



FINANCIAL POLICY

We strongly feel all patients deserve the very best medical care that we can provide. Everyone benefits when financial arrangements are agreed upon. We have prepared this material to acquaint you with our policy. Our professional services are rendered to you, not the insurance company.

Payment for treatment is ultimately your responsibility.

Financial/insurance Agreements:

I hereby authorize the release of any information necessary to process insurance claims and request payment of benefits to be made for services rendered to me or to my dependents to Sawyer Eye Center. I understand I am responsible at the time of services for paying any required co-pay or deductible. If, after my claim has been filed, my insurance does not cover my services, I understand that I will be billed and am responsible to pay. I understand if I fail to pay amounts owed, the clinic has the right to secure an outside collection agency and/or attorney to collect the unpaid debt and to report the unpaid debt to a credit-reporting agency. I further understand that I will be responsible for any additional charges or fees necessitated by securing the collection agency or attorney, including reasonable attorney's fees. In the event I have no insurance coverage, I understand that I am responsible for payment of services rendered to me or my dependents at the time of service.

I HAVE READ AND UNDERSTAND THE PAYMENT POLICY OF THIS OFFICE AND AGREE TO ABIDE BY THE SAID POLICY. I UNDERSTAND A \$30 CHARGE WILL BE ASSESSED ON ALL RETURNED CHECKS.

_____	_____	_____
Patient/Parent/Guardian	Relationship to patient	Date

PRIVACY

Due to the Health Portability and Accountability Act (HIPAA) of 1996, the following information must be filled out by each patient.

I authorize Sawyer Eye Center to release any of my protected health information necessary to process my medical claims and coordinate/manage my healthcare.

I authorize the practice to disclose or provide my protected health information to the following individual(s). This will allow the practice to discuss my protected health information including care, treatment, and diagnosis with this (these) individual(s). If I want to limit disclosure to specific items, I can request a Limited Patient Authorization for Disclosure of Protected Health Information form from Sawyer Eye Center.

_____	Relationship _____	Phone _____
_____	Relationship _____	Phone _____
_____	Relationship _____	Phone _____

A copy of my HIPAA Patient Rights, and Privacy Notice has been given to me.

I acknowledge that I have read and understand my rights.

_____	_____	_____
Signature (Patient or Parent/Guardian if Minor)	Printed Name	Date



PRESCRIPTION POLICY

Sawyer Eye Center utilizes an Electronic Medical Records (EMR) system in our office. We have the ability to check your prescription eligibility and download your pharmacy history into our system. We can also fax “mail-order” prescriptions, review prescription benefits and drug formulary – all while you are in our office.

By signing below, you are granting Sawyer Eye Center permission to obtain this information on your behalf.

REFRACTION POLICY

What is refraction and refraction fees?

A refraction is the determination of your best corrected vision when we flip various lenses in front of your eyes and ask, “which is better 1 or 2?”. The results from the refraction may be used to prescribe new glasses. The results from the refraction are also necessary to determine whether any medical or surgical treatment may be needed for you. As an example, a refraction is used to gauge whether a cataract may be worsening, necessitating surgery. A refraction is needed to decide if an eye disease is causing your loss of vision. In other words, a refraction is used to assess the overall health of the eyes.

Why do I have to pay the refraction fee if my glasses prescription did not change?

It is impossible for us to determine whether your prescription has changed unless a refraction is done. Over time, the eye naturally changes shape and /or develops aging characteristics which can affect your glasses prescription, vision and/or some health issues related to the eye.

The refraction is an essential part of the eye examination, but unfortunately, it is NOT a covered service by Medicare and many insurance companies. Our office fee for the refraction is \$35 and this fee is collected at the time of service in addition to any co-payments, co-insurance, and deductibles. This fee is subject to change from year to year. By signing below, you agree to pay this fee at the time of service.

Signature of patient or Guarantor: _____

PRINT Patient’s Name: _____ Date: _____

Print legal Guardian’s name, if applicable _____



INFORMATION REGARDING DILATING DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of the eye. The dilating eye drops are necessary to diagnose your condition.

Dilating drops frequently blur vision for several hours, which varies from person to person and may make you much more sensitive to light. Because of this sensitivity, sunglasses should be worn when your eyes are dilated. Disposable sunglasses are available free of charge at our check-out desk.

It is not possible for your ophthalmologist to predict how much your vision will be affected. After an examination, your ability to drive safely may be impaired due to the effect of the dilating drops on your vision. Therefore, it is up to you to determine your ability to drive. You may need to make arrangements to be driven to and from your appointments.

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 have read and completely understand the above information regarding dilating eye drops. I have been advised that because my vision may be impaired, I may need to make arrangements to have someone drive me. If I choose to drive or operate machinery despite this warning, I assume full responsibility (financial and otherwise) for the consequences resulting from this choice.

I agree that my doctor, Sawyer Eye Center, PLLC, and its employees are released from all liability resulting from my driving or operating machinery while my eyes are dilated.

I hereby authorize Dr. Sawyer, and/or such assistants as may be designated by him, to administer dilating eye drops.

I understand that the use of dilating drops may be necessary to diagnose and evaluate my condition. I hereby consent to the use of dilating drops at my initial visit, and when necessary, at any future visits.

PRINTED PATIENT NAME _____ DATE _____

PATIENT SIGNATURE _____



MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Preferred Name _____ Date of Birth ____/____/____

Primary Care Physician: _____ Referring /Specialty Dr. _____

Pharmacy: _____ Location (street, city, zip) _____

Race: American Indian or Alaska Native Asian Black or African American
 Native Hawaiian or Other Pacific Islander White

Ethnicity: Hispanic Not Hispanic

Height: _____ Weight: _____

Chief Complaint: _____

Allergies:	Reaction	Severity
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe

Past Ocular History: (Please mark all that apply) No history of eye problems

Do you wear Contact Lens () Yes () No Mono Vision Contact Lens ()Yes () No

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hyperopia (Far sighted) | <input type="checkbox"/> Myopia (Near sighted) | <input type="checkbox"/> Amblyopia (Lazy eye) |
| <input type="checkbox"/> Diabetic Retinopathy | <input type="checkbox"/> Iritis | <input type="checkbox"/> Optic Neuritis | <input type="checkbox"/> Aphakia |
| <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Keratoconus | <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Astigmatism |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Macular Degeneration | | |

Other _____

Ocular Surgeries: (Please mark all that apply) No prior ocular surgery

- | R - L | R - L | R - L | R - L |
|--|--|---|---|
| <input type="checkbox"/> Foreign Body Removal | <input type="checkbox"/> Punctal Plugs | <input type="checkbox"/> Laser | <input type="checkbox"/> Cataract Surgery |
| <input type="checkbox"/> Blepharoplasty | <input type="checkbox"/> Retinal Laser Surgery | <input type="checkbox"/> RK | <input type="checkbox"/> LASIK |
| <input type="checkbox"/> PRK | <input type="checkbox"/> Vitrectomy | <input type="checkbox"/> Corneal Transplant | |
| <input type="checkbox"/> Strabismus (eye muscle) Surgery | | | |
- Other _____

Current Eye Medications: (Please list)

Other Medical History: No history of illnesses

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> COPD | <input type="checkbox"/> High Blood Pressure | |
| <input type="checkbox"/> Arthritis (rheumatoid or osteo) | <input type="checkbox"/> Diabetes Type 1 | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Diabetes Type 2 | <input type="checkbox"/> HIV/ AIDS | <input type="checkbox"/> Polymyalgia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eczema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Psychiatric Disorder |
| <input type="checkbox"/> Auto Immune disorders | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Skin Cancer |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Hepatitis A / B / C | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Herpes Zoster / Shingles | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Toxoplasmosis |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Histoplasmosis | <input type="checkbox"/> MRSA | <input type="checkbox"/> Wound Infection |
| <input type="checkbox"/> Herpes Simplex | <input type="checkbox"/> Headache | <input type="checkbox"/> Lupus | <input type="checkbox"/> Thyroid Disease |
- Cancer: If yes, what type, year of diagnosis, treatment performed, and is it active or in remission:

Other _____

General Surgeries / Operations: (Please list)

_____	_____	_____
_____	_____	_____
_____	_____	_____

All Other Medications: (Please list)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History: (Please list only ONE immediate family member with the diagnosis)

- | | | |
|--|--|---|
| <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Kidney Disease _____ |
| <input type="checkbox"/> Blindness _____ | <input type="checkbox"/> Glaucoma _____ | <input type="checkbox"/> Lazy eye _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Macular degeneration _____ |
| <input type="checkbox"/> Cataracts _____ | <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Retinal Disease _____ |
| <input type="checkbox"/> TB _____ | <input type="checkbox"/> Stroke _____ | |

Other _____

Social History: (Please mark all that apply)

- Smoking: current everyday smoker current some day smoker former smoker never smoked
- Alcohol Use: Yes No If yes how much and how often? _____
- Drug Use: Yes No If yes what and how often? _____