasses?** □ Yes □ No

**Are you interested in contact lenses?** □ Yes □ No □ Unsure

If you wear contacts, what have you worn?

□ astigmatism correcting □ extended wear □ rigid gas permeable □ monovision □ multifocal □ soft

Do you sleep in your contacts? □ never □ always □ sometimes □ naps only

|  |  |
| --- | --- |
| **Eye Conditions** (check all that apply) | **Eye History** (check all that apply) |
| □ decreased vision | □ floaters | □ cataracts | □ cornea disease |
| □ fluctuating vision | □ glare/halos | □ amblyopia (lazy eye) | □ diabetic retinopathy |
| □ double vision | □ eye pain | □ glaucoma | □ iritis |
| □ shadowy/distorted vision | □ dryness/burning | □ macular degeneration | □ retinal tear |
| □ itchy eyes | □ discharge/mucus | □ strabismus (eye turn) | □ retinal detachment |
| □ gritty/sandy feeling | □ excess tearing | □ eye injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |
| --- | --- |
| **Eye Surgical History** (check all that apply) | **Family Eye History** (check all that apply) |
| □ none | □ cataracts | □ blindness | □ retinal detachment |
| □ LASIK | □ eyelid | □ cataracts | □ retinal dystrophy |
| □ PRK | □ retina | □ cornea dystrophy | □ macular degeneration |
|  |  | □ lazy eye | □ glaucoma |
|  |  |  |  |
| Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Social History**

|  |  |  |  |
| --- | --- | --- | --- |
| Smoker | □ Yes | □ No | □ Previous |
| Chewing Tobacco | □ Yes | □ No | □ Previous |
| Alcohol Use | □ Yes | □ No | □ Previous |
| Recreational drugs | □ Yes | □ No | □ Previous |
| STD / STI (circle type) | □ HIV | □ Hepatitis A B C |
| Drug/alcohol abuse | □ Yes | □ No |  |
| Pregnancy | □ Current | □ Previous | □ None |

**Surgical History**

|  |
| --- |
|  |
|  |
|  |
|  |

**Diabetic History**

**Do you have:** □ none □ pre diabetes □ Type I Diabetes □ Type II Diabetes □ Gestational

|  |  |  |
| --- | --- | --- |
| When was it diagnosed? |  |  |
| What was your last A1C? |  | When was it taken? |  |
| What was your last fasting blood sugar? |  | When was it taken? |  |

**Review of Systems:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| General: | □ weight loss | □ weight gain | □ fatigue |  |  |
| Ear, Nose, Throat: | □ allergies | □ sinus | □ cough | □ dry mouth/throat |  |
| Cardiovascular: | □ high blood pressure | □ heart surgery | □ vascular disease |  |  |
| Respiratory: | □ asthma | □ bronchitis | □ COPD |  |  |
| Genital, Kidney, Bladder: | □ kidney stones | □ frequent urination | □ impotence |  |  |
| Muscles, Bones, Joints: | □ arthritis | □ joint pains | □ head or neck injury |  |  |
| Skin: | □ rashes | □ psoriasis | □ skin cancer |  |  |
| Neurological: | □ headaches | □ migraines | □ seizures |  |  |
| Psychiatric: | □ depression | □ anxiety | □ PTSD | □ Insomnia |  |
| Hematologic: | □ anemia | □ high cholesterol | □ bleeding disorder | □ lymph |  |
| Immunologic: | □ rheumatoid | □ lupus | □ fibromyalgia |  |  |
| Gastrointestinal: | □ diarrhea | □ constipation | □ GERD | □ Ulcer | □ IBS |
| Endocrine: | □ hypothyroid | □ hyperthyroid | □ hypoglycemia |  |  |
| Other: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |

**Family Medical History**

|  |  |
| --- | --- |
| □ Arthritis | □ Cancer |
| □ Heart Disease | □ Diabetes |
| □ Hypertension | □ Mental illness |
| □ Obesity | □ Stroke |
| Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Medications** □ no known drug allergies

|  |  |
| --- | --- |
|  |  |
|  |  |
|  | **Allergies** |
|  |  |
|  |  |

**Medical History**

|  |
| --- |
| Who is your primary care provider? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| When did you see them last? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |