OREGON TRAIL EYE CENTER, PC

PATIENT INFORMATION *Please PRINT In BLACK Ink*

Patient ID# _____

Patient's Name: _____ (First / Initial / Last) **Date of Birth:** _____ **Age:** _____

Social Security #: _____ **Sex:** ◯M ◯F **Marital Status:** ◯Married ◯Single ◯Divorced ◯Widowed

Mailing Address: _____ **City, State, Zip:** _____

E-mail Address: _____ **County:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

May we leave a message at your home or cell number? **Yes** ◯ **No** ◯

Occupation: _____ **Employer:** _____ **Phone:** _____

Referring Physician: _____ **Personal/Family Physician:** _____

Spouse's Name: _____

RESPONSIBLE PARTY INFORMATION *(If different than above)*

Responsible Party: _____ **Patient Relationship:** _____

Date of Birth: _____ **Social Security #:** _____

Address: _____ **City, State, Zip:** _____

Employer: _____ **Phone:** _____

EMERGENCY CONTACT *Please give name and phone number of a friend or relative that does not live at your present address.*

Name: _____ **Phone:** _____

Relationship: _____

Person(s) with who(m) we may share your healthcare information: _____

PRIMARY INSURANCE

Insurance Name: _____

Subscriber Name: _____

Subscriber ID#: _____

Date of Birth: _____

_____

Group Number **Certificate Number**

SECONDARY INSURANCE

Insurance Name: _____

Subscriber Name: _____

Subscriber ID#: _____

Date of Birth: _____

_____

Group Number **Certificate Number**

Insurance Authorization and Assignment **(PLEASE READ)**

I authorize Oregon Trail Eye Center, P.C. to provide any applicable personal or medical health care information contained in my records for treatment, account balance resolution and other healthcare operations to appropriate agencies, including collection agencies, insurance companies and third party payers.

I request that payment of medical benefits be made on my behalf to the Oregon Trail Eye Center PC for any services provided to me by Shawna R. Collier,MD, Keegan A. Harkins, MD, Brian L. Colburn, OD, and/or Jared Smedley, MD. I authorize any holder of medical information about me to release to the Health Care Financing Administration or other Health Care Organizations and it's agents any information needed to determine their benefits. I understand that if the balance is my responsibility.

I authorize treatment of the person named above, I CERTIFY THAT I AM THE PATIENT OR LEGAL GUARDIAN OF THE PATIENT, and agree to pay all fees and charges for such treatment. I agree to pay all charges shown by statements promptly, unless credit arrangements are made. I am responsible for all charges regardless of insurance coverage, and all proceeds of insurance are assigned to this office where applicable. All past due accounts will be charged 10% interest per year. The above information is for the purpose of extending credit and is warranted to be true.

X_____ **X**_____

Patient / Responsible Party Signature **Date**

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OREGON TRAIL EYE CENTER, PC

Patient Name: **DOB:**

Past Medical History

*Are you or have **ever** you been treated for:*

Diabetes	Y	N
High Blood Pressure	Y	N
Heart Disease (MI, irregular beat)	Y	N
Lung Disease (Asthma, COPD)	Y	N
GI/Colitis/Liver Disease	Y	N
Neuro Disease/Stroke	Y	N
Vascular Disease	Y	N
Arthritis	Y	N
Cancer	Y	N
Bleeding Disorder/Anemia	Y	N
HIV/AIDS/STD	Y	N
Kidney Disease/Dialysis	Y	N
Thyroid Disease	Y	N
High Cholesterol	Y	N

Past Surgical History:

Please list all past surgeries and/or injuries:

Oral Medications, including vitamins

Please list all medications; name, dosage, frequency:

(Use separate sheet of paper if needed)

Food, Drug, Other Allergies: *(Use separate sheet of paper if needed)*

Eye Disease/Surgery

Do you have or have you been treated for:

Retinopathy (Diabetes, Hypertension)	Y	N
Macular Degeneration	Y	N
Macular Edema	Y	N
Macular Hole	Y	N
Retinal Vein Occusion	Y	N
Vitreous Floaters	Y	N
Vitreous Hemorrhage	Y	N
Retinal Tear	Y	N
Retinal Detachment	Y	N
Cataract	Y	N
Glaucoma	Y	N
Infection	Y	N
Inflammation	Y	N
Strabismus/Amblyopia	Y	N
Dry Eyes	Y	N
Corneal Disease	Y	N

Other:_____

If yes, please explain (treatment, duration, surgery):

Eye Medications - *Please list name, dosage, frequency:*

(Use separate sheet of paper if needed)

Family and Social History - Do **any** medical or eye diseases run in your family? If Yes, please list & explain:

History of Tobacco use? Y N Type?_____ How Much? _____ Age quit?_____

Did you have the Influenza Vaccine this flu season (October 1st - March 31st)? Y N

Have you (in your lifetime) had pneumococcal vaccine? Y N

Have you had two or more falls in past year or any fall with injury in the past year? Y N

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Visual Assessment

Patient Name:_____ DOB: _____ Date:_____

1. **Does your vision with glasses make it a problem for you to:**

(Select only one description from each row)

	Not at all	Somewhat	A lot
A. Read Traffic signs	○	○	○
B. Drive during the daytime	○	○	○
C. Drive at night	○	○	○
D. See steps or curbs	○	○	○
E. Read labels on medicine bottles	○	○	○
F. Read a magazine/newspaper/book/phone	○	○	○
G. Watch television/use computer	○	○	○
H. Do household chores or hobbies (cooking, cleaning, sewing, cards, fine handiwork, etc)	○	○	○

2. **How much are you bothered by the following:**

(Select only one description from each row)

	Not at all	Somewhat	A lot
A. Walking outside on a sunny day	○	○	○
B. Driving towards the sun	○	○	○
C. Driving toward oncoming headlights (glare)	○	○	○
D. Seeing halo's around lights	○	○	○
E. Seeing in poor or dim light	○	○	○

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FINANCIAL POLICY

Thank you for choosing OTEC for your eye care. We are committed to providing you with high quality and technologically advanced care.

1. Registration: All patients must complete our patient information form to facilitate communications and billing. We must obtain a copy of your driver's license, or photo ID, and valid insurance card(s). Failure to provide OTEC with current patient or insurance information, may result in the patient being responsible for the balance of a claim.

2. Insurance: Your insurance benefit is a contract between you and the insurance company; we are not a party to that contract. Knowing your insurance terms, including deductibles, copays, coinsurance, and maximum out-of-pocket amounts, as well as your benefits, including covered and noncovered services, is your responsibility. We participate in many insurance plans to facilitate payment for our patients.

3. Patient payment: All copayments and deductibles are to be paid at the time of service.

4. Insurance Claims: The Assignment of Benefits (AOB) allows us to submit, make corrections to, and receive payment for, your insurance claims. Please be aware that the balance of your claim is your responsibility, whether your insurance company pays or not. You will receive a monthly statement of any self-pay balance that is due upon receipt. Any account balance over 90 days will be subject to review for collection action.

5. Uninsured patients: We offer a 10% discount to our uninsured patients when the charges are paid in full at the time of service. Otherwise, you will receive a monthly statement that is due upon receipt. Partial payments will not be accepted unless otherwise negotiated. Any account balance over 90 days will be subject to review for collection action.

6. Collection: Please be aware that accounts deemed uncollectible by OTEC will be sent to a collection agency.

I have read and understand the financial policy and agree to abide by its guidelines.

Patient Name:

X_____ Date:

Signature of patient or responsible party including relationship

OREGON TRAIL EYE CENTER, PC

Authorization to Release Information to Family, Friends, or Legal Representative

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

This Authorization to Release Information is for:

_____

Patient's Name Date of Birth Medical Record Number

I authorize Oregon Trail Eye Center to release my records and any information requested to the following individuals:

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____
3. _____ Relation to Patient: _____
4. _____ Relation to Patient: _____

_____ I DO NOT wish to disclose my information to anyone.

Authorization Regarding Messages
(*Please check any that apply*)

_____ I authorize you to leave a detailed message on my home or cell number regarding appointments

_____ I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information

_____ I authorize you to leave a message with anyone who answers the phone

_____ Messages may only be left with _____

_____

Patient's Signature Date

_____

Parent/Legal Guardian/P.O.A. Signature Date

PRINT

Medicare Secondary Payer Questionnaire

(Short Form)

The information contained in this form is used by Medicare to determine if there is other insurance that should pay claims primary to Medicare.

1. **Are you receiving benefits from any of the following programs?**

   Black Lung ☐ YES (Long form Part I) ☐ NO
   Research Grant ☐ YES (Long form Part I) ☐ NO
   Veteran Affairs ☐ YES (Long form Part I) ☐ NO

2. **Was illness/injury due to a work related accident/condition?**

   ☐ YES ☐ NO

   If **YES,** answer the following:
   ☐ Work related accident (complete Part I of long form).
   ☐ Non-work related accident (complete Part II of long form).

3. **Is the patient currently employed?**

   ☐ YES (answer next question) ☐ NO

   Do you have group health plan (GHP) coverage? If yes, are there under or over 20 employees?
   ☐ OVER (Long form Part IV) ☐ UNDER

4. **Is the patient's spouse currently employed?**

   ☐ YES (answer next question) ☐ NO

   Does your spouse have group health plan (GHP) coverage? If yes, are there under or over 20 employees?
   ☐ OVER (Long form Part IV) ☐ UNDER

5. **Is the patient entitled to Medicare benefits as a result of:**

   Age _____

   End Stage Renal (Kidney) Disease? ☐ YES (Long form part VI) ☐ NO

   Disability? ☐ YES (Long form part V) ☐ NO

6. **Are you currently a patient in a skilled nursing facility such as a nursing home? (Long form not required, ALERT: If yes bill SNF not Medicare)**

   ☐ YES ☐ NO

I confirm that the above information is correct.

Patient Name: _____ Date: _____

Patient Signature: _____

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/msp105c03.pdf