Welcome to Kapolei Eye Care

☐NN Paper **Acct#:** _____

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

PATIENT INFORMATION (Please provide your picture ID to the receptionist to scan)

Last Name: _____ **First Name:** _____ **M.I.:** _____

Nickname: _____ **Gender:** ☐Male ☐Female **Marital Status:** ☐SINGLE ☐MARRIED ☐WIDOWED ☐DIVORCED

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

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____
(P.O. Box or Street Name)

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

PREFRERRED PHONE NUMBER TO CONTACT YOU: ☐Home ☐Work ☐Cell

Primary Care Physician: _____ **Optometrist:** _____

How did you hear about our office? _____

Email address: _____ **May we contact you through email?** ☐Yes ☐No

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

Relationship to patient: _____ **Contact Number:** _____

EMPLOYER INFORMATION

Employer: _____ **Job Position:** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____
(P.O. Box or Street Name)

☐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 18, this part MUST be filled out by a parent/guardian)

Person Responsible for Payment: _____ **Relationship to Patient:** _____

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

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____
(P.O. Box or Street Name)

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

INSURANCE INFORMATION (Please give your insurance card(s) to the receptionist to scan)

Primary Insurance: _____ **Subscriber Name:** _____

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

Subscriber ID#: _____ **Subscriber's Birthdate:** _____

Secondary Insurance: _____ **Subscriber Name:** _____

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

Subscriber ID#: _____ **Subscriber's Birthdate:** _____

Tertiary Insurance: _____ **Subscriber Name:** _____

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

Subscriber ID#: _____ **Subscriber's Birthdate:** _____

FOR OFFICE USE ONLY

☐Info entered on: _____ by: _____ ☐Akamai entered on: _____ by: _____

☐Scanned by: _____ on: _____

MEDICAL HISTORY RECORD

Patient's Name: _____ Date: _____

HISTORY OF PRESENT ILLNESS

What are you coming in for today? (please state duration and frequency of problem)

_____

MAJOR ILLNESSES

Have you had any surgeries? ☐NO ☐YES (please list below):

_____

Do you have any history or have been diagnosed with any of the following? If YES, please check box.

☐Diabetes ☐High Blood Pressure ☐Glaucoma ☐Macular Degeneration ☐Retinal Detachment

☐Cataracts ☐Blindness ☐Cancer ☐HIV/AIDS ☐Heart Disease/Stroke

Last blood pressure reading? _____ Last A1C reading? _____

Do you take any medications? ☐NO ☐YES (please list below):

Name of Medication	Reason for use	Frequency

Do you have any allergies? ☐NO ☐YES (please list below):

_____

OCULAR SURFACE DISEASE

Have you had any of the following symptoms? If YES, please check box.

☐Itchy Eye ☐Red Eyes ☐Watery Eyes ☐Swollen Eyes ☐Dry Eyes ☐Foreign Body Sensation

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: _____

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 problems) ☐Musculoskeletal (joint pain, muscle pain) ☐Skin (rash, dryness) ☐Neurological

☐Psychiatric (anxiety, depression, etc.) ☐Endocrine (thyroid, hormonal changes) Are you pregnant? ☐NO ☐YES If YES, how many weeks? _____ ☐Other: _____

FAMILY HISTORY

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

☐Diabetes ☐High Blood Pressure ☐Glaucoma ☐Macular Degeneration ☐Retinal Detachment

☐Cataracts ☐Blindness ☐Cancer ☐HIV/AIDS ☐Heart Disease/Stroke

SOCIAL HISTORY

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? _____

The U.S. Census Bureau is asking all medical offices to collect demographics from all patients.

Preferred Language _____

RACE (please check all that apply)

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White
- ☐ Hispanic or Latino
- ☐ Declined To Specify

☐ Other Race(s) _____

ETHNICITY

☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Unknown

COMMUNICATION PREFERENCE

- ☐ Phone
- ☐ E-mail
- ☐ Letter
- ☐ All of the above
- ☐ Declined

PLEASE READ CAREFULLY

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.

WE WILL NOT RELEASE YOUR PERSONAL HEALTH INFORMATION TO ANYONE WITHOUT YOUR CONSENT.
Please list anyone you would like to authorize release of your Personal Health Information to below:
(ex: mother, father, legal guardian, caregiver, etc.)

_____

- **Date or event when authorization expires**: Indefinite from the date of this signed document.
- **Description of each purpose of the requested use or disclosure**: Obtain payment from the 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 based upon my original permission, or (2) the authorization was obtained as a condition in securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that the use and disclosures already made based upon my original permission cannot be taken back. To revoke the authorization, I must do so in writing and send it to: **Nancy Chen, M.D., dba Kapolei Eye Care, at P.O. Box 75625, 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. I may receive a copy of the full HIPAA disclosure for review upon my request.

Signature of Patient or Legal Guardian _____ **Date** _____

If signing for a minor or as a legal representative:

Print Name _____ Name of Patient _____

Relationship & Authority *(parent, legal guardian, power of attorney, etc.)* _____

PUPIL DILATION CONSENT

Dilation drops are used to dilate or enlarge the pupils of the eye to allow your Optometrist/Ophthalmologist a better view of the inside of your eye. **You will only be dilated if your doctor finds it necessary for further treatment. You have the right to refuse dilation, but it is required for certain tests and to complete full eye exams.**

Dilation of the pupils will cause temporary blurry vision and some light sensitivity. It is not possible for your doctor to predict how much your vision will be affected. Therefore, we advise caution in operating any equipment or machinery, including driving, until the effects of the drops have worn off. Adverse reactions, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I, _____, authorize dilation drops to be used from this day forward in the treatment and management of my eye health.

Date or event when authorization expires: Indefinite from the date of this signed document.

Signature of Patient or Legal Guardian _____ **Date** _____

If signing for a minor or as a legal representative:

Print Name _____ Name of Patient _____

Relationship & Authority *(parent, legal guardian, power of attorney, etc.)* _____

ACCOUNT HOLDER FINANCIAL RESPONSIBILITY (PLEASE READ CAREFULLY)

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 AlohaCare 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.

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, etc.) payment(s) will be collected in full from me for all services, where for exam or appliances and 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 allows to disclose that information to providers, only to 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 manner, 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 my 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 the deductibles and patient portions on the day of the 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 VISA, MasterCard, debit cards, money orders, personal check, and CareCredit. There will be a $25 service charge for all returned 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 deductible 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-ended 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 part who accepts assignment/participation with my insurance company.

Signature of Patient or Legal Guardian _____ **Date** _____

If signing for a minor or as a legal representative:

Print Name _____ Name of Patient _____

Relationship & Authority *(parent, legal guardian, power of attorney, etc.)* _____