August OPTICAL
EXPERT EYECARE SINCE 1970

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. if you have any questions we'll be glad to help you. We look forward to meeting your eye care needs with professional vision care.

A PATIENT INFO

Date: _____

Time: Mr. Mrs. Dr. Miss Ms. Rev.

Name: _____

Address: _____

_____
City State Zip

Sex: ☐ M ☐ F Age: _____ Birthdate: _____

Patient SS# _____

Occupation: _____

If Student, Grade and School: _____

Hobby: _____

Employer: _____

Spouse's Name: _____

Reason for Eye Exam: _____

_____

_____

Whom may we thank for referring you? _____

B INSURANCE

Who is responsible for this account? _____

Relationship to Patient: _____

Vision Insurance Co: _____

Policy # / Group # _____

Is patient covered by additional insurance? ☐Yes ☐No

Subscriber Name: _____

Birthdate: _____ SS# _____

Relationship to Patient: _____

Medical Insurance Co. _____

Policy # / Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. August Krym's all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges wether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

I WILL PAY my portion today by:

☐ Cash ☐ Check ☐ Credit Card

C PHONE NUMBERS

Home: _____ Work: _____ Ext _____ Spouse's Work: _____

Best time and place to reach you: _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household)**:**

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

D EYE HEALTH HISTORY

Are you interested in laser vision correction? ☐Yes ☐No

Date of last eye exam: _____

Name of doctor: _____

Do you wear glasses? ☐Yes ☐No

How old are they? _____

Do you wear contacts? ☐Yes ☐No

Type: _____ Hours/Day: _____

How old are they?

Check to indicate if any of the following apply to your eyes:

Headaches	☐Yes	☐No
Blurred Vision - distance	☐Yes	☐No
Blurred Vision - near	☐Yes	☐No
Burning, stinging, itching eyes	☐Yes	☐No
Watering eyes	☐Yes	☐No
Dry eyes	☐Yes	☐No
Red or bloodshot eyes	☐Yes	☐No
Seeing halos, floaters, spots, or light flashes	☐Yes	☐No
Dimness of Vision or loss of vision	☐Yes	☐No
Difficulty with night vision	☐Yes	☐No
Eye strain or pain	☐Yes	☐No
Double vision	☐Yes	☐No
Light sensitive	☐Yes	☐No
Twitching eyelid	☐Yes	☐No
Poor Vision	☐Yes	☐No

E HEALTH HISTORY

Physician's Name:_____ Date of last visit:_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following. Also place a mark to indicate if blood relative has had any of the following.

	Yourself		Family Members	
AIDS/HIV	☐Yes	☐No	☐Yes	☐No
Arthritis	☐Yes	☐No	☐Yes	☐No
Artificial Heart Valve	☐Yes	☐No	☐Yes	☐No
Artificial Joints	☐Yes	☐No	☐Yes	☐No
Asthma	☐Yes	☐No	☐Yes	☐No
Bleeding	☐Yes	☐No	☐Yes	☐No
Blindness	☐Yes	☐No	☐Yes	☐No
Cancer	☐Yes	☐No	☐Yes	☐No
Cataracts	☐Yes	☐No	☐Yes	☐No
Chemical Dependency	☐Yes	☐No	☐Yes	☐No
Diabetes	☐Yes	☐No	☐Yes	☐No
Drug Sensitivity	☐Yes	☐No	☐Yes	☐No
Emphysema	☐Yes	☐No	☐Yes	☐No
Epilepsy	☐Yes	☐No	☐Yes	☐No
Eye Surgery	☐Yes	☐No	☐Yes	☐No
Glaucoma	☐Yes	☐No	☐Yes	☐No
Hay Fever	☐Yes	☐No	☐Yes	☐No
Heart Condition	☐Yes	☐No	☐Yes	☐No
Hepatitis (Type _____)	☐Yes	☐No	☐Yes	☐No
High Blood Pressure	☐Yes	☐No	☐Yes	☐No
Kidney Disease	☐Yes	☐No	☐Yes	☐No
Lazy Eye	☐Yes	☐No	☐Yes	☐No
Lupis	☐Yes	☐No	☐Yes	☐No
Migraine Headaches	☐Yes	☐No	☐Yes	☐No
Pacemaker	☐Yes	☐No	☐Yes	☐No
Poor Color Vision	☐Yes	☐No	☐Yes	☐No
Retinal Disease	☐Yes	☐No	☐Yes	☐No
Rheumatic Fever	☐Yes	☐No	☐Yes	☐No
Shingles	☐Yes	☐No	☐Yes	☐No
Skin Conditions	☐Yes	☐No	☐Yes	☐No
Stroke	☐Yes	☐No	☐Yes	☐No
Thyroid Conditions	☐Yes	☐No	☐Yes	☐No
Tuberculosis	☐Yes	☐No	☐Yes	☐No
Turned Eye	☐Yes	☐No	☐Yes	☐No

Are you pregnant? _____ Number of children:___

Tobacco use: _____ Alcohol use: _____

MEDICATIONS

List medications you are currently taking, including eye drops:

_____

_____

_____

_____

Pharmacy Name: _____

Phone: _____

ALLERGIES

List your allergies to medications or other substances:

_____

_____

_____

_____

_____

_____

F MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. August Krymis for any services furnished me by that doctor, I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved health claim forms or electronically submitted claims, my signiture authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the determination of the Medicare carrier.

_____ Signature of Beneficiary

_____ Date

The following August Optical Privacy Notice describes how your medical information may be used and disclosed, and how you can get access to this information. Effective December 12, 2002 until further notice.

- ·Your confidential healthcare information may be released to other healthcare professionals within the organization, to your insurance provider, to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence, to other healthcare providers, to a public health organization or federal organization in the event of a communicable disease or to report a defective device or untoward event to a biological product (food or medication)
- ·Your confidential healthcare information may be released to other healthcare providers in the event you need emergency care.
- ·Your confidential healthcare information may be released only after receiving written authorization from you. You may revoke your permission to release confidential healthcare information at any time.
- ·You may be contacted by August Optical to remind you of any appointments, healthcare treatment options or other health services.
- ·You have the right to restrict the use of your confidential healthcare information. However, August Optical may choose to refuse your restriction if it is in conflict of providing you with quality healthcare or in the event of an emergency.
- ·You have the right to receive confidential communication about your health status.
- ·You have the right to amend your protected healthcare information.
- ·You have the right to know who has accessed your confidential healthcare information and for what purpose.
- ·August Optical is required by law to protect the privacy of its patients.
- ·August Optical reserves the right to make changes to this notice and continue to maintain the confidentiality of all healthcare information.
- ·You have the right to complain to August Optical if you believe your rights to privacy have been violated. All complaints will be investigated. Please mail your complaint to: August André Krymis, Jr. August Optical, 4425 West Main, Kalamazoo, Michigan 49006.
- ·I acknowledge and authorize the use of my signature on all insurance claims.
- ·I acknowledge consent to your disclosures of my healthcare information, which you deem necessary in connection with my treatment, and to secure payment.
- ·I acknowledge while August Optical does verify patient benefit coverage; this is not a guarantee of payment. Final determination is made at the time the claim is submitted. I assign directly to August Optical Medical all insurance benefits. I am responsible in full for any balance my insurance does not pay.

I WILL PAY my portion today by: ☐Cash ☐Check ☐Credit Card

MEDICARE ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN). MEDICARE does not pay for everything, even some care that you or your healthcare provider want. we expect MEDICARE will pay for the medical portion of the examination, if you have medical eye condition symptoms.

☐OPTION ONE I want the examination & eyeglasses. I will pay the REFRACTION portion not covered by MEDICARE.

☐OPTION TWO I don't want the examination & eyeglasses. I only want to know if i have a condition that can be billed to MEDICARE. I understand with this choice I am not responsible for payment, of the REFRACTION, only that portion MEDICARE does not pay.

A REFRACTION TO DETERMINE IF YOUR COMPLAINT IS A MEDICAL CONDITION OR A NEED FOR GLASSES NOT COVERED BY MEDICARE OR SOME PRIVATE INSURANCES. AS A COURTESY, IF YOU PAY FOR THE REFRACTION PORTION TODAY. WE CAN DISCOUNT YOUR COST TO $25.00. IF YOU WISH US TO BILL YOU FOR THIS. YOU WILL NOT BE ELIGIBLE FOR THE DISCOUNT AND WILL BE REQUIRED TO PAY THE FULL $40.00. SOME INSURANCES PAY FOR THE REFRACTION BUT NOT THE MEDICAL PORTION OF YOUR VISIT. AS A COURTESY, IF YOU PAY FOR THE MEDICAL PORTION OF THE EXAMINATION TODAY, WE CAN DISCOUNT YOUR COST EVEN IF YOU HAVE NO INSURANCE. YOU WILL BE TOLD THE AMOUNT DUE PRIOR TO SEEING THE DOCTOR, SO YOU CAN DECIDE.

Office policy: cancellations left on the answering machine must be 24 hours in advance, or you will not be given future appointments. This allows your appointment time to be given to patients who are waiting. You must provide all insurance information and your insurance card at each visit. You must know and pay your co-payment at every visit. If you do not pay your co-payment at your visit, your account will be charged ten dollars to cover additional paperwork to bill you. We submit all claims on your behalf to your insurance company. You are responsible for all charges not covered by your insurance. You are responsible for the advice given to you by your doctor and for follow up visits.

Patient signature or for dependant Date