

Welcome! We thank you for choosing us as your eye care provider!! We take great pride in providing thorough eye exams along with exceptional customer service.

Below are a few suggestions that we ask you to read before your visit to ensure that it is as efficient as it can be:

- We ask that you fill out and bring with you the three-page “Welcome to Office Form and Lifestyle Questionnaire” along with signing the “Insurance Policies” form before your visit. Please arrive 15 minutes prior to your appointment.
- Please bring the following if applicable:
 - ❖ Medical and vision cards
 - ❖ Medication list
 - ❖ Current contact lens information, including current case and solution
 - ❖ Any drops you now use (prescription and over-the-counter)
 - ❖ Current eyeglasses
 - ❖ Prescription and nonprescription sunglasses
 - ❖ Previous records
- Please be reminded that minors must be accompanied by their legal guardian.
- Find out the specifics of your insurance benefits. If you are coming in for a medical reason, we will bill your medical insurance. We can also assist with referrals, if needed.
- Please be aware that most of our communication will be by email and/or text.

If you have any questions, please do not hesitate to contact us by phone or email!

We look forward to serving your future eye care needs.

Sincerely,

Dr. Paist and the Staff at Limerick Eye Associates, PC

Date: _____

Welcome to Our Office!!

Mr. Mrs. Dr. Miss Ms. Rev.

Patient's name _____

Preferred Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____

Preferred Way To Be Contacted (Please Mark) Cell Work Home

Email Address _____

Can we leave personal/medical information on a voicemail/answering machine or with a family member? Y N

Are there any family members that you allow us to discuss your personal information with? Please list name (s).

How did you hear about our office? (See below)

Insurance Word of Mouth Internet Physician Referral Family Member(s) Come Here

CareCredit West-Mont Soccer Sponsorship Walking By

If you did an internet search, what words did you use? _____

If you were referred, whom may we thank? _____

Please list any other family members that come here _____

Occupation _____

Name of employer _____

(Please See Other Side)

Do you have any of the following: Y (Please Circle Below) N

Cataracts / Glaucoma/ Lazy Eye/ Macular degeneration / Diabetes/ High blood pressure/Allergies/Dry Eyes

Any immediate family members(parents, grandparents, siblings) have the following: Y (Please Circle Below) N

Glaucoma / Macular degeneration / Lazy Eye/ Diabetes

Any injuries or surgeries to your eyes? Y N Describe_____

Do you smoke? Y N

Are you currently pregnant or nursing? Y N

List any other medical/eye health problems_____

Current List of Medications including drops (Both prescribed and Over-the Counter)

Family physician_____ Date Last Seen_____

Previous eye doctor_____ Date Last Seen_____

Allergies to any medications, drops or contact lens solutions? Y N (List)_____

Do you presently wear glasses? Y N How old are the glasses?_____

Do you wear glasses for driving? Y N

Are you planning on purchasing new glasses today? Y N Only if there is a change

Do you presently wear contact lenses? Y N If no, have you ever worn contacts? Y N

As a contact lens wearer, do you have eyeglasses? Y N

Are you interested in wearing contact lenses? Y N

Are you interested in LASIK? Y N

Do you have vision care insurance? Y N Name_____

Do you have medical insurance? Y N Name_____

Please note:

Insurance may cover none or only part of your fees. If we do not accept direct payment from your insurance plan, you will pay our office at the time of service and submit your receipt for reimbursement to your insurance company. If your insurance does not pay as expected, you are ultimately responsible for all charges. We cannot be responsible if you are not eligible for benefits. We will be happy to assist you with your claims. Please give any forms to the receptionist. If referred to a third-party collection agency, you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

I acknowledge that I have been offered and read the *Notice of Privacy Practice* from Limerick Eye Associates, PC.

Signature:_____ Date:_____

Are you signing as a parent or legal guardian? Y N Please print name:_____

Insurance Policies

Limerick Eye Associates, PC participates with most major medical insurances and vision plans. We do our best to verify all copays, coinsurances and deductibles prior to your appointment. However, what we find out is not always a guarantee of payment until the explanation of benefits comes back from your insurance company. Some insurance companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any balances not paid by your insurance company. All copays, coinsurances and deductibles will be collected at the time of the visit.

Optometry is in the unique position in that we participate with both medical and vision insurances. We will ask to make a copy of any insurance cards that you may have to keep on file.

Vision insurance is typically used for “wellness” visits and for materials such as eyeglasses and contact lenses. It does not cover any medical decision-making as it related to your ocular and systemic health.

Medical insurance is used for any visits that involve medical decision-making. Most visits will fall under this category.

- ❖ Many patients come in without any complaints, however sometimes it isn't until we do a thorough history and exam that we uncover some chief complaint that the patient forgot to mention or felt it wasn't important to bring up. This is the perfect example in which the patient was coming in “routinely” but really this visit would be billed medically.
- ❖ Prior patients that have any medical diagnosis on file will be billed medically such glaucoma, dry eyes, macular degeneration, cataracts etc.
- ❖ Patients that come in with a systemic condition that may have an effect on their ocular health such as diabetes will be billed medically.

Your medical insurance will also be billed for any procedures done in the office such as fundus photography, optical coherence tomography, automated visual field testing, visually evoked potential testing etc. There must be a medical diagnosis that supports the medical necessity of the procedure(s). Please ask the front desk for all codes that you may be coming back for so that you are prepared to call your insurance about coverage prior to your next visit.

Your signature below indicates understanding and agreement with our insurance policies as stated above and that you remain liable for payment of all service/procedures provided by Limerick Eye Associates, PC along with collection fees for any past due and unpaid amounts.

Patient Name _____

Signature _____ Date: _____

Are you signing as a parent or legal guardian? Y N

Please print name: _____