Wallerich EYE CARE

Patient Information	
Name (legal name)	
Date of Birth	
Address	
City, State, Zip	
Phone	
Email	

	Vision Plan	MEDICAL POLICY
Name of Insurance	No Vision Plan	VA Community Care Network
ID (all #s/letters)		
Group #		

Primary Member's Information (Subscriber Member)	
Legal Name	
Date of Birth	
Last 4 of SS	

Primary HealthCare Provider ☐ *N/A*	
Name of Clinic	
Primary Care Provider	
Address/Location	
Telephone	
Fax	

Reason for Examination

☐ Comprehensive Eye Examination
☐ Contact Lens Evaluation/Updated Contact Lens RX
☐ Diabetic Eye Examination
☐ Office Visit (red eye, floaters, eye pain, etc.)
☐ Neuro-Optometric Evaluation
☐ Specialty Contact Lenses

Current/History of Eye Problems			
Flashes of light	☐ Yes ☐ No	***Eye strain***	■ Yes ☐ No
Floaters	☐ Yes ☐ No	***Dry eyes?***	☐ Yes ■ No
Vision loss	☐ Yes ☐ No	***Watery eyes?***	☐ Yes ☐ No
Headaches?	☐ Yes ☐ No	***Eye pain?***	☐ Yes ☐ No
Double vision?	☐ Yes ☐ No	***Itchy eyes?***	☐ Yes ☐ No
Eye turn	☐ Yes ☐ No	***Burning?***	☐ Yes ☐ No
Light sensitivity?	☐ Yes ☐ No	***Red eyes***	☐ Yes ☐ No
Other:			
Glasses wearer?	☐ Yes ☐ No		
Contact lens wearer?	☐ Yes ☐ No		
Last eye exam?	(MM/YYYY)		
Have you been dilated before?	☐ Yes ☐ No ☐ Unknown		

Medical Eye History	Self	Family ☐ N/A
Glaucoma/Glaucoma Suspect	☐ Yes ☐ No	
Cataracts	☐ Yes ☐ No	
Macular Degeneration	☐ Yes ☐ No	
Blindness	☐ Yes ☐ No	
Retinal Detachment	☐ Yes ☐ No	
Corneal Ulcer	☐ Yes ☐ No	
Past Eye Surgeries	☐ Yes ☐ No	

Medical History		Self	Family
* Check "Y" if the condition applies to you; ☐ Adopted/Unknown Fam Hx			
General	Weight change (10 lbs. in last year)	☐ Y	
	Appetite change	☐ Y	
	Pregnant/Nursing	☐ Y	
Endocrine	Type 1 Diabetes	☐ Y	
	Type 2 Diabetes	☐ Y	☐ Y ☐ N
	Hypothyroid (Low)	☐ Y	☐ Y ☐ N
	Hyperthyroid (High)	☐ Y	☐ Y ☐ N
Cardiovascular	Heart Disease	☐ Y	☐ Y ☐ N
	High Blood Pressure	☐ Y	☐ Y ☐ N
	High Cholesterol	☐ Y	
Ear, Nose, & Throat	Cold symptoms	☐ Y	
	Hearing changes	☐ Y	
Respiratory	Asthma	☐ Y	
	Loud snoring	☐ Y	
	Sarcoidosis	☐ Y	
Neurological	Headaches	☐ Y	
	Concussion	☐ Y	
	Multiple sclerosis	☐ Y	
	Epilepsy/seizures	☐ Y	
	Stroke	☐ Y	
	Alzheimer's disease	☐ Y	
Psychiatric	ADHD	☐ Y	
	Anxiety	☐ Y	
	Depression	☐ Y	
	Sleep Problems	☐ Y	
Genitourinary/ Kidney	Prostate Cancer	☐ Y	
	Kidney Disease	☐ Y	
Musculoskeletal	Arthritis	☐ Y	
	Myasthenia gravis	☐ Y	
Gastrointestinal	Colitis/Crohn's	☐ Y	
	Acid reflux	☐ Y	
Skin	Lupus	☐ Y	
	Rosacea	☐ Y	
Blood/lymph	Sickle cell disease	☐ Y	
	Bleeding disorder	☐ Y	
Allergic/Immunologic	HIV Positive	☐ Y	
	History of Shingles	☐ Y	
	Lyme's disease	☐ Y	
	Sjogren's Syndrome	☐ Y	
	Seasonal allergies	☐ Y	
Other			
List Eye Drops	☐ None		
List of ALL Medications	☐ None		
Allergies to Medications	☐ Yes ☐ No List:		
Eye Surgeries	☐ None ☐ Yes (list) -		
List of Injuries/Surgeries	☐ None ☐ Yes (list) -		
Tobacco use?	☐ Yes-current ☐ Yes - Prior ☐ No		
Do you drink alcohol?	☐ Yes ☐ No		

SECTION 1 - HIPAA PRIVACY

I understand that Wallerich Eye Care, LLC (WEC) may use and disclose necessary personal health information (PHI) to another party to permit Dr. Wallerich & his associates to perform administrative duties, provide me with eye care services and products, and to process my vision/medical benefit claims. Please notify staff if you would like a copy of "*Notice of Privacy Practices*".

SECTION 2: BUSINESS PRACTICE POLICIES

In order for WEC & third-party billing services to service my account, or to collect any amounts I may owe, I agree that I may be contacted at any phone number/address I have provided during all visits for billing and reminder/recall eye care services. **If you plan on using insurance benefits, insurance information must be presented before time of service.** If you have not presented your insurance or have any questions about co-pays or fees, please address the staff now.

I understand that my eye exam and any optional contact lens evaluation or fitting copayments are due at the time of service today. I have 60 days to complete the contact lens evaluation process unless otherwise specified. I also understand that fees for services are non-refundable/non-negotiable. I furthermore agree to pay any collection expenses incurred to collect any amount I may owe due to non-payment. I understand that I am solely responsible for the cost of all non-covered services.

I authorize the release of my information for WEC or a third-party insurance billing service to file insurance claims if we are a participating provider for your plan. However, there is no guarantee of benefit information and/or coverage and if my insurance denies payment for any claims submitted, I will be responsible for full payment and can contact my insurance company directly should there be a dispute.

SECTION 3: ROUTINE VISION CARE vs. ROUTINE MEDICAL EYE CARE

The Eye Care Industry is under the regulation of many government agencies and is subject to ever-changing laws dictating the coding and reporting of each visit with a healthcare professional. The purpose of these regulations/laws is to ensure your visit is of the highest quality. WEC continues to meet those high standards and quality control measures. In order to do so, your provider must be specific regarding the nature of each visit and must accurately & specifically code your visit based upon clinical findings and concerns addressed. The doctor then determines if the vision problems you currently have are normal or are disease-related changes. The doctor may order additional testing, refer you to another doctor or specialist, or advise of other treatments as needed.

If a medical eye concern is discovered and/or addressed (based upon your concerns, systemic medical history, prior eye history, etc.) during your routine eye exam today, the exam must be submitted to your medical insurance carrier. This may have copays or may have fees that Wallerich Eye Care has no control of, as your insurance carrier ultimately determines associated costs with your visit.

Please sign below to confirm you understand your routine eye exam today may be billed to your vision plan or medical insurance. By signing below, you acknowledge & confirm WEC's notice of privacy practices, business practice policies and that you have reviewed your medical insurance/vision plan and understand how each applies to your insurance plan benefits.

Patient/ Guardian Signature:		Date:	

SECTION 4: INFORMED CONSENT FOR DILATION

The dilated eye exam allows the doctor to perform a more thorough eye health exam. Dilation is recommended for the following patients: new patients, a change/increase in floaters or flashes of light, highly nearsighted, unexplained headaches, vision loss, head trauma or other medical conditions (diabetes, hypertension, etc.). A dilated eye exam requires the use of eye drops that take about 10-25 minutes to dilate your pupils. This may cause light sensitivity for 1-5 hours and blurry near vision for 1-3 hours. This is a covered service for your eye exam.

☐ Yes, I consent to having dilation done this visit.

SECTION 5: INFORMED CONSENT FOR EDUCATIONAL RESEARCH/CASE PRESENTATIONS

Dr. Wallerich & associates provide educational seminars for skilled nursing home staff, eye care professionals, physicians and advanced practice providers nationally on topics regarding geriatric eye care, neuro-ophthalmic disease, anterior segment disease, traumatic/acquired brain injuries, and other topics. Case reports are presented with photos, diagnostic imaging, and clinical information to advance the learning of participants to improve patient care nationwide. Personal health information is removed from all imaging/reports to protect private patient information.

☐ Yes, I consent.
☐ No, I do not consent.

How did you hear about our practice (check all that apply)?

☐ Friend ☐ Family Member ☐ Healthcare Provider ☐ Online ☐ Target ☐ Other:_____

Please provide the name of the referrer?

First/Last Name: _____