ABESSI EYE CARE & SURGERY

Welcome to Abessi Eye Care & Surgery!

Our mission at Abessi Eye Care & Surgery is to provide exceptional medical and surgical eye care services that are personalized to you. Whether you are here for a routine exam or a surgical consultation, our primary focus is to address your visual needs and form a treatment plan to help improve your eyesight.

For your first visit, please **review and complete** the following forms:

1. Patient and health information forms
2. Financial policy form
3. HIPAA release form
4. Notice of privacy practice

Please bring the completed forms to your office visit OR email them to info@abessieye.com prior to your visit.

Please make sure you **bring**:

1. Insurance card(s) - Medical and/or Vision
2. Your most recent eyeglasses
3. Details of your current contact lens prescription (including brand, base curve, and diameter). Can be actual box or photo.
4. A referral from your primary doctor (if required)

Please be aware that a refraction service is not always covered by insurance companies and is an additional fee if not covered. In addition, contact lens evaluations are not covered by insurance and are an additional fee. Further information is detailed in our financial policy.

We look forward to meeting you and providing high quality eye care!

Sincerely,

Dr. Bryan Abessi & Staff

ABESSI EYE CARE & SURGERY

Patient Information

Last Name: _____ First Name: _____ MI:_____

Sex: ☐ M ☐ F Date of Birth: _____ Age: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell Phone #: _____

Work Phone #: _____ Email: _____

Preferred Method of Contact: ☐ Home Phone ☐ Cell Phone ☐ Email
Consent to text: ☐ Yes ☐ No (for automated text messages)
Consent to calls: ☐ Yes ☐ No (for automated calls)

Primary Language: _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ White ☐ Other ☐ Unknown

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Employer Name: _____ Occupation: _____

Spouse Name/Parent Name if minor: _____

Emergency Contact: _____ Phone #: _____ Relationship:_____

Insurance

Primary Insurance: _____ Policy#: _____ Group #: _____

Policy Holder: _____ DOB of Policy Holder: _____ SSN: _____

Relationship to patient: ☐ Self ☐ Parent ☐ Spouse ☐ Other

Do you have a separate vision plan? ☐ Yes ☐ No If yes, which one: _____

Secondary Insurance: _____ Policy#: _____ Group #: _____

Policy Holder: _____ DOB of Policy Holder: _____ SSN: _____

Relationship to patient: ☐ Self ☐ Parent ☐ Spouse ☐ Other

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Health Information

Primary Care Physician: _____ Phone #: _____

Referring Physician Name: _____ Phone #: _____

Pharmacy Name: _____ Phone #: _____

Pharmacy Address: _____

Medical History

Do you wear glasses? ☐ Yes ☐ No Have you had LASIK or PRK? ☐ Yes ☐ No

Do you wear contact lenses? ☐Yes ☐ No If Yes, please list brand, base curve (B.C.), & power:

Brand: _____ Right Eye: _____ Left Eye: _____

Patient's Eye Conditions: (check all that apply)

☐ Amblyopia ("Lazy Eye")
☐ Cataracts
☐ Corneal Dystrophy
☐ Dry Eye Syndrome
☐ Keratoconus
☐ Glaucoma
☐ Diabetic Retinopathy
☐ Macular Degeneration

List Current Eye Drop Medications:

Other: _____

Patient's Medical Conditions: (check all that apply)

☐ Asthma
☐ Diabetes
☐ High blood pressure
☐ Heart disease
☐ Stroke
☐ Rosacea
☐ Cancer (type:_____)
☐ Thyroid disorder
☐ Sleep Apnea
☐ Rheumatoid Arthritis
☐ Lupus
☐ Currently Pregnant/Nursing
☐ Hepatitis C
☐ HIV
☐ Seasonal Allergies
☐ Multiple Sclerosis
☐ Pacemaker/Defibrillator
OTHER:_____

Patient's Surgical History:

_____

_____

Family History: Please check if a blood relative has had any of the following conditions?

Glaucoma		Thyroid Disorder	
Macular Degeneration		Heart Disease	
Keratoconus		Autoimmune conditions	
Diabetes		Blood Disorders	
Retinal Detachment		Other	

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Please list any medications you take, prescribed or over the counter:

MEDICATIONS			
MEDICATION NAME	**REASON**	**MEDICATION NAME**	**REASON**

Any Allergies? _____

Tobacco Use: Do you smoke? ☐ Yes ☐ No
If yes, how many cigarettes per day: _____ # of years smoking: _____

Alcohol Use: Do you drink alcohol? ☐ Yes ☐ No

Review of Systems

		Yes	No			Yes	No
Constitutional	Headache			**Neurologic**	Numbness		
	Fever				Seizures		
	Nausea				Dizziness		
	Vomiting				Weak limbs		
Cardiovascular	Chest pain			**Gastrointestinal**	Diarrhea		
	Palpitations				Constipation		
Respiratory	Cough			**Endocrine**	Excessive thirst		
	Wheezing				Fatigue		
	Shortness of breath				Excessive hot/cold		
Musculoskeletal	Joint pain			**Hematologic**	Easy bleeding		
	Back pain				Swollen glands		
Skin	Rash			**Allergy**	Runny Nose		
	New skin lesions				Itching		
EYE SYMPTOMS		**Yes**	**No**			**Yes**	**No**
Blurred Vision				Double vision			
Eye Discharge				Eye redness			
Eye Dryness				Eye tearing			
Loss of vision				Flashes of light /floaters			
Glare and halos				Light Sensitivity			

I authorize the release of any medical information necessary to process all claims and I authorize the release of payment for medical benefits to my provider at Abessi Eye Care & Surgery LLC.

_____ _____

Patient/guardian signature **Date**

ABESSI EYE CARE & SURGERY

FINANCIAL POLICY

- It is your responsibility to notify Abessi Eye Care & Surgery LLC of your insurance coverage and any changes to your insurance information or demographics prior to the date of service.
- It is your responsibility to verify that the physician is under contract with your insurance plan.
- Co-pays, deductibles, coinsurances, and any non-covered services must be paid for at the time of service and are the patient's financial responsibility. If you are self-pay or a member of a plan that we do not participate in, payment is due at the time of service. Payment can be made in cash, personal check, or credit card.
- You are responsible to obtain a referral **before** you arrive for your appointment if your insurance carrier requires a referral.
- **REFRACTION** is a test to determine the patient's best visual acuity. Medicare and many medical insurance carriers consider refraction to be a non-covered service. You are responsible for any **non-covered services**, which may include the office fee for refraction of **$50**.
- A contact lens evaluation may be required for a contact lens prescription. Contact lens evaluations and fittings are not covered by insurance and you will be required to pay at the time of service.
- For Workers' Compensation and motor vehicle accidents, you are responsible for submitting bills to your insurance company. You are responsible for any bills not paid in full within 30 days.
- If you fail to make payments in a timely manner, you may be referred to an outside collection agency. Outstanding account balances after 90 days of service may be referred to a collection agency and you will be responsible for all costs of collection monies owed.
- Returned checks will be subject to an additional fee of $25.

I have read the Financial Policy and agree to the terms and conditions set forth above.

_____ _____

Patient/guardian signature **Date**

ASSIGNMENT OF BENEFITS:

I authorize that payment of medical benefits be made to my provider at Abessi Eye Care & Surgery LLC for professional services rendered. I authorize the release of any information to my insurance carrier needed for payment. This assignment of benefits will remain in effect until revoked by me in writing.

_____ _____

Patient/guardian signature **Date**

ABESSI EYE CARE & SURGERY

HIPAA Acknowledgment & Consent Form

Patient Name: _____ Date of birth: _____

You have the right to read our Notice of Privacy Practices, which describes how we may use and disclose your protected health information.

I have received and understand the Notice of Privacy Practices and by signing below, I am giving my consent to use my protected health information as stated.

_____ _____

Patient/Legal Guardian Signature Date

HIPAA Release Form

☐ I authorize the release of my protected health information, including diagnosis, examination, and claim information to the following:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

☐ I do not authorize the release of my protected health information.

The release of information will remain in effect until terminated by me in writing.

_____ _____

Patient/Legal Guardian Signature Date