Patient Information & Medical History

Patient's Name:____ Date of Birth: ________________

Sex: M / F Race:____________ Ethnicity: _________ Language: __________ Soc. Sec. No.: ________________

Address:__________________________________ City:________________ State/Zip Code: ______________

Landline Phone: _____________________ Cell Phone: __________________ Work Phone: ________________

E-Mail: ____ Employer:____________________________

Spouse: ________________________ Date of Birth: _______________ Phone: ____________________

Emergency Contact: _______________ Relationship: _______________ Phone: ____________________

Referring Doctor: __________________ PCP: ___________________ Other: ______________________

Optometrist: _____________________ Last Eye Exam Date: __________

If Patient Is A Minor

Parent/Guardian Name: ____ Phone No: _________________

Date of Birth: __________ Employer: ____________________________ Email: _____________________

Consent to Text or Email for Reminders and Other Healthcare Communications

By initialing below, I agree to Des Moines Eye Surgeons communicating by SMS text message and/or email. I confirm that the mobile number is correct, and I will notify the practice of any changes. I am aware that I can withdraw consent at any time by informing the Des Moines Eye Surgeons.

Preferred Contact Method: ☐ Landline Phone Call ☐ Text Msg ☐ Email

_________ Healthcare related text messages/emails

- Appointment reminders via text message
- Due/overdue, follow-up care, recall reminders via text message/email
- Eyewear/contact lens notifications via text message/email
- Post-appointment office survey
- ASAP/move-up list via text message/email

_________ Marketing related text messages/emails

- Eyewear/optical shop discounts
- Birthday discounts

☐ I DO NOT WISH TO RECEIVE TEXT OR EMAIL REMINDERS.

Continued on Back →

REVIEW OF SYSTEMS: Do you currently have any of the following? *Check the box of those that pertain to you.*

Diabetes: ☐ Type 1 ☐ Type 2 ☐ No

☐ Diet-controlled ☐ Oral Medication-Controlled ☐ Insulin-Controlled

General: fever, fatigue, weight gain/loss, anemia, cancer	☐ Y ☐ N	**Musculoskeletal**: Muscle aches/joint pain, arthritis, gout	☐ Y ☐ N
ENT: hearing loss, sinus/throat trouble, nasal congestion	☐ Y ☐ N	**Psychiatric**: Depression, anxiety	☐ Y ☐ N
Cardiovascular: chest pain, irregular heartbeat, high blood pressure	☐ Y ☐ N	**Urinary**: Pain urinating, blood in urine, ulcer, discharge	☐ Y ☐ N
Neurological: Numbness, weakness, headaches, memory loss, epilepsy, stroke	☐ Y ☐ N	**Hematologic**: high cholesterol, anemia	☐ Y ☐ N
Gastrointestinal: heartburn, abdominal pain, diarrhea, ulcers	☐ Y ☐ N	**Endocrine/Immunologic**: Allergies, immune disorders, hypothyroidism, Grave's Disease	☐ Y ☐ N
Respiratory: Shortness of breath, asthma, emphysema, TB	☐ Y ☐ N	HIV/AIDS	☐ Y ☐ N
Skin: Rashes, psoriasis, rosacea, skin cancer, eczema	☐ Y ☐ N	Other (*list*):	☐ Y ☐ N

EYE HISTORY: *(have you been diagnosed with)*		SOCIAL HISTORY:		QUANTITY/WK:
Cataracts	☐ Y ☐ N	Caffeine	☐ Y ☐ N	
Diabetic Retinopathy	☐ Y ☐ N	Tobacco	☐ Y ☐ N	
Macular Degeneration	☐ Y ☐ N	Alcohol Use	☐ Y ☐ N	
Corneal Problems	☐ Y ☐ N	Pneumonia Vaccination	☐ Y ☐ N	
Glaucoma	☐ Y ☐ N			
Retinal Disorders	☐ Y ☐ N			

FAMILY HISTORY: *(Identify blood relatives with the following)*

Diabetes	☐ Y ☐ N	☐ Father ☐ Mother ☐ Grandparent ☐ Sibling
High blood pressure	☐ Y ☐ N	☐ Father ☐ Mother ☐ Grandparent ☐ Sibling
Stroke	☐ Y ☐ N	☐ Father ☐ Mother ☐ Grandparent ☐ Sibling
Heart Disease	☐ Y ☐ N	☐ Father ☐ Mother ☐ Grandparent ☐ Sibling
Glaucoma	☐ Y ☐ N	☐ Father ☐ Mother ☐ Grandparent ☐ Sibling
Macular Degeneration	☐ Y ☐ N	☐ Father ☐ Mother ☐ Grandparent ☐ Sibling

PATIENT'S DRUG ALLERGIES	SURGERIES/HOSPITALIZATIONS < 5 YEARS

Authorization to Disclose Protected Health Information (PHI)

I authorize Des Moines Eye Surgeons/Eye Designs' to speak to the following people regarding my health information as deemed necessary:

Spouse: ________________________________ Physicians: ______________________________________

Other: ____

This Authorization is effective through (*check one*) ☐ ____/_____/_____ or ☐ No Expiration, unless revoked or terminated by the patient or the patient's personal representative. You may revoke or terminate this authorization by submitting a written revocation to our office.

Dilating Eye Drops

Dilating eye drops are used to enlarge the pupils of the eye to allow the doctor to examine the inside of your eye. The drops frequently blur vision for a period of time and may make bright lights bothersome. Because driving may be difficult immediately after your exam, it's best to make arrangements not to drive yourself.

Lost or Stolen Items

Des Moines Eye Surgeons is not responsible for lost or stolen items left by a patient within our office.

Patient Acknowledgments

1) I hereby certify that to the best of my knowledge all the information I have furnished on these forms are complete, true and accurate.
2) I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Des Moines Eye Surgeons/Eye Designs' Notice of Privacy Practices. By signing below, I am only giving acknowledgement that I have received or have had the opportunity to receive the Notice of our Privacy Practices. Our Practice will not condition treatment, payment, enrollment, or eligibility for benefits on whether the individual signs this Authorization of Disclosure of PHI.
3) I authorize my doctor and/or such assistants to administer dilating eye drops as needed today and all future exams.
4) I agree to assign insurance benefits to Des Moines Eye Surgeons whenever applicable. I also agree I will be responsible for fees not covered by my insurance.

________________________________ ________________________________ ______________

Name of Patient/Guardian (Type/Print) Signature of Patient/Guardian Date

Medication List on Back If Needed→

MEDICATIONS: List all the medications you are currently taking

Include vitamins and supplements

Pharmacy name: _________________________________ Pharmacy address/location: _______________________________

Name of Medication	Dosage – (amount/how often)

Des Moines Eye Surgeons Financial Policy

updated 6/19/19

Your Responsibility You are financially responsible for the services we provide to you. We understand that many patients arrange for insurance companies to pay for a large portion of medical care. However, the patient (or legal guardian) is ultimately responsible for the bill if the insurance company does not pay. As a courtesy to you, we will file a claim to your primary and secondary insurance plans.

Payment of co-payments are collected at the time of check-in.

Insurance has asked that we collect the patient's out-of-pocket responsibility at the time of service. We will bill your insurance carrier for the remaining cost according to their fee schedule's allowed amount.

Be prepared to provide your current insurance information with the Check-IN Assistant. Your Check-IN Assistant will take copies of all your active medical insurance cards (primary/secondary/tertiary) and will collect any active vision plan insurance information as well. We participate with most medical insurance plans; however, we only participate with three vision plans: VSP, Avesis, and EyeMed. **Please advise us of any address, phone number or insurance changes promptly.**

If you are unsure of your financial responsibility, please contact your insurance company in advance to obtain this information. Any balance remaining after insurance has paid their covered portion will be due upon receipt of a statement.

PLEASE NOTE: If you have a medical diagnosis associated with your exam, your exam charges will be submitted to your medical insurance **AS REQUIRED**, **NOT** your vision insurance.

Medicare patients Des Moines Eye Surgeons accepts Medicare assignment. You are responsible for the applicable coinsurance, deductibles and charges for non-covered services. **Refractions are NOT covered by Medicare and some commercial carriers; therefore, a payment of $40 is included in your out-of-pocket responsibility on the day of service at CHECK-IN.** In addition to the bill we send, you should also receive an explanation from Medicare indicating how much you owe.

Patients without insurance We are pleased to be able to provide services to patients that do not have insurance. However, you will be expected to pay for all services prior to being seen per our cash-pay fee schedule.

Private insurance patients Des Moines Eye Surgeons accepts assignment for most major insurances. You will be required to pay applicable co-pay amounts at the time of service and you are responsible for any coinsurance, deductibles and for all unpaid non-covered services.

Workers compensation. Des Moines Eye Surgeons accepts workers compensation. Please contact your adjuster to obtain prior approval and a listing of approved providers.

Medicaid patients. If Des Moines Eye Surgeons participates with your Medicaid assignment, a current Medicaid card must be presented at each visit and you will be required to pay the co-pay at the time of service, if required by your plan. If you have exceeded the legislative limits for the year per Medicaid, you will be held responsible for the charges. If you have a Medicaid HMO please bring your referral from your primary care physician to see the specialist physician.

HMO patients. If Des Moines Eye Surgeons participates with your insurance, you will be required to pay the applicable co-pay at the time of requested service. When required by your HMO plan, you are responsible for obtaining a referral from your primary care physician. If you do not have a proper referral, you may be required to reschedule your appointment. If services are rendered without a valid referral authorization you will be expected to sign a waiver and be responsible for full payment.

Liability insurance. If you are involved in an accident, we will be pleased to provide medical care for you. We do not, however, file claims to third-party liability insurance plans. We will either file the claim with your personal medical insurance or we will expect your payments for all balances incurred.

Methods of payment. We accept cash, check, Carecredit, VISA, MasterCard, and Discover. We do not accept post-dated checks, nor will we hold checks for any length of time. Payment arrangements may be made as necessary by calling 515-225-3546. **Returned checks.** There will be a $25 fee assessed for any and all checks returned from your bank for any reason. **Prior balance:** Patients with a prior balance at the time of services are requested and will be asked to pay in full prior to being seen. If the balance cannot be paid in full, then you will speak with a financial counselor to make payment arrangements prior to your appointment.

Contact Lens Fittings/Rechecks: The process of measuring the curvature and size of the cornea to determine proper fit of new or existing contact lenses is called a "Fit" or "Contact Lens Recheck". There will be a fee to assess the fit of your current contact lenses or to re-fit you to a different lens. The fee is based upon the type of contact lenses required and if the patient is an established or new patient within our office.

Collection procedures. Members of our billing department are always available to help you with questions and/or payment arrangements. Once made in writing, agreements are binding. We consider payments by the patient for services to be an important part of the patient's role in the patient/physician relationship. Prompt payment for services rendered is expected and failure to comply or respond to repeated communication from our office may result in discharge from the practice and/or involvement of an outside collection agency. Once an account has been rendered to an outside agency, prior balances must be resolved before being seen by a provider.

I have read and understand the DMES financial policy. I agree to assign insurance benefits to Des Moines Eye Surgeons whenever applicable. I also agree I will be responsible for fees not covered by insurance.

____________________________	________________________________	_____________
Patient (or guardian)	Print Name	Date