Welcome to Bird Eye Institute / *Bienvenido a Bird Eye Institute*

Patient Information / ***Información del Paciente*** Date / *Fecha*______________________

____*F*___*M*___

First Name / *Nombre* Last Name / *Apellido* Sex / *Sexo*

Social Security Number / *Número de Seguro Social* Date of Birth / *Fecha de nacimiento*

Address / *Dirección*

City / *Ciudad* State / *Estado* Zip / *Código postal*

Home Phone Number / *Teléfono particular* Work Phone Number / *Teléfono laboral*

Cell Phone Number / *Teléfono celular* Email / *Correo electronic*

Race _____White _____Asian _____Black _____Native Hwaiaan _____American Indian _____Other

Ethnicity _____Not Hispanic_____Hispanic_____Other Preferred Language _____English_____Español

Primary Care Physician Name / *Médico de Atención Primaria* Phone/ *Teléfono* Fax

Pharmacy/*Farmacia* Address / *Dirección* City / *Ciudad* Phone/ *Teléfono*

Emergency Contact Name / *Nombre del contacto de emergencia* Phone Number / *Teléfono*

Employer/*Empleador*

Employer Name / *Nombre del Empleador* Occupation/ *Ocupacion* Phone/ *Teléfono*

Student/ *Estudiante* Schoo Name/ *Nombre de Escuela* Retired/ *Retirado*

Policy Holder/Responsible Party Information / ***Información del Responsable/Titular de Póliza***

Primary Insurance/ *Seguro Primario* Secondary Insurance/ *Seguro Secundario*

Policy and Group Number/ *Número de Póliza y de Grupo* Policy and Group Number/ *Número de Póliza y de Grupo*

Medical History / ***Antecedentes médicos***

Allergies/ *Alérgias*

List all medications you are currently taking: / Mencione todos los medicamentos que esté tomando actualmente:

Social History

Do you drive ___No ___Yes   If yes, do you have visual difficulty when driving? ___No ___Yes

Explain:____

Do you use tobacco products? ___No ___Yes   If yes, amount/how long?________________________
Do you drink alcohol? ___No ___Yes   If yes, amount/how long?________________________
Do you use illegal drugs? ___No ___Yes   If yes, amount/how long?________________________
Have you ever been exposed to or infected with? ___No ___Gonorrhea ___Hepatitis ___HIV___Syphilis

Present and Past Medical History

Constitutional

Fever, Weight Loss/ Gain ___No ___Yes

Integumentary
Skin ___No ___Yes

Neurological
Headaches ___No ___Yes
Migraines ___No ___Yes
Seizures ___No ___Yes
Cva/Stroke ___No ___Yes

Eyes
Loss of Vision ___No ___Yes
Blurred Vision ___No ___Yes
Distorted Vision/ Halos ___No ___Yes
Loss of Side Vision ___No ___Yes
Dryness ___No ___Yes
Mucous Discharge ___No ___Yes
Redness ___No ___Yes
Sandy of Gritty Feelings ___No ___Yes
Itching/ Burning ___No ___Yes
Foreign Body sensation ___No ___Yes
Excess Tearing/ Watering ___No ___Yes
Glare/ Light Sensitivity ___No ___Yes
Eye Pain or Soreness ___No ___Yes
Chronic Infection of Eye or Lid ___No ___Yes
Sites of Chalazion ___No ___Yes
Flashes/ Floaters in Vision ___No ___Yes
Tired Eyes ___No ___Yes

Diabetes ___No ___Yes
Thyroid/ Other Glands ___No ___Yes
Psychiatric ___No ___Yes
Pregnant ___No ___Yes
Nursing ___No ___Yes

Ear, Nose, Mouth and Throat

Allergies/ Hay Fever ___No ___Yes
Sinus Congestion ___No ___Yes
Runny Nose ___No ___Yes
Post-Nasal Drip ___No ___Yes
Chronic Cough ___No ___Yes
Dry Throat/ Mouth ___No ___Yes

Respiratory
Asthma ___No ___Yes
Chronic Bronchitis ___No ___Yes
Emphysema ___No ___Yes

Vascular/ Cardiovascular
Diabetes ___No ___Yes
Heart Disease ___No ___Yes
High Blood Pressure ___No ___Yes
Vascular Disease ___No ___Yes
Chest Pain ___No ___Yes
Heart Attack ___No ___Yes

Gastrointestinal
Diarrhea ___No ___Yes
Constipation ___No ___Yes

Genitourinary
Genitals/ Kidney/ Bladder ___No ___Yes

Bones/ Joints / Muscle
Rheumatoid Arthritis ___No ___Yes
Muscle Pain ___No ___Yes
Joint Pain ___No ___Yes

Lymphatic / Hematologic
Anemia ___No ___Yes
Bleeding Problems ___No ___Yes
Allergic/ Immunologic ___No ___Yes

________________________________   ________________________
Patient Signature or guardian   Date

Bird Eye Institute

Notification of Additional Services Your Insurance Company Does Not Cover

I understand that my insurance company will not cover the following services (Including Medicare). I will be financially responsible for the service fee in **full**.

Determination refractive state (Prescription for glasses	(92015)	$ 15.00
First time contact lens fitting	(92310)	$150.00
Multi focal contact lens fitting (bifocal)	(92310)	$200.00
Contact lens fitting for Keratoconus	(92310)	$400.00
Re-fit for contact lens	(92310)	$ 75.00
Re-fit for bifocal contact lens	(92310)	$100.00
No show fee (To avoid this charge you must cancel your appointment 24 hours in advance)		**$ 40.00**

In some cases the vision plan may cover for these services. Contact lens fittings need to be authorized in advance by your insurance.

______________________________ ____________________

Patient Signature or guardian Date

Refraction

What is a refraction? A refraction is the portion of your eye exam where your prescription is determined for glasses and/or contact lenses. A machine (phoropter) is put in front of your eyes and the technician or physician asks you which one looks better "one or two".

Is it necessary? If you are referred for a cataract evaluation, or if you are considering a change in glasses during the upcoming year for any reason (blurry vision, unable to see small print, unable to see T.V., or the street signs, lenses are scratched, broken frames) or if your vision is worse than 20/40 in either eye- a refraction will be necessary to properly diagnose/treat and give you a prescription.

Why is it separate from my normal exam? Several years ago in an effort to trim costs, Medicare decided glasses did not fall under the window of health (similar to most dental work). Most insurance companies followed Medicare's lead.

What is the cost? Our practice charges $15.00 for the prescription for eye glasses obtained by refraction. Contact lens fitting or adjustment is a **separate** fee which is not covered by your medical insurance, and **not** included in the refraction fee.

Who pays? The patient is responsible at the time of service for the refraction fee. This fee is applicable even if your new prescription has not changed from your current prescription.

_____ I do accept the refraction fee for new glasses **Signature** ______________________________

_____ I do not accept the refraction fee and understand I will **not** get a RX for glasses

Notice of Insurance Benefits

Proof of active insurance is not a guarantee of payment for services at Bird Eye Institute. It is the patient's responsibility to verify with the insurance company for benefits. Most of the insurances will not cover for basic eye exam for determination of refractive state (prescription for glasses. Unfortunately Dr. Cynthia Franco only accepts Eyemed and Advantica Vision Plans. We are providers with most major medical insurances.

I acknowledge that I have read and understood the above statement and that I am responsible for charges **NOT** covered by my insurance policy.

______________________________ ____________________

Patient Signature or guardian Date

Lifetime Authorization

____
Patient Name

I hereby give consent to Eugenio F. Bird, MD and Cynthia E. Franco, OD to provide whatever treatment the assigned physician may deem necessary to the patient named above.

I understand I am responsible for payment of services provided to me. I hereby assign insurance benefits, otherwise payable to me, to be paid directly to Bird Eye Institute for Professional Physician's fees and authorize release of information for insurance purposes. I understand I am responsible for charges not covered by the insurance policy.

I herby request payment of authorized Medicare benefits and/or any other insurance benefits to be made either to me or on my behalf to Bird Eye Institute for any services furnished me by the physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration (HCFA) and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 12 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer of agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible are based upon the charge determination of the Medicare carrier.

I request that any payment of authorized MEDIGAP benefits be made on my behalf to Bird Eye Institute for any services furnished me by Eugenio F. Bird, MD or Cynthia E. Franco, OD. I authorize any holder of medical information about me to release to my insurance any information needed to determine these benefits or the benefits payable for related services.

______________________________ ______________________
Patient Signature or guardian Date

Authorization for use or disclosure of health information

I understand that under the Health Insurance Portability & Accountability Act of 1196 (HIPPA), I have certain rights to privacy regarding my protected heath information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved my treatment directly or indirectly. Obtain payment from third-party payers. Conduct normal healthcare operations.

Specific description of the information to be used or disclosed including the dates of service(s):
_____ All medical information
Other ____

Persons or class of persons authorized to make the use of disclosure:
_____ All medical information
Other ____

Persons of class of persons to whom the use or disclosure may be made:
_____ All medical information
Other ____

This authorization expires on: _____________ or this is a **lifetime** authorization: _____

Signature of patient: ______________________ Date: _____________

For personal representative of the patient (if applicable):

Print name of personal representative: ______________________ Relationship:_____________

______________________________ ______________________
Signature of personal representative Date