KAPOLEI EYE CARE 674- CARE (2273)
579 Farrington Hwy, 101 www.KapoleiEyeCare.com

Account Holder Financial Responsibility (PLEASE READ AND SIGN)

Initial

1. I understand that I will be responsible for all known patient portions and non-covered services on the day of my visit. I understand that the collected amount is an **ESTIMATE ONLY** and that the correct amount will not be known until you bill my insurance. Any other charges that I am responsible for will be mailed to me after my insurance pays, or collected from me upon my next visit.

Initial

2. I understand that if I am covered under **HMSA QUEST, Medicaid or Aloha Care** it is my responsibility to make sure that I did not use my benefits for an eye exam and glasses for that year. If my benefits have been exceeded, I understand that I will be responsible for the whole amount due.
   I also understand that I am responsible to obtain referrals from my Primary Care Physician. If that is not obtained prior to my visit, I will have to reschedule my appointment until the referral is received.

Initial

3. I understand that Kapolei Eye Care will make an effort to verify eligibility with my insurance plan(s), but ultimately, it is my responsibility to know the benefits of my own plan(s).

Initial

4. I understand that if I am part of a Union (ex: Carpenters, Painters…) payment(s) will be collected in full from me for all services, whether for exam or appliances and I will be reimbursed accordingly. It will be my responsibility to verify that I am eligible for any type of appliances for that year. (Union insurances are not allowed to disclose that information to providers, but only to the members)

Initial

5. I understand that it is my responsibility to inform Kapolei Eye Care of any insurance change(s) throughout the year. If no updates are received from me on a timely matter, I understand that my insurance may reject/deny my claim(s) due to “timely filing deadline exceeded” and that I will be responsible for the whole amount owed.

Initial

6. I understand that there are non-covered services and taxes that my insurance may not cover at all and payment for these services are my responsibility. (ex: **Refraction--**determination of the power of my eyes to correct my vision with glasses or contact lenses, and **Contact Lens Fitting—**the fitting of contacts over the cornea, by determining the base curve, shape, and diameters, etc). These procedures are not covered by Medicare and many other insurance plans. Charges determined by my insurance to be my responsibility thereafter will be billed to me.

Initial

7. I understand that it is my responsibility to pay for all deductibles and patient portions on the day of services. I understand that Kapolei Eye Care is unable to accept payment plans except on emergency cases. Self-pay patients paying for services in full today may receive a discount off the visit, which must be paid in whole. Kapolei Eye Care accepts all major credit cards (except American Express), checks, debit cards, money orders, and Care Credit. There will be a $ 25.00 service charge for all returned unpaid checks. In the event of default, I promise to pay legal interest (35%) on the debts, together with such collection costs and reasonable attorney fees as may be required to affect collection of this note.

While the filing of insurance claims is a courtesy that we extend to our patients, some charges such as deductibles and copayments are your responsibility. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we ask that you contact us promptly for assistance with the management of your account.

AUTHORIZATION:

I certify that the information I have provided to Kapolei Eye Care is true and correct. I acknowledge that I’ve read the above information. Further, I understand that I am responsible for payment of all charges for services and items provided. I understand that this is an open-end agreement.

I authorize release of any information from my files including, but not limited to, my medical and financial records necessary to process my insurance claim(s) and request payment of insurance benefits to either myself or the party who accepts assignment/participation with my insurance company.

____________________	____________________	____________
Signature of Patient or Legal Guardian	**Print Patient Name**	**Date**
Print name of parent or legal guardian	**Relationship to Patient**	

Welcome to Kapolei Eye Care…. ☐NN Paper Acct #:________________

PLEASE COMPLETE ALL PORTIONS OF THIS FORM (FRONT & BACK) AS BEST AS YOU CAN

Patient Information (Please give your picture ID to the receptionist to scan)

Last Name: ________________ First Name: ________________ M. I. : ________

Gender: ☐MALE ☐FEMALE Marital Status: ☐SINGLE ☐MARRIED ☐WIDOWED ☐DIVORCED ☐OTHER

Birthdate: ________________ Social Security #: ________________ (REQUIRED for electronic claims filing)

Address: ________________________________
(P.O. Box or Street Name, City, State, and Zip Code)

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

Primary Care Physician: ________________ Optometrist: ________________

How did you hear about our office? ________________

Email address: ________________

In case of an emergency, whom may we contact? ________________

Relationship to Patient: ________________ Contact Number: ________________

Employer Information

Employer: ________________ Job Position: ________________

Employer Address: ________________

☐Employed Full Time ☐Employed Part Time ☐Self-Employed ☐Retired ☐Unemployed ☐Student Full Time ☐Student Part Time

Responsible Party (Person responsible for bill(s). If patient is under age 18, this part MUST be filled out parent/guardian)

Person Responsible for Payment: ________________ Relationship to Patient: ________________

Birthdate: ________________ Social Security Number: ________________

Address: ________________

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

Insurance Information (Please give your insurance card(s) to the receptionist to scan)

Primary Insurance: ________________ Subscriber: ________________

Patient's Relationship to the Subscriber: ☐SELF ☐SPOUSE ☐CHILD ☐PARTNER ☐OTHER: ____________

Subscriber ID #: ________________ Subscriber's Birthdate: ________________

Secondary Insurance: ________________ Subscriber: ________________

Patient's Relationship to the Subscriber: ☐SELF ☐SPOUSE ☐CHILD ☐PARTNER ☐OTHER: ____________

Subscriber ID #: ________________ Subscriber's Birthdate: ________________

Tertiary Insurance: ________________ Subscriber: ________________

Patient's Relationship to the Subscriber: ☐SELF ☐SPOUSE ☐CHILD ☐PARTNER ☐OTHER: ____________

Subscriber ID #: ________________ Subscriber's Birthdate: ________________

FOR OFFICE USE ONLY

☐Info Entered On:________________ By:____________

☐Scanned by: ________________ On: ____________

Medical History Record

Name: ____ Date: ____________________

Review of Systems: Do you have problems with any of these systems? If "YES", please check box.

☐ Fever
☐ Weight Loss (rapid loss or gain)
☐ Ear/Nose/Throat
☐ Cardiovascular (chest pain, poor circulation, etc)
☐ Respiratory (cough, shortness of breath)
☐ Gastrointestinal (vomit, diarrhea,heart burn,cramp)
☐ Genital Urinary (urine or bowel problem)
☐ Musculoskeletal (joint pain, muscle pain)
☐ Skin (rash, dryness)
☐ Neurological
☐ Psychiatric (anxiety, depression, etc.)
☐ Endocrine (thyroid, hormonal changes)
☐ Other: ______________________________

Do you have any allergies? ☐ No ☐ Yes (If "yes", please list below) :

____

Please check "YES" or "NO"

Do you smoke? ☐ NO ☐ YES How much? ____________________
Do you drink alcohol? ☐ NO ☐ YES How much? ____________________
Do you use illegal drugs? ☐ NO ☐ YES How much? ____________________

Do you take any medications? ☐ No ☐ Yes (please list below)

Name of Medication	Reason for use	How often taken?

Family History: Do you have family history of any of the following? If "YES", please check box.

☐ Diabetes ☐ Glaucoma ☐ High Blood Pressure ☐ Macular Degen. ☐ Retinal Detachment
☐ Cataracts ☐ Hypertension ☐ Blindness ☐ Cancer ☐ Heart Disease/Stroke

Personal Eye Information:

Have you had any eye operations? ☐ NO ☐ YES, Type: ____________________
Have you had any eye injuries? ☐ NO ☐ YES, Type: ____________________
Do you wear glasses? ☐ NO ☐ YES, How old are they? ____________________
Do you wear contact lenses? ☐ NO ☐ YES, Type: ____________________
Any other eye conditions? ☐ NO ☐ YES, Type: ____________________
Are you pregnant? ☐ NO ☐ YES, How far long? ____________________

Kapolei Eye Care HIPAA Authorization for Use or Disclosure of Health Care Information

By signing this form, I, ____, authorize the use and disclosure of health information as described below:

- **Description of information:** Submission of health and personal information to all insurance companies involved in the payment of the office visit or any other entity responsible for the payment of the visit.
- **Name or class of person(s) authorized to make the used or disclosure:** Any office employee directly involved in the care or claim submission to the insurance companies. Other(s): Please list… (eg: Primary Care Physician, mother, father, caregiver, etc.)

____

- **Date or event when authorization expires:** 10 (ten) years from the date of this signed document.
- **Description of each purpose of the requested use or disclosure:** Obtain payment from insurance companies, pre-authorization and post-authorization reviews.

I understand that I have the right to revoke this authorization, in writing, at any time, except (1) where uses or disclosures have already been made base upon my original permission, or (2) the authorization was obtained as a condition securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back. To revoke this authorization, I must do so in writing and send it back to: **NANCY CHEN, M.D., dba KAPOLEI EYE CARE at 579 FARRINGTON HWY #101, KAPOLEI, HI, 96707.**
I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and no longer protected by the Federal Privacy Standards.

______________________________ ____________________
SIGNATURE **DATE**

If signing as a personal representative of the patient, describe your relationship to the patient and the source of authority to sign this form:

______________________________ ____________________
RELATIONSHIP TO PATIENT **PRINT NAME**

Source of Authority: ______________________________

KAPOLEI EYE CARE

Nancy Chen, M.D.

579 Farrington Hwy #101
Kapolei, HI 96707
Phone: (808) 674-2273 Fax: (808) 674-2552

Contact Lens Consent Form

____________________________________,
(Patient Name)

This consent is to make you aware of our policies regarding fitting contact lenses.

1. **Contact Lens Fitting** is not covered by most insurance, because it is cosmetic. (You will be responsible for the fitting fee that can vary from $50 to $120 depending on your eyes needs). Fees includes up to 3 trials, additional charges will apply if more trials are needed.
   For patients that have VSP (Vision Service Plan), please initial this line if you would like us to bill your contact lens fees to VSP, this will use your benefit allowance for glasses or contact lenses. _________ (initials)

2. If Dr. Chen examines your eyes and she finds something wrong with them, she may bill your Medical Insurance for your visit.

3. Payments should be made when services are rendered.

By signing below, I, ___________________, understand the above policies of Kapolei Eye Care.

____
PATIENT and/or GUARDIAN SIGNATURE DATE

____
NANCY CHEN, MD DATE