2448 76th Ave SE, Suite 106
Mercer Island, WA 98040

Office: 206-232-1633
www.mifamilyeyecare.com

Mercer Island Family Eye Care

WELCOME TO OUR OFFICE!

Please PRINT legibly:

Patient Name_____Date_____

Address_____

City_____ State_____ Zip_____

Home Phone_____ Cell/Work Phone_____

E-mail _____ SSN#_____ Gender: ☐ Male ☐ Female

Date of Birth_____ Age_____ Race (optional) _____

Employer_____ Occupation_____

Spouse (or Parent if under 18) _____

Reason for Current Eye Exam_____

Date of Last Eye Exam _____ Where _____

Have you experienced any of the following recently?

___ Dry or Watery eyes
___ Itchy/Swollen eyes
___ Discharge in the morning around eye lashes
___ Eye infections / Red eyes
___ Eye injuries / surgeries
___ Floaters / Flashing Lights
___ Curtain loss of vision / waviness of vision
___ Color vision changes
___ Double vision

Do you wear contact lenses? ☐ Yes ☐ No
Brand:_____
Power: Right Eye_____Left Eye_____
Diameter_____B.C. (base curve)_____

___ Disposable
___ Nondisposable
___ Gas Permeable
___ Hard Contacts
___ Daily Wear (take out at night)
___ Extended Wear (overnight)
___ Soft Spherical
___ Soft Toric (for astigmatism)
___ Monovision/Bifocal
___ Colors

Solution Used_____
How often do you replace your contact lenses?:_____
Interested in contact lenses for first time or getting back into contact lenses? ☐ Yes ☐ No

UNIQUE VISUAL NEEDS

How many hours do you spend on a computer a day? _____
How many hours a day do you drive? _____
Hobbies? (golf, racquetball, swimming, etc.) _____
Do you own a pair of 100% UV sunglasses? ☐ Yes ☐ No
Are there times where you rather not wear eyewear? ☐ Yes ☐ No (please specify) _____
Do you spend a lot of time outdoors? ☐ Yes ☐ No (please specify) _____
Do you own more than one pair of current Rx eyewear? ☐ Yes ☐ No (please specify) _____
Does your profession/lifestyle require the use of safety eyewear? ☐ Yes ☐ No (please specify) _____

How did you learn about our office?
___ Previous Patient
___ Personal Referral *Name:*_____
___Internet (please specify) ☐ Website (www.mifamilyeyecare.com) ☐ Google/google maps ☐ Yelp ☐ Zocdoc
___Saw the Sign on the Building/I live near by
___Mercer Island Living Magazine
___Other (please specify) _____

MEDICAL HISTORY

Primary Care Physician: _____

Phone Number: _____ **Last Visit:** _____

Address: _____

Check All That Apply:	**You**		**Family**	
	Yes	**No**	**Yes**	**No**
* Eye Surgery	☐	☐	☐	☐
* Lazy Eye/Amblyopia	☐	☐	☐	☐
* Vision Therapy/Patching	☐	☐	☐	☐
* Cataracts	☐	☐	☐	☐
* Glaucoma	☐	☐	☐	☐
* Macular Degeneration	☐	☐	☐	☐
* Retinal Detachment	☐	☐	☐	☐
* High Blood Pressure	☐	☐	☐	☐
* Heart Disease	☐	☐	☐	☐
* Diabetes	☐	☐	☐	☐
* Thyroid Problems	☐	☐	☐	☐

Review of the Systems:	**Yes**	**No**
* Ear/Nose/Throat: sinus problem, sore throat, ear infection	☐	☐
* Respiratory: asthma, emphysema, chronic bronchitis	☐	☐
***** Neurological: numbness migraines, seizures, weakness	☐	☐
***** Heart: chest pain, irregular heart beat	☐	☐
***** Musculoskeletal: arthritis, joint pain, swollen joints	☐	☐
***** Skin: rosacea, eczema	☐	☐
***** Lymphatic/Hematologic: anemia, bleeding problems	☐	☐
***** Psychiatric: depression, anxiety, hyperactive	☐	☐
***** Gastrointestinal/Stomach Disease	☐	☐
***** Kidney/Urinary Tract Disease	☐	☐
***** Cancer: (if yes, what type: _____)	☐	☐

Other Medical Conditions: _____

Environmental Allergies: _____

Drug Allergies: _____

Current Medications: (including over the counter medication) _____

_____

Are you currently pregnant? ☐Yes ☐No If "Yes", how many months? _____

If dilation is needed, can we dilate your eyes today? ☐Yes ☐No

VISION INSURANCE:

We are a provider for the following insurance plans (please check the box next to your vision coverage):

☐	**Regence BlueShield**	☐	**VSP**
☐	**Aetna**	☐	**Eyemed**
☐	**Premera BlueCross**	☐	**DSHS**
☐	**First Choice**	☐	**Community Health Plan**
☐	**PacifiCare**	☐	**Molina**
☐	**Uniform Medical**	☐	**Spectera**
☐	**LifeWise**	☐	**United HealthCare**
☐	**HMA**	☐	**Cigna (PPO and Open Access)**
☐	**Medicare**	☐	_____

We do not directly bill any other insurance. Insurance coverage and verification of coverage for reimbursement is the sole responsibility of the patient. Professional fees are non-refundable.

Primary Insurance Co: _____ SS# or ID#: _____ Group#: _____

Subscriber Name: _____ DOB: _____

Secondary Insurance Co: _____ SS# or ID#: _____ Group#: _____

Subscriber Name: _____ DOB: _____

NOTICE OF OFFICE PRIVACY PRACTICES SUMMARY

Mercer Island Family Eye Care is committed to protecting the confidentiality of your medical information and is required by law to do so. The Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations, and for other purposes that are permitted and required by law. It also describes your rights to access and control your protected health information. We ask for your consent to use and disclose your PHI, as outlined in our Notice of Privacy Practices, by asking you to sign the Welcome to Office form regarding your care. Generally, unless specifically allowed by state or federal regulations without an authorization Mercer Island Family Eye Care will seek a signed authorization from a consumer or personal representative before disclosing PHI to a third party.

USES AND DISCLOSURES

Mercer Island Family Eye Care may use or disclose your protected health information as follows:

Uses and Disclosures with Your Permission: Uses and disclosures of PHI will generally only be made with your written permission, called a "Release of Information". You have the right to revoke a Release at any time.
For Treatment: Our office will use and disclose your PHI to provide and coordinate our health care and any related services. We may also disclose your PHI to another health care provider working outside of our office for purposes of your treatment.

For Payment: Our office may use and disclose PHI about you for the purpose of determining coverage, billing, claims management, medical data processing, and reimbursement. The information may be released to an insurance company or a third party payer, or its agent. You may request restriction of this if paying for your own services.

For Health Care Operations: Our office may use and disclose PHI about you in order to support quality improvement and other business activities of our organization. These uses and disclosures are necessary for our operations and ensure the quality of care received by our patients.

Other Uses and Disclosures Provided by Law without Authorizations: Our office may use and disclose PHI about you for other purposes and to other individuals and entities without a signed authorization, as provided by state and federal law. This includes but is not limited to court orders, child abuse reporting, adult protective services reporting, etc.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

You have the following rights regarding your protected health information (PHI):

- Right to inspect and have a paper/electronic copy
- Right to request confidential communications
- Right to request an Amendment
- Right to request restrictions
- Right to a paper copy of Notice
- Right to an accounting of certain disclosures
- Right to be notified of breach of unsecured PHI

To file a violation complaint with our office, contact our office manager or the Secretary of the Department of Health and Human Services. All complaints must be made in writing. You will not be retaliated against for filing a complaint.

In addition to this summary, you are being offered a full detailed cop of the Notice of Privacy Practices. You may also at any time receive a copy by asking for one when you are at our office or request for one to be mailed to you.

NOTICE OF PRIVACY PRACTICES:

I have received or reviewed the Notice of Privacy Practices for the office of Mercer Island Family Eye Care effective 11/15/2013 and understand that all my medical information will be used in accordance with this notice.

Print Patient Name:_____

Patient Signature:_____

(Parent/Guardian Signature if under 18)

Date:_____

NOTICE OF OFFICE POLICIES

I hereby authorize Mercer Island Family Eye Care to release any medical or other information necessary in order to process insurance claims billed on my behalf. I also authorize payment directly to the doctor for any benefits available under my insurance plan. I understand that I am financially responsible for any fees that the insurance companies do no pay including co-payments, deductibles and non-covered services. Mercer Island Family Eye Care does not accept responsibility for collecting or negotiating disputed insurance claims past 60 days. Regardless of your coverage you are responsible for all incurred charges. Non- participating plans may reimburse you directly. A standard billing service charge of $2.00 will be posted on all accounts 30 days or older. A bank service fee of $40 will be charged on any checks returned for insufficient funds. Accounts 90 days old will be submitted to a collection agency. Missed appointments may be charged a $25 fee.

If for any reason within the first 30 days of picking up your eyewear, you are not happy with the fit, comfort, style, color or performance of your eyewear, please bring them back to us and we will do what we can to meet your expectations. Eyeglass lens orders are highly customized and cannot be canceled once they have been placed with the lab. A restocking fee may be assessed on stopped orders. If the job has been processed, there is a 50% cancellation fee for lenses because lab charges will have accrued on the order. A 25% restocking fee will be applied for all frame returns.

Note to all contact lens patients - Contact lens exams, fittings, trainings, and evaluations are not a covered benefit under MOST insurance plans. If you choose to be examined for contacts and/or need to be fit with contact lenses, you will be responsible for the professional services due on the day of your exam. ALL contact lens exams and follow ups must be completed within 60 days of initial exam. Monitoring your eye health is the doctor's responsibility, therefore a ONE year expiration for the contact lens prescription may be deemed medically necessary to prevent eye damage and encourage correct contact lens compliance.

Print Patient Name:_____

Patient Signature:_____

(Parent/Guardian Signature if under 18)

Date:_____