THE EYE CENTER

Julie M. Sturm, MD
Daniel J. Watson, MD
Thomas E. Stickel, OD
Mark J. Reddan, OD

Patient Name: _____

Appointment Date: _____ **Time:** _____

Physician: _____

Office Location:

Florissant
900 N Hwy 67
Florissant, MO 63031
Ph: 314-838-0300
Fax: 314-838-4682

St. Peters
4750 Mexico Road, Suite 200
St. Peters, MO 63376
Ph: 636-441-1200
Fax: 636-442-5014

Welcome to the Office of the Eye Center, Inc.

Our health team is dedicated to providing you and your family with the best possible medical treatment. With your understanding, improved health carte is a goal we can all achieve.

Appointments

The office is open from 8:00 AM to 5:00 PM Monday through Friday. Patients are seen by appointment only. We will try to honor your scheduled appointment time because we value your time. Please understand that medical emergencies do occur, and in these circumstances we ask for your consideration. If you cannot keep an appointment, we ask that at least 24 hours be given to the office. This makes it possible for us to give that appointment time to another patient.

Registration

Please complete the Patient Registration forms prior to your first visit. It is important that the information you provide be accurate since we will rely on this date to diagnose and treat you. Please advise us whenever there is a change of address, telephone number or insurance coverage.

Please bring this completed paperwork, insurance card(s), a current medication list, your eyeglasses and/or contact lenses, an insurance referral from your primary care doctor if needed, and co-pays if applicable. Your eyes may be dilated during the exam, so you may want to plan on having someone with you to drive home.

Thank you,
The Doctors and Staff of The Eye Center, Inc.

THE EYE CENTER

Today's Date: _____

Prefix Mr. Mrs. Miss Ms. Dr. Preferred Name:

Patient's Name:

First *Middle* *Last*

Address

Street & Apt # *City* *State* *Zip*

SS#: Birthdate: Age: Sex:

Marital Status: Married to: ☐Other:

Home Phone: Cell Phone: Work Phone:

Emergency Contact: Relationship to Patient: Phone:

Preferred Pharmacy: Phone:

Street Name / City / State / Zip

Patient's Employer: Occupation:

Ethnicity: Language:

Race: Email:

How did you hear about us? ☐Friend ☐ Insurance ☐Internet ☐Other Details:

Referring Doctor: Primary Care Doctor:

INSURANCE INFORMATION

Primary Insurance: **ID #:** **Group #:**

Insured: DOB: SS #:

Relationship to the insured: ☐Self ☐Child ☐Spouse ☐Other

Secondary Insurance: **ID #:** **Group #:**

Insured: DOB: SS #:

Relationship to the insured: ☐Self ☐Child ☐Spouse ☐Other

Vision Insurance: **ID #:** Group #:

Insured: DOB: SS #:

Relationship to the insured: ☐Self ☐Child ☐Spouse ☐Other

PLEASE SEE REVERSE SIDE TO COMPLETE

WE ACCEPT ASSIGNMENT ON PART B MEDICARE PATIENTS. YOU WILL BE EXPECTED TO PAY YOUR DEDUCTIBLE AND 20% COINSURANCE. WE WILL ONLY FILE TO ONE SECONDARY POLICY.

MEDICARE AUTHORIZATION

I understand that my signature requests 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 claim forms or electronically submitted claims, my signature authorizes the release of medical 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 the uncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Name: _____ *Date:* _____

Signature: _____ *Medicare Policy #:* _____

FINANCIAL CONTRACT / RELEASE OF INFORMATION / CONSENT TO TREAT AGREEMENT

The Eye Center, Inc. is committed to your successful treatment. Please understand that payment of your account is considered a part of your treatment. If you do not have your current insurance card at the time of service, you will be treated as a "self pay" patient.

- All co-pays are due prior to seeing the physician (we accept Cash, Checks, MasterCard, Visa, Discover and American Express).
- All "self pay" patients are asked to pay this visit fee in full at the time of service unless other prior arrangements are made.
- All patients covered under an HMO plan must have a valid referral at the time of their visit.
- The adult accompanying a minor and/or guardians of the minor are the responsible party for payment of the account.
- **Refractions are not covered by Medicare or most insurances. The $50 fee is due at the time of the visit.**
- Once per calendar year we assess a contact lens evaluation fee (often covered by vision plans).

I authorize the use of this form on all insurance submissions and authorize release of information needed to process a claim to my insurance companies and permit a copy of this authorization to be used in place of the original. I authorize the provider to act as my agent in obtaining payment from my insurance companies, but understand the provider is not responsible for collecting my insurance claims or for negotiating a settlement on disputed claims. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand it is my responsibility to know my insurance benefits and that I will receive a monthly statement for any balance due by me. All returned checks will be assessed a $30 fee.

Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and medically necessary under the Medicare program and/or other medical insurance coverage. We are not liable for any misquoted benefit information. **You are fully responsible for verifying the benefits of your policy.**

I consent to the medical and surgical care as deemed advisable by my physician.

I understand and agree to the Agreement as stated above:

Initials: _____ *Date:* _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES / WRITTEN ACKNOWLEDGMENT FORM

I have received a copy of The Eye Center Notice of Privacy Practices. I give my permission to discuss my medical condition with the following family members:

☐ Spouse _____

☐ Other family members (please list & state relationship):_____

_____

Patient Name (please print):_____

Signature: _____ *Date:* _____

The above authorizations are valid for one year from date signed unless retracted in writing by the patient

GOLTSCHMAN STURM EYE CENTER

Initial Visit Health History

Name: «Person_First_Middle_Last»
DOB: «Person_Birth_Date»

Please
- No food or drinks past the front lobby
- No cell phone ringers or phone conversations in the building
- No false eyelashes (must be removed or visit rescheduled)

History of Eye Health

Most recent eye exam:_____

Circle any of these you use:

Reading Glasses Bifocals No-Line Bifocals Contact Lenses

Circle any problems seeing:

Newspaper/Books Computer TV Driving Driving at Night

Circle any symptoms you are experiencing:

Blurry Vision Burning/Itching Light Sensitivity Tearing/Watery Eyes

Mucous in/around Eyes Redness Scratchy/Gritty Eyes Fluctuating Vision

Circle the conditions you have been diagnosed with:

Cataracts Diabetic Eye Problems Dry Eyes Glaucoma Macular Degeneration

Other:_____

Circle any procedures you have had:

LASIK/PRK Cataract Surgery Injections in Retina Laser Treatment in Retina

Other:_____

History of General Health

Most recent physical:_____

Circle conditions you have been diagnosed with or are receiving treatment for:

Type 1 / 2 Diabetes (HbA1C or Average AM Blood Sugar_____ / Year Diagnosed___)

Heart Disease High Blood Pressure High Cholesterol Congestive Heart Failure

Stroke/TIA (what year?_____) Pacemaker Thyroid Disease

COPD/Emphysema Lung Cancer BPH/Prostate Cancer Breast Cancer

Rheumatoid Arthritis Lupus Sjögren's Syndrome HLA-B27+

History of General Health (continued)

Do you use tobacco? Never Used to Sometimes Daily

Have you had a flu shot in the last year? Yes No

Have you ever had a pneumonia shot? Yes No

Family Health History

Does/did your Grandparents, Mother, Father, Sisters or Brothers have:

Cataracts Glaucoma Macular Degeneration Retinal Detachment Corneal Disease

Other Eye Problems:_____

Cancer Diabetes Thyroid Disease High Blood Pressure Stroke/TIA

Medications/Allergies

Medication	*Dose*

Allergy	*Reaction*