EYE PHYSICIANS
OF LAKEWOOD

Welcome to Eye Physicians of Lakewood!

Please bring the following items to your appointment:

1. Completed forms
2. Insurance card, ID card, and Co-pay (if applicable)
3. Current medication list
4. Any eye drops that you use
5. Eyeglasses
6. Referral-Authorization from your PCP, if needed
7. Interpreter, if needed

Based upon WA Department of Health guidance for healthcare facilities, we are still requesting that patients wear masks to their appointments. We will have masks available.

Thank you, and we look forward to meeting you!

5920 100TH ST. SW, SUITE 8,
LAKEWOOD, WA 98499
P: 253-584-1777 • F: 253-584-0645
EYEPHYSICIANSOFLAKEWOOD.COM

EYE PHYSICIANS OF LAKEWOOD

MEDICAL HISTORY

NAME: _____ OCCUPATION: _____

AGE: _____ WHAT RACE DO YOU IDENTIFY YOURSELF? _____

PLEASE LIST CURRENT MEDICATIONS, EYE MEDICATIONS FIRST: _____

_____

PLEASE LIST ANY MEDICINES TO WHICH YOU HAVE ALLERGIES: _____

_____

PLEASE LIST ANY OTHER MAJOR DISEASES YOU HAVE: _____

_____

SYSTEMIC REVIEW OF SYSTEMS

DO YOU HAVE:	Y	N
HIGH BLOOD PRESSURE	☐	☐
DIABETES	☐	☐
LUNG DISEASE SUCH AS ASTHMA	☐	☐
HEART DISEASE	☐	☐
INFECTIOUS DISEASES SUCH AS HIV OR HEPATITIS	☐	☐
AUTOIMMUNE DISEASES SUCH AS LUPUS	☐	☐
MAJOR SKIN DISEASES SUCH AS ACNE ROSACEA	☐	☐
NEUROLOGIC DISEASES SUCH AS STROKE	☐	☐
CANCERS	☐	☐
HAVE YOU HAD ANY SEIZURES?	☐	☐

OCULAR HISTORY

DO YOU HAVE:	Y	N
EYE INJURIES?	☐	☐
EYE DISEASES?	☐	☐
EYE SURGERY (LIST BELOW OR ON BACK)?	☐	☐
EYE MEDICATIONS (LIST BELOW OR ON BACK)?	☐	☐
DO YOU WEAR CONTACT LENSES?	☐	☐

REVIEWED BY: _____ CHECK HERE IF USED BACK OF SHEET ☐

PATIENT MEDICAL HISTORY INTAKE 08 2015 PQRS COMPLIANT

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PATIENT REGISTRATION

NAME: _____

BIRTH DATE: _____ AGE: _____ SSN: _____

(CIRCLE) MALE / FEMALE MARRIED / SINGLE / WIDOWED / DIVORCED / SEPARATED

HOME ADDRESS: _____

MAILING ADDRESS: _____

PHONE NUMBERS: **HOME** _____ **WORK** _____

EMPLOYER: _____

PCP/REGULAR DR: _____ PHONE NUMBER: _____

PRIMARY INSURANCE COVERAGE

RELATIONSHIP TO PATIENT: **(CIRCLE)** SELF / SPOUSE / PARENT NO INSURANCE COVERAGE ☐

NAME OF INSURANCE: _____ ID#: _____

SUBSCRIBER'S NAME: _____

SUBSCRIBER'S DOB: _____ SSN: _____ **(CIRCLE)** M / F

SECONDARY INSURANCE COVERAGE

RELATIONSHIP TO PATIENT: **(CIRCLE)** SELF / SPOUSE / PARENT NO SECONDARY COVERAGE ☐

NAME OF INSURANCE: _____ ID#: _____

SUBSCRIBER'S NAME: _____

SUBSCRIBER'S DOB: _____ SSN: _____ **(CIRCLE)** M / F

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Consent to Use or Disclose Health Information for Treatment, Payment, and Health Care Operations

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office.

We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail. You are free to refer to this Notice at any time before you sign this consent document. Our Notice of Privacy Practices will be updated whenever our privacy practices change.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform health care operations. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent. We can decline to serve you if you elect not to sign this consent form.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment, or health care operations, but as described in our Notice of Privacy Practices, we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for a restriction.

I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

_____ _____

Signature of Patient or Authorized Representative | Date

_____ _____

Print Name | Relationship to Patient (if applicable)

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If you wish to have your medical information, any diagnostic test results and/or financial information released to anyone other than yourself, please indicate authorized individuals below. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

1. _____ Relation to Patient:_____

2. _____ Relation to Patient:_____

3. _____ Relation to Patient:_____

4. _____ Relation to Patient:_____

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Patient Financial Responsibility Form

Thank you for choosing Eye Physicians of Lakewood (EPOL) as your eye care provider. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- You are responsible for the payment of your treatment and care.
- If the patient is a minor, then as the patient's guardian you are ultimately responsible for payment of the minor's treatment and care, even if you are not the carrier of your child's insurance policy.
- If you have insurance, we will attempt to bill your insurance for you. However, for every visit, you are required to provide correct and updated information regarding insurance.
- You are responsible for payment of:
    - Co-payments
    - Co-insurance
    - Deductibles
    - All other procedures or treatments not covered by your insurance plan
- Co-payments are due at the time of service.
- Co-insurance, deductibles, and non-covered items are due in a timely manner or incur additional collection fee for past due accounts.
- If you do not have insurance, you are responsible for payment for your treatment and care. Payments made on the day of service may be eligible for a same day pay discount.
- If you are here for a Workers' Compensation visit, you must provide appropriate employer and billing information for use to process the claim. Without this information, we will consider payment for the visit to be your responsibility.
- You may incur, and are responsible for payment of additional charges, if applicable.

By my signature below, I hereby acknowledge that I understand that I am responsible for full payment (less any adjustments that EPOL is contractually required to make) within 30 days of receipt of my statement. I understand that I am financially responsible for charges not covered by my insurance.

I have read, understand, and agree to the provisions of the Patient Financial Responsibility Form.

_____ _____

Name of patient (please print) **Date**

_____

Signature of patient or guardian

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