THANK YOU FOR CHOOSING

LEVIN LUMINAIS CHRONISTER EYE ASSOCIATES

WELCOME TO OUR PRACTICE. WE LOOK FORWARD TO SERVING YOU.

LAST_____FIRST_____MI_____

ADDRESS _____

CITY_____ STATE_____ ZIP_____

EMAIL ADDRESS_____ DATE OF BIRTH_____

PHONE(S) Home _____ Work _____Cell _____

Please circle the number you wish us to use as your primary phone

SS#_____ OCCUPATION_____

RACE ☐American Indian ☐Asian ☐Black/African American
☐White ☐Native Hawaiian/Pacific Islander ☐Other

ETHNICITY ☐Hispanic/Latino ☐Not Hispanic/Latino

FAMILY PHYSICIAN NAME_____

CONTACT PERSON (Relative/Friend)_____ PHONE_____

How did you hear about our practice? Relative/Friend Family Physician Optometrist
Internet Other _____

In an effort to serve our patients in a more timely and efficient manner, Levin Luminais Chronister Eye Associates has an online patient portal with Follow My Health.

As part of our commitment to quality of care and in compliance with new federal regulations, the patient portal can provide you with timely access to a current report of your eye health. You can also communicate securely with your doctor regarding your vision care, office visits and medications.

To receive an invitation to join our portal, please email your name and date of birth to info@lleaeyes.com. You must use the email invitation to join; you cannot sign up independently.

All copays are due at the time of service.

Medical History Form

Patient name: _____**Occupation:** _____
Email Address: _____
Family Physician (Name and Phone): _____

Drug allergies: None Other:_____

Do you have now or have you ever had:		**Comment:**
Skin problems like eczema or psoriasis	YES ____NO ____	_____
Problems with your hearing	YES ____NO ____	_____
Breathing problems like asthma or emphysema	YES ____NO ____	_____
High blood pressure/heart problems	YES ____NO ____	_____
Heart problems/surgery	YES ____NO ____	_____
Stomach or acid reflux problems	YES ____NO ____	_____
Kidney/bladder/prostate problems	YES ____NO ____	_____
Muscle or joint pain/arthritis	YES ____NO ____	_____
Neurological/headache	YES ____NO ____	_____
Headaches/migraines	YES ____NO ____	_____
Diabetes – date of onset: _____	YES ____NO ____	_____
Treatment: Diet Controlled _____ Oral medications ____ Insulin ____		
Thyroid problems	YES ____NO ____	_____
Blood problems like anemia	YES ____NO ____	_____
High cholesterol	YES ____NO ____	_____
Depression or anxiety	YES ____NO ____	_____
Seasonal/environmental allergies	YES ____NO ____	_____
Infectious disease like HIV or Hepatitis	YES ____NO ____	_____
Cancer -location: _____ year: _____	YES ____NO ____	_____
Treatment: Chemotherapy ____ Surgery ____ Radiation _____		
Head/eye trauma	YES ____NO ____	_____
Major surgeries or hospitalizations	YES ____NO ____	_____

Please explain: _____
_____

Do you smoke? Never Former Current **Drink alcohol?** Yes No Social

Current Medications (name and dosages): ***please use other side for additional medications***

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Current Eye Medications:

1. _____
2. _____
3. _____
4. _____

Over the Counter Preparations (vitamins etc)

1. _____
2. _____
3. _____
4. _____

Preferred Pharmacy Name and Address _____

Patient Responsibility

I understand and agree that I am financially responsible for all charges for any and all services rendered. This includes any medical service or visit, routine examination, refraction, testing, contact lens services and any other screening ordered by the doctor or staff.

I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.

I understand and agree that it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full.

I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered.

I agree to inform the office of any changes in my insurance coverage. If my insurance has changed or is terminated at the time of service, I agree that I am financially responsible for the balance in full.

If I am a Medicare patient, I understand that I need to provide the office both my Medicare ID card and my secondary ID card. If the office does not have the proper information for a secondary insurance, the secondary will not be billed. It will be my responsibility to pay the balance and then file a claim with the secondary for reimbursement.

I have received and/or been given the opportunity to review Levin Luminais Chronister Eye Associates' Notice of Privacy Practices.

_____ _____ _____

Printed Patient Name (and Guardian Name if applicable) Signature Date

_____

LLCEA/PS Witness

Our office does not make the rules. They are determined by your specific medical insurance or vision plan.

Levin Luminais Chronister Eye Associates

Dedicated to Excellence in Eye Care Since 1977

It is important that you read and acknowledge our Policies and Procedures in full.

Policies and Procedures

Payment in full for services and products are due at the time services are performed or products are ordered. As the patient/guarantor, you are financially responsible for any fees and costs associated with any services or products you receive from our office. This includes any medical service or visit, routine examination, testing, contact lens services and any other screening ordered by the doctor or staff.

Co-payments will be collected at the time of service. Professional fees, services fees, co-payments and deductibles are NOT refundable. There will be a $20 fee for returned checks.

As the patient/guarantor, it is your responsibility to know your insurance benefits and to provide our office with accurate and current insurance information. If your specific insurance plan requires a referral, it is your responsibility to obtain the referral from your primary care physician. If you arrive for an appointment without a referral on file, you have the option to reschedule the appointment or to pay in full for all services rendered.

If you are a Medicare patient with a secondary insurance to your Medicare plan, it is your responsibility to provide both insurance identification cards. If the office does not have the proper information for a secondary insurance, the secondary will not be billed.

We will bill your insurance as applicable, however, you are ultimately liable for any fees and costs not covered or paid by your insurance. Questions about non-payment should be directed to your insurance company.

If you are unable to keep your scheduled appointment, we ask that you give adequate notice (24 hours when possible, or prior to appointment time on the same day in an emergency situation) so that we may open your reserved time for another patient. If you miss two appointments without prior cancellation, you will be required to pay a $35 deposit prior to scheduling further appointments. This is a good-faith deposit to reserve your appointment time. When the appointment is kept, this $35 fee will be applied to your office visit fees or refunded as appropriate. If the appointment is missed without proper notice of cancellation, the deposit becomes non-refundable.

Medical vs. Vision Insurance

Medical Insurance: when a medical condition exists such as (but not limited to) cataracts, glaucoma, dry eyes, diabetes, high blood pressure, or any other condition related to the health of the eye, it will be necessary for the doctor to perform a full and comprehensive ocular health exam. This exam may include further testing beyond the scope of a routine eye exam. With a medical diagnosis, your exam and testing will be billed to your medical insurance and you will be responsible for any co-pays, deductibles and/or co-insurance as dictated by your specific plan. If you are diabetic, your exam will be billed to your medical insurance without exception.

Vision Care Insurance: vision coverage for a routine examination is designed to provide a screening evaluation of the eye to determine a prescription for glasses only. This evaluation is not a comprehensive ocular health examination and excludes any testing to diagnose, evaluate and follow medical issues. This evaluation also does not include a contact lens evaluation or any fees associated with contact lenses.

Refractions: a refraction is the portion of the examination process wherein the doctor or technician places various lenses in front of your eyes to determine your best corrected vision for your spectacle prescription. This service is considered to be a non-covered service by Medicare and most secondary insurance plans. The fee for this service is $40 and is collected when a refraction is performed whether or not you have had a change in your prescription. A spectacle prescription is valid for two years from the date of the refraction; you will need to have refractions as part of your exam in order to maintain a current prescription.

Contact Lenses: contact lens services are considered to be elective and therefore not covered by medical insurance, and often not covered by vision insurance. A contact lens prescription is valid for one year from the date of issue. In order to maintain a current contact lens prescription, you must have annual contact lens evaluations with your doctor. Payment for a contact lens evaluation, whether performed independently or as part of your comprehensive eye exam, is expected at the time of service. A separate contact lens agreement will be signed prior to a contact lens fitting or refitting.