WELCOME TO OUR PRACTICE

We look forward to meeting you and caring for your eyes. Below you will find a list of items that we require for your next visit:

1) Bring your **Medical and Vision Insurance** cards-we cannot bill your insurance company without them.
2) Bring your **driver's license** or some form of picture ID (if you do not have a driver's license).
3) Make certain a referral **has been generated** if you have an HMO (or a Point of Service that requires one).
4) Bring your **eyeglasses.**
5) Wear your **contact lenses** (if applicable) if you would like us to renew your current prescription. Please bring any information that you might have on your current contacts.

Co-payments, refraction and contact lens fittings/evaluation fees: are due on the date of service.

Contact Lens Services: Please notify us in advance if you currently wear contact lenses *or* wish to be fitted for them. We need to allow the proper amount of time for this kind of appointment. There is an additional charge for contact lens fittings and evaluations.

Medical Exams: If your visit is for a known or suspected eye disease or injury, we will bill your medical insurance.

Routine Exams: If your visit is routine, (new glasses), we will bill your vision Plan.

Optical: If you are interested in eyewear, we have a large selection at very competitive prices. Come in and browse our optical during your visit. Our optical participates with many vision insurance plans, including Blue Cross Vision, Han Vision, DMC Heritage Optical, MEBS, MECA, Vision Advantage, VSP, Vision Care Plan, Vista Vision, and some Cole Managed Vision plans.

Just a note: We do our best to understand the many insurance benefits that our patients carry. Of course the expert about *your* own plan should be you! Please become familiar with your insurance so that you understand referrals (if required), co-pay and benefit levels. Your knowledge assists us in submitting a claim on your behalf. We promise to do our best to make your visit in our office as pleasant and convenient as possible.

Please complete the enclosed pre-registration forms and return them in our self-addressed stamped envelope.

Sincerely,

Carl F. Clavenna, M.D.
Gregory B Fitzgerald, M.D.
And Staff

Vision Insurance VS Medical Insurance

What is the difference? We hope we can clarify this question for you.

Your vision insurance is a "rider" that either you or your employer purchases to receive coverage for a routine eye exam and glasses or contact lenses. Medical insurance is intended to cover services when a medical condition exists.

One of the reasons that you choose to see an ophthalmologist rather than an optometrist is because an Ophthalmologist is a medical doctor and can offer you a higher level of care. Dr. Clavenna and Dr. Fitzgerald are ethically obligated to give you the highest level of care, which means that they must evaluate any and all medical conditions that exist.

How do I know if my visit is medical or vision?

Your vision insurance would apply for a routine eye examination if you:

- Have no known problems with your eyes except for needing new glasses.

AND

- Were not referred by another physician.

AND

- Your previous eye examinations by Dr. Clavenna or Dr.Fitzgerald did not show any medical conditions.

If the above does not apply then we need to address the medical condition and use your medical insurance.

Examples of medical conditions: Cataracts, glaucoma or suspicion of glaucoma, macular degeneration, implants, red eyes, tearing, irritation, pain, etc.

PATIENT INFORMATION

NAME_____(Dr. Mr. Mrs. Miss Ms.) circle one BIRTHDATE_____

Circle preferred phone #

SOCIAL SECURITY #_____HOME PHONE_____CELL PHONE_____

ADDRESS_____CITY_____ST_____ZIP_____

E-MAIL ADDRESS_____

PATIENT EMPLOYER_____PHONE #_____

EMERGENCY CONTACT_____PHONE _____ALTERNATE PHONE_____

HOW DID YOU HEAR ABOUT OUR OFFICE?_____

PRIMARY CARE PHYSICIAN_____ ADDRESS_____

CITY_____ STATE_____ZIP_____PHONE _____

PRIMARY INSURANCE

SUBSCRIBER'S NAME_____RELATIONSHIP TO PATIENT_____BIRTHDATE_____

SOCIAL SECURITY #_____HOME PHONE_____CELL PHONE_____

SUBSCRIBER'S EMPLOYER_____WORK PHONE_____

INSURANCE: Medicare (please circle) or Other:_____

SECONDARY INSURANCE

SUBSCRIBER'S NAME_____RELATIONSHIP TO PATIENT_____BIRTHDATE_____

SOCIAL SECURITY #_____HOME PHONE_____CELL PHONE_____

SUBSCRIBER'S EMPLOYER_____WORK PHONE_____

INSURANCE: Medicare (please circle) or Other:_____

OTHER or VISION INSURANCE

SUBSCRIBER'S NAME_____RELATIONSHIP TO PATIENT_____BIRTHDATE_____

SOCIAL SECURITY #_____HOME PHONE_____CELL PHONE_____

SUBSCRIBER'S EMPLOYER_____WORK PHONE_____

INSURANCE : _____

GUARANTOR INFORMATION -same as patient YES____ NO_____ please complete if No is your answer

GUARANTOR'S NAME_____RELATIONSHIP TO PATIENT_____BIRTHDATE_____

SOCIAL SECURITY #_____HOME PHONE_____CELL PHONE_____

EMPLOYER_____WORK PHONE_____

Financial Policy :I hereby authorize the release of the necessary medical information to process claims and direct payment of benefits to Clavenna Vision Institute. I understand I am responsible to pay all non-covered services, co-pays, and deductibles. I understand if my insurance requires a referral authorization and I fail to bring a referral, I will be responsible for all charges. If my account falls in arrears, I agree to reimburse Clavenna Vision Institute the fees of any collection agency at a maximum percentage of 26% of the debt, and all costs and expenses, including reasonable attorney fees, associated with such collection efforts. I understand and agree to this financial policy.

_____ _____

SIGNATURE OF PATIENT, GUARANTOR (IF PATIENT IS A MINOR), DATE

LEGAL GUARDIAN OR LEGAL REPRESENTATIVE

UPDATE SIGNATURES (FOR FUTURE APPOINTMENTS)

Signature	Date	Signature	Date
Signature	Date	Signature	Date

This signature page is designed for you to establish limitations on what information we can share with people **other than your insurance company or Drs. who coordinate your care.** If you have certain family members or caregivers that normally assist you in either your health care decisions or financial decisions, you may wish to include them in Section "A" of this form. **If you do not authorize anyone in section "A" be aware that we will not be allowed to answer any questions regarding your care, including billing, to anyone but *you*** (including your spouse, siblings, adult children, and caregivers).

Section A

AUTHORIZATION TO RELEASE RECORDS

I AUTHORIZE THE PERSON(S) NAMED BELOW TO DISCUSS MY CARE IN MY ABSENCE AND OBTAIN MY MEDICAL RECORDS IF NECESSARY. **(THIS DOES NOT INCLUDE DOCTORS WHO ARE INVOLVED IN MY CARE).** I UNDERSTAND THIS AUTHORIZATION IS IN EFFECT UNLESS I REVOKE THE AUTHORIZATION IN WRITING.

DESCRIPTION OF THE SPECIFIC INFORMATION TO BE DISCLOSED:

_____

ALL MEDICAL RECORDS ☐

NAME	RELATIONSHIP	PHONE

_____ _____

PATIENT SIGNATURE DATE

PAST MEDICAL, FAMILY, SOCIAL HISTORY AND REVIEW OF SYMPTOMS

Date_____

Patient Name_____ Acct #_____ Date of Birth_____

Medication allergies and your reaction:_____

Known allergy to Latex- **YES** [ ] **NO** [ ] Are you pregnant **YES** [ ] **NO** [ ] Are you nursing **YES** [ ] **NO** [ ]

PAST OCULAR HISTORY & SURGERIES: *Have you had any of the following:*

YES	NO	
[ ]	[ ]	Glaucoma
[ ]	[ ]	Lazy Eye
[ ]	[ ]	Macular Degneration
[ ]	[ ]	Cataracts

CURRENT EYE MEDICATIONS AND DOSAGES:_____

_____

_____

PAST MEDICAL AND SURGICAL HISTORY-*Have you had any of the following:*

YES	NO		YES	NO	
[ ]	[ ]	Breathing/Lung Disease- Specify_____	[ ]	[ ]	Autoimmune disease □ *Crohns* □ *MS* □ *Fibromyalgia* □ *Rheumatoid Arthritis* □ *Sarcoid* □ *Lupus* □ *Other*_____
[ ]	[ ]	Liver Disease			
[ ]	[ ]	Kidney Disease			
[ ]	[ ]	Hypertension	[ ]	[ ]	HIV/AIDS
[ ]	[ ]	Stroke	[ ]	[ ]	Cancer - *specify*_____
[ ]	[ ]	Heart Disease	[ ]	[ ]	Diabetes - *age diagnosed*_____
[ ]	[ ]	Thyroid			*Type* I or II (circle)
[ ]	[ ]	High Cholesterol	[ ]	[ ]	Insulin Dependant

CURRENT MEDICATIONS and VITAMINS (including over the counter) **AND DOSAGES:**_____

_____

_____

FAMILY HISTORY-*Have any family members had the following:*

YES	NO		**Relation** *If grandparent, list maternal or paternal*	**Living:**	**YES**	**NO**
[ ]	[ ]	Arthritis	_____		[ ]	[ ]
[ ]	[ ]	Blindness	_____		[ ]	[ ]
[ ]	[ ]	Cancer	_____		[ ]	[ ]
[ ]	[ ]	Cataracts	_____		[ ]	[ ]
[ ]	[ ]	Diabetes	_____		[ ]	[ ]
[ ]	[ ]	Glaucoma-	_____		[ ]	[ ]
[ ]	[ ]	Heart Disease	_____		[ ]	[ ]
[ ]	[ ]	High Blood Pressure	_____		[ ]	[ ]
[ ]	[ ]	Kidney Disease	_____		[ ]	[ ]
[ ]	[ ]	Lazy Eye	_____		[ ]	[ ]
[ ]	[ ]	Macular Degeneration	_____		[ ]	[ ]
[ ]	[ ]	Retinal Disease	_____		[ ]	[ ]
[ ]	[ ]	Stroke	_____		[ ]	[ ]
[ ]	[ ]	Tuberculosis	_____		[ ]	[ ]

SOCIAL HISTORY-*Do you or have you used the following:*

YES	NO		YES	NO		YES	NO	
[ ]	[ ]	Drugs	[ ]	[ ]	Current Tobacco User	[ ]	[ ]	Alcohol
If Yes, What Drug:_____			[ ]	[ ]	Former Tobacco User	If Yes, how much:_____		
			*If former tobacco user, when did you quit:*_____					

Please answer the following questions: (you have the option to choose not to answer)

What is your preferred Language_____ I prefer not to answer ☐

What race are you:

- [ ] American Indian or Native Alaskan
- [ ] Asian
- [ ] African American
- [ ] Pacific Islander
- [ ] Caucasian
- [ ] I prefer not to answer

Are you Hispanic or Latino YES NO

I prefer not to answer ___

REVIEW OF SYSTEMS

Date_____

Patient Name_____ Acct #_____ Date of Birth_____

Are you experiencing any of the following:

EYES	YES	NO
Previous Surgery	[]	[]
Contact Lens	[]	[]
Pain	[]	[]
Double Vision	[]	[]
Glaucoma	[]	[]
Cataracts	[]	[]
Macular Degeneration	[]	[]
Dry Eyes	[]	[]
Flashes	[]	[]
Floaters	[]	[]

EARS,NOSE,THROAT	YES	NO
Difficulty hearing	[]	[]
Ringing in ears	[]	[]
Vertigo	[]	[]

CARDIOVASCULAR	YES	NO
Chest Pain	[]	[]
Dizziness	[]	[]
Fainting spells	[]	[]
Shortness of breath	[]	[]
Irregular heartbeat	[]	[]
Difficulty lying flat	[]	[]

CONSTITUTIONAL	YES	NO
Fatigue/weakness	[]	[]
Fever	[]	[]
Weight gain or loss	[]	[]

RESPIRATORY	YES	NO
Cough	[]	[]
Congestion	[]	[]
Wheezing	[]	[]
Asthma	[]	[]

GASTROINTESTINAL	YES	NO
Heartburn	[]	[]
Nausea/vomiting	[]	[]
Jaundice/hepatitis	[]	[]

URINARY	YES	NO
Pain or difficulty urinating	[]	[]
Blood in urine	[]	[]
History of kidney stones	[]	[]
History of sexually transmitted diseases	[]	[]

PSYCHIATRIC	YES	NO
Anxiety/depression	[]	[]
Mood swings	[]	[]
Difficulty sleeping	[]	[]

ENDOCRINE	YES	NO
Increased thirst	[]	[]
Increased hunger	[]	[]
Increased urination	[]	[]
Increased sweating	[]	[]
Fingernail changes	[]	[]

BLOOD/LYMPHNODES	YES	NO
Easy bruising	[]	[]
Gums bleed easily	[]	[]
Prolonged bleeding	[]	[]
Heavy aspirin use	[]	[]

MUSCULOSKELETAL	YES	NO
Stiffness	[]	[]
Arthritis	[]	[]
Joint pain/swelling	[]	[]

SKIN	YES	NO
Rash/sores	[]	[]
Lesions	[]	[]
Hives/eczema	[]	[]

NEUROLOGICAL	YES	NO
Seizures	[]	[]
Weaknees/paralysis	[]	[]
Numbness	[]	[]
Tremors	[]	[]
Dementia	[]	[]

IMMUNOLOGICAL	YES	NO
Hives	[]	[]
Itching	[]	[]
Runny Nose	[]	[]
Sinus pressure	[]	[]