Ophthalmology, P.C.
300 N. Grandview
Dubuque, IA
52001-6397

Bryan P. Pechous, M.D.
Lucas S. Flamich, O.D.

We thank you for trusting us with your medical/ophthalmic needs and look forward to meeting you at your upcoming appointment!

We've been providing ophthalmic care to patients since 1969 and we will do our absolute best to ensure that you receive the proper care and attention that your condition requires in a friendly and welcoming environment. We have an answering service 24 hours, 7 days a week for emergencies.

If you are unable to make your appointment, we do ask for 24 hours' notice. To change your appointment, please call our office at 563-588-4675, so we may give that appointment to someone else in need.

This packet of information contains your registration/medical form, some information on our privacy practices and consent for treatment form.

Please bring these completed forms with you for your upcoming appointment.

PLEASE **ARRIVE 15 MINUTES PRIOR** TO YOUR APPOINTMENT

Appointment Date:________________________________Time:__________________AM/PM

Provider: □ Dr. Pechous □ Dr. Flamich

In addition to your completed forms, please bring:

- Medical and vision insurance cards
- Photo id
- Co-payment –due upon arrival
- List of all oral medications, eye drops, and ointments you are currently using.
- Sunglasses-You most likely will be dilated. Dilation can last up-to 4 hours.

When the receptionist takes a copy of your insurance cards, please inform us whether your insurance has medical coverage, vision coverage, or both.

<u>By giving us your email, you have secure access to your medical information.</u>

We are providers for many insurance programs. But unfortunately, not all. Your insurance is a contract between you and your insurance company. With all the different types of insurance/vision plans offered, it's important for **<u>you</u>** to call and verify your eligibility and coverage for your individual plan. Keep in mind, medical and vision insurances are separate plans and each one may have different in network providers.

We provide services directly to you and expect payment at the time of service. Our staff will kindly assist you with any questions or concerns before your appointment

We look forward to meeting you!
Sincerely,
Ophthalmology, PC

Ophthalmology, PC Patient Registration Form

(Please Print)

Patient's Last Name: First: Middle: Preferred Name:				☐ Mr. ☐ Ms. ☐Father/Rev ☐ Mrs. ☐ Dr. ☐ Sister
Social Security #:	Birth Date:	Age:	Sex: ☐ Male ☐ Female	Email Address:
Street Address:		City:		State: Zip:
P.O. Box:	Home Phone Number:		Cell Number:	Appointment Reminder: ☐ Home ☐ Cell ☐ Text
Employer:	Employer Phone Number: ( ) -		Other Family Member Seen Here:	
Occupation: ____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐Widowed	Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino; Primary Language: ☐ English ☐ Spanish ☐ Marshallese ☐ Other:		Referred By/How did you hear about us? ____ Race: ☐ White ☐ Asian ☐ Black/ African American ☐ Native Hawaiian/other Pacific Islander ☐ American Indian/ Alaska Native	

Spouse's Name:	Birth Date / /	Employer:	Social Security #: - -
EMERGENCY CONTACT			
Name:	Home#:	Cell #:	Relationship:
***COMPLETE NEXT SECTION--- ONLY IF PATIENT IS A MINOR**			
Mother's Name	Birth Date: / /	Employer:	Social Security #: - -
Father's Name	Birth Date: / /	Employer:	Social Security #: - -

INSURANCE INFORMATION

Primary Insurance: ______________________ ☐ Medical Insurance ☐ Vision Insurance Subscriber's Name:______________________ Birth Date:__________ SS#:__________

Group #:______________ Policy#:______________ Co-Pay $:__________

Patient's Relationship to Subscriber: ☐ Self ☐Spouse ☐ Child ☐ Other

Employer:______________________

Secondary Insurance:______________________ ☐Medical Insurance ☐ Vision Insurance Subscriber's Name:______________________ Birth Date:__________ SS#:__________

Group #:______________ Policy#:______________ Co-Pay $:__________

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Employer:______________________

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for all costs of treatment. I also authorize Ophthalmology, PC or insurance companies to release any medical information required to process my claims. I authorize Ophthalmology, PC for treatment.

______________________ ______________

Signature of Patient or Legally Responsible Person Date

Patient Medical History Form

(Please Print)

Patient's Last Name: First: Middle:	Birth Date:
Primary Care Physician:	Pharmacy:

Please mark either **YES or NO** if you have **EVER** had the following:

- ☐ Yes ☐ No Cataracts
- ☐ Yes ☐ No Macular Degeneration
- ☐ Yes ☐ No Crossed Eyes
- ☐ Yes ☐ No Iritis
- ☐ Yes ☐ No Cornea Disease
- ☐ Yes ☐ No Glaucoma
- ☐ Yes ☐ No Cataract Surgery (date________)
- ☐ Yes ☐ No LASIK Surgery (date________)
- ☐ Yes ☐ No Other Eye Surgery (what eye___)
- ☐ Yes ☐ No Eye Injury____________________
- ☐ Yes ☐ No Other Eye Disorder_____________
- ☐ Yes ☐ No High Blood Pressure
- ☐ Yes ☐ No Asthma, Bronchitis, Emphysema
- ☐ Yes ☐ No Kidney Disease
- ☐ Yes ☐ No Tuberculosis
- ☐ Yes ☐ No Had bad response to anesthesia
- ☐ Yes ☐ No Do you currently Smoke
- ☐ Yes ☐ No Have you ever smoked
- ☐ Yes ☐ No Diabetes (number of years_____)
- ☐ Yes ☐ No Disability__________________
- ☐ Yes ☐ No Migraines
- ☐ Yes ☐ No (Woman) Are you Pregnant
- ☐ Yes ☐ No Heart Attack
- ☐ Yes ☐ No Congestive Heart Failure
- ☐ Yes ☐ No Sickle Cell Anemia
- ☐ Yes ☐ No Head or Spinal Injuries
- ☐ Yes ☐ No Seizures, Convulsions/Fainting
- ☐ Yes ☐ No Temporal Arteritis
- ☐ Yes ☐ No Carotid Artery Disease
- ☐ Yes ☐ No Stroke
- ☐ Yes ☐ No Cancer
- ☐ Yes ☐ No Do you have a driver's license
- ☐ Yes ☐ No Sleep Apnea
- ☐ Yes ☐ No Have you ever been hospitalized
- ☐ Yes ☐ No Other:______________________

CURRENT MEDICATIONS (or bring them along)		ALLERGIES	
Medication Name:	Dosage:	Allergic to:	Reaction:

SURGICAL HISTORY and DATES	DO YOU TAKE ANY OF THE FOLLOWING
	Flomax/Tamsulosin ☐ Yes ☐ No
	Hytrin/terazosin ☐ Yes ☐ No
	Cardura/Doxazosin ☐ Yes ☐ No
	Uroxatral/Alfuzosin ☐ Yes ☐ No

FAMILY HISTORY * (What Family Member)*****

- ☐ Yes ☐ No Glaucoma__________________
- ☐ Yes ☐ No Cataracts___________________
- ☐ Yes ☐ No Cornea Disease_____________
- ☐ Yes ☐ No Macular Degeneration___________
- ☐ Yes ☐ No Retinal detachment____________
- ☐ Yes ☐ No Cancer _______________
- ☐ Yes ☐ No Heart Disease _____________
- ☐ Yes ☐ No Retinitis Pigmentosa _________
- ☐ Yes ☐ No Diabetic Retinopathy__________
- ☐ Yes ☐ No Other:______________________

_____________________________________ ____________________

Signature of Patient or Legally Responsible Person Date

Consent for Treatment, Financial Agreement & Release of Information and HIPAA

Patient:______________________________________ Date of Birth: _____________________

1. Consent for Health Care Services: I authorize consent for medical treatment at Ophthalmology, P.C.
2. Authorization for Release of Information: Ophthalmology, P.C. may release information from my medical records to any health care provider involved in my care and treatment. Ophthalmology, P.C. may also release information from my medical records to any person or organization liable for all or part of my charges, such as my insurance carrier, any third-party payer, the Medicare programs, and my employer's workers' compensation carrier. I acknowledge that upon the disclosure of medical record information to an insurance company or other payer pursuant to this authorization, Ophthalmology, P.C. is no longer solely responsible for the confidentiality of any information known or possessed by the payer.
3. Financial Agreement: I understand that there is no guarantee of payment from any insurance company or other payer. I agree to pay all charges for the services provided by Ophthalmology, P.C. which are not paid by my health insurance or other payer. All charges are due and payable when I receive the bill. If payment is not made within 90 days from the date the bill was mailed from Ophthalmology, P.C. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I understand that any credit or refund that I may be owed will be forwarded to the address on file with Ophthalmology, P.C. I understand that I am responsible for a $40.00 returned check fee in addition to any other associated bank charges. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance.
4. Pre-authorization Requirements: I accept the responsibility to obtain all referrals or pre-authorizations and to comply with all requirements of any insurance or medical coverage plan.
5. Assignment for Direct Payment: I authorize that payment of any insurance (including auto insurance and health-care insurance) benefits for health care services or goods may be made directly to Ophthalmology, P.C.
6. My signature also authorizes Ophthalmology PC and/or any entity authorized by my healthcare provider, including those using automated dialing systems, messages, email, text messaging or other electronic communication to contact me for any reason by using any telephone number, email address and/or mailing address provided by me. If an email address is not provided you are forfeiting your right to electronic continuity of care documentation and will be opted out unless you otherwise notify the office.
7. As a courtesy to you, we will submit an insurance claim for our services if you present your current health insurance card at the time of your appointment. This is not a guarantee that we have a contractual relationship with your insurance plan or that your specific insurance policy covers the services that were provided. If you do not hear from your insurance company within 30 days or you do not agree with their determination of payment, it is up to you to contact them to negotiate a solution.
8. Acknowledgment of Receiving Privacy Notice and Disclosure of "PHI" to family or friends: I hereby acknowledge receipt of Ophthalmology PC's privacy notice. Any "PHI" (protected health information) about the listed patient, should not be discussed with, or released to the following person or people:____

I acknowledge that:

- I have read this form and understand its contents.
- I am the patient, or person duly authorized either by the patient or otherwise, to sign this agreement, consent to, and accept its terms.
- I am responsible for the payment and/or co-payment that is due at the time of service.
- I have received and read the copy of Ophthalmology, PC's HIPAA Policy
- I understand it is my responsibility to contact my insurance(s) before my appointment(s) to make sure the visit(s) will be covered and that no limitations exist.
- I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

_______________________________________ _____________________

Signature of Patient or Legally Responsible Person Date