ORION EYE CENTER – MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____

Height: _____ Weight: _____

Pregnant/possibility of being pregnant: Y/N If yes – estimated gestation: _____

Do you have of any of the following conditions? If yes, please explain:

Cardiovascular

- ☐ High Blood Pressure
- ☐ Congestive Heart Failure
- ☐ Heart attack – **When**: _____
- ☐ Pacemaker or similar device
- ☐ Heart Disease
- ☐ A-Fib or other arrythmias
- ☐ Blood Clots
- ☐ Varicose Veins
- ☐ Use of Blood Thinners

Other/Explain:

Respiratory

- ☐ Shortness of Breath
- ☐ Asthma
- ☐ COPD/Emphysema
- ☐ Chronic Cough
- ☐ Bronchitis

Explain:

Neurological

- ☐ Stroke – **When**: _____
- ☐ Seizures
- ☐ Memory Issues
- ☐ History of Head Injury/Trauma
- ☐ Headaches/Migraines
- ☐ Parkinson's Disease
- ☐ Other/Explain:

Infections

- ☐ HIV/AIDS
- ☐ MRSA
- ☐ Shingles/Herpes Zoster
- ☐ Cold Sores
- ☐ C. Diff
- ☐ Hepatitis

Other/Explain:

Autoimmune

- ☐ Rheumatoid Arthritis (RA)
- ☐ Multiple Sclerosis (MS)
- ☐ Ankylosing Spondylitis
- ☐ Sjogren's Syndrome
- ☐ Psoriasis
- ☐ Lupus
- ☐ Other

Explain:

Other Conditions

- ☐ Sleep Apnea Y/N CPAP? Y/N
- ☐ Pain Disorder
- ☐ Thyroid Condition – **Explain**: _____
- ☐ Cancer – **Type/Treatment/ When diagnosed**: _____

If yes – do you have any limb restrictions? Y/N _____

- ☐ History of STDs/STIs
- ☐ Kidney Disease – Dialysis? Y/N

If yes, dialysis schedule: _____

- ☐ Other _____

Musculoskeletal

- ☐ Contractures
- ☐ Fused neck/back
- ☐ Inability to lie flat
- ☐ Involuntary body movements
- ☐ Arthritis
- ☐ Use of ambulatory device (cane, walker, wheelchair etc.)

If yes – please specify: _____

_____

- ☐ Other/explain: _____

_____

Metabolic

- ☐ Diabetes Type 1
- ☐ Diabetes Type 2

Date Diagnosed: _____

- ☐ Average blood sugar: _____
- ☐ Most recent blood sugar: _____

_____

- ☐ Known Vitamin Deficiency: _____

_____

- ☐ Other/explain: _____

_____

_____

Social History

Smoking Status:

- ☐ Current — How many cigarettes do you smoke per day? _____ How many years? _____
- ☐ Former — When did you quit? _____ How long did you smoke? _____
- ☐ Never

Do you use recreational drugs? Yes No If yes, how often? _____

Do you drink alcohol? Yes No If yes, how many drinks per week? _____

Present Ocular Assessment - Current Visual Complaints/Issues

Complaint	Right Eye	Left Eye	Complaint	Right Eye	Left Eye
Blurry Vision	☐	☐	Flashing Lights	☐	☐
Double Vision (Vertical/Horizontal/Oblique)	☐	☐	Floaters	☐	☐
Crossed Eyes	☐	☐	Curtain/veil coming over any part of your vision	☐	☐
Eye redness	☐	☐	Central vision missing/diminished	☐	☐
Eye pain – Rate 1-10:	☐	☐	Peripheral vision missing/diminished	☐	☐
Sensitivity to light	☐	☐	Distorted vision, straight lines appearing wavy	☐	☐
Gritty or sandy sensation	☐	☐	Eyelid swelling or swelling of surrounding tissue	☐	☐

Do you have a history of eye or head trauma? Yes No If yes, when/where: _____

Do you currently wear contact lenses? Yes No If yes, are they soft or hard? _____

How long have you worn them? _____

Have you ever been diagnosed or treated for any of the following?

- ☐ Cataracts
- ☐ Dry Eye
- ☐ Uveitis/Iritis
- ☐ Keratoconus
- ☐ Macular Hole
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Strabismus
- ☐ Retinal Detachment
- ☐ Retinal Hole/Tear
- ☐ Fuchs' Corneal Dystrophy
- ☐ Other: _____

If you checked yes any of the above, please explain:

Do you use any eye drops? If yes, which drops and how often?

Drop Name	Directions	Prescribing Doctor

Have you had ANY prior EYE surgery? (Cataracts, LASIK, PRK, RK, retinal detachment repair, laser etc.)

Surgery	Which Eye	Who/Where performed	Date of Procedure

Do you have any known FAMILY HISTORY of the following –

☐ Glaucoma ☐ Macular Degeneration ☐ Dry Eye

☐ Corneal Disease ☐ Retina Detachment/Holes/Tears

☐ Other: _____

Do you take any prescription or over-the counter medications? Yes No If yes, list below:

Include all medications including oral, topical, nasal, IV, vitamins etc.

Medication Name	Dosage	Directions

Do you have any allergies or sensitivities? Yes No **If yes, list below:**

Allergy	Reaction

Have you had any major surgery NOT related to the eyes? Yes No **If yes, list below:**

(Especially any cardiac, respiratory or neurological procedures)

Procedure	Laterality (R/L)	Who/Where performed	Date Performed

Please list any other medical history, information, or concerns that you feel would be pertinent to your visit today:

Patient PRINTED Name : _____

Patient Signature: _____ Date Completed: _____

POA/Guardian Signature (if applicable):

Orion Eye Center, LLC - REGISTRATION – Page 1

(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name: _____ (Last) _____ (First) _____ (Middle) **Preferred Name**

Mailing Address: _____ (Street & Apt #) _____ (City) _____ (State) _____ (Zip)

Home Phone #: _____ **Cell** Phone #: _____

Email Address: _____

*Preferred Method of Contact for **Appointment Confirmation** (Choose One):

☐ Call to Home Phone ☐ Call to Cell Phone ☐ Text Message ☐ Email

Birthdate: _____ SS#: _____ Gender: _____

Marital Status: ☐ Single ☐ Married to: _____ Other: _____

Primary Care Doctor: _____ **Optometrist:** _____

Other Medical Providers: _____

Employment Status: ☐ Retired ☐ Full-Time ☐ Part-Time ☐ Unemployed **Student** Status: ☐ Full-Time ☐ Part-time

Emergency Contact Name: _____ Relationship: _____

Primary Phone: _____ 2nd Phone: _____

***Do you authorize Orion Eye to share your health information with this person?* Yes: ☐ No: ☐**

The State of Oregon would like you to tell us your racial/ethnic background so that the legislators can review the treatment that all patients receive and make sure that everyone gets the highest quality of care. You have a choice if you would like to provide this information or, if you prefer, you may decline.

Ethnicity:
Do you consider yourself Hispanic / Latino?
☐ Declined to Provide
☐ Yes
☐ No

Race:
Which category best describes your race?
☐ Declined to Provide
☐ American Indian / Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian / Other Pacific Islander
☐ Caucasian

I understand that office visit charges are payable on the day service is rendered. I authorize Orion Eye to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Orion Eye Center, LLC and myself.

Signature _____ **Date** _____

Demo updated (staff initials)_____

Orion Eye Center, LLC - REGISTRATION – Page 2

Signature on File, Assignment of Benefits, Financial Agreement

1. Medicare - I request that payment of authorized Medicare benefits be made on my behalf to ORION EYE CENTER, LLC, for services furnished me by ORION EYE CENTER, LLC. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. ORION EYE CENTER, LLC accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.
2. Medigap - I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to ORION EYE CENTER, LLC, if possible, or otherwise to me.
3. Release of Information - ORION EYE CENTER, LLC may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to ORION EYE for reimbursement for services rendered and (2) any health care provider for continued patient care. ORION EYE may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.
4. Other Insurance - I understand that ORION EYE CENTER, LLC may contract with other insurance providers. I agree that I am individually obligated to pay the full charges of all services rendered to me by ORION EYE CENTER, LLC if I belong to a plan that ORION EYE CENTER, LLC does not contract with.
5. Non-Covered Services - I understand that ORION EYE CENTER, LLC's contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are "covered" by the health care service plans. Accordingly, I accept full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient, and treatment or tests not authorized by the health care service plan. I agree to cooperate with ORION EYE CENTER, LLC to obtain necessary health care service plan authorizations.
6. Financial Agreement - I agree that in return for the services provided to the patient by ORION EYE CENTER, LLC, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to ORION EYE CENTER, LLC for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring me, or any other party liable to the patient, is hereby assigned to ORION EYE CENTER, LLC. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to ORION EYE CENTER, LLC. However, it is understood that I am primarily responsible for the payment of my bill.
7. If I am signing on behalf of the patient, I hereby confirm that I have full legal authority to do so, and hold myself personally responsible for performing all acts required of the patient.

Patient Name: _____ **Date of Birth:** _____

Signature: _____ **Date:** _____

Orion Eye Center, LLC - REGISTRATION – Page 3

HIPAA Acknowledgement and Consent

I understand that Orion Eye Center, LLC will use and disclose health information about me.

I understand that my health information may include information created by ORION EYE CENTER, LLC or received by another provider, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnosis, treatments, procedures, prescriptions, demographic, insurance information, and similar types of health-related information.

I understand and agree that ORION EYE CENTER, LLC may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatments: refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment.
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies of others who may be responsible to pay for some or all of my health care, and
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how ORION EYE CENTER, LLC will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of ORION EYE CENTER, LLC, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of ORION EYE CENTER, LLC's Notice of Privacy Practices in effect will be posted in a waiting / reception area and on the practice's website.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that ORION EYE CENTER, LLC is not required by law to agree to such request.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

****HIPAA RELEASE**** Please list the names below of anyone with whom we may share your health information with. This includes anyone who may call in on your behalf, with medical, appointment, or billing questions. This shall remain in place until we are otherwise notified by you.	
Name and Phone Number of authorized person	**Name and Phone Number of authorized person**
Name and Phone Number of authorized person	**Name and Phone Number of authorized person**

Patient Name: _____ **Date of Birth**: _____

Signature: _____ **Date**: _____

Orion Eye Center, LLC – FINANCIAL POLICY acknowledgment

I have read the practice's Financial Policy and I agree to bind by its terms. I also understand and agree that such terms may be amended by the practice periodically.

_____ **Date**: _____

Signature of Patient/Parent or Guardian

_____ _____

Printed Patient Name Relationship to Patient

Orion Eye Center Financial Policy

Thank you for choosing Orion Eye Center for your medical care. Our practice firmly believes that a good physician-patient relationship is based upon understanding and good communications. Questions about financial arrangements should be directed to the medical practice. We are here to help you.

- **Payment:** I am expected to provide proof of insurance and pay at the time of my visit. I can pay with cash, check, or debit/credit card. Payment will include any unmet deductible, co-insurance, co-payment amount or non-covered charges from my insurance company.
    - *Cash Pay* - If I do not have insurance coverage, I will be required to pay for the appointment at the time of service. I will receive a 15% discount for paying in full.
    - *New Patients/cash pay* that are seen on an emergent basis will need to make a minimum $100.00 payment at the time of the appointment. This $100.00 will go towards the office visit and/or procedure, but may not cover the entire balance due. If a balance remains and a statement has to be printed, there will be a $15.00 past due fee added to the bill each month until I have paid my bill in full.
    - *Minors* – Orion Eye Center will look to the adult accompanying a minor for payment of all services rendered to minor patients less than 18 years of age. The accompanying adult must be present and remain with the minor throughout the appointment.
- **Insurance**: I understand that Orion Eye Center is a participating provider with several insurance plans. As a courtesy, Orion Eye Center will bill my insurance when I assign the benefits to Orion Eye Center. **If my insurance company does not reimburse Orion Eye Center for services rendered within a 90-day period, I will be responsible for payment**. I will be refunded any overpayment that I may make in the event that my insurance pays.
    - *Doctor not listed on my plan* - If my doctor is not listed in my plan's network, I will be responsible for partial or full payment. Due to many different insurance products, Orion Eye Center can not guarantee my eligibility and coverage. It is my responsibility to understand my insurance coverage and benefits. Many websites have erroneous information and are not a guarantee of coverage.
    - *Referral/Authorization* - I am responsible for obtaining a properly dated referral/authorization if required by my insurer. I am responsible for payment if my claim is rejected based on the lack of a referral.

  Any balance remaining after my health plan pays or denies as non-covered under my plan will be my responsibility. I understand that payment is due upon receipt of a statement from Orion Eye Center.
- **Late Charges:** I understand that a $15.00 a month rebilling fee will be applied to all accounts over 30 days past due.
- **Motor Vehicle Accident & Workers Compensation Claims:** If my visit is regarding a motor vehicle accident or a workers compensation claim I will provide my private insurance information at the time of my first visit. This will allow Orion Eye to bill them in the event my claim(s) has been denied or benefits are exhausted.
- **Returned Checks:** A $50.00 service charge will incur for all returned checks. I will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $50.00 service charge to pay the balance prior to receiving services from Orion Eye staff or my physician. I understand that a stop payment of a check constitutes a breach of payment, and I will be subject to the $50.00 service fee and collection action. I understand that any bad check that I write to this office is subject to collection and I will be prosecuted in Deschutes County.
- **Accounting Principals:** I understand that my payments and credits are applied to the oldest charges first, except for co-pays and insurance payments which are applied to the corresponding dates of service.

- **Surgery:** I understand that if I have not met my deductible by the date of my surgical procedure and if there are any facility co-pays, they are due on my date of surgery. Any balance remaining after my health plan has paid will be due upon receipt of a statement. I understand that most procedures include a 10-90 day period for post- operative care. I understand that special order lenses require payment in full at the time of my counseling visit. If I am a cash pay patient, I understand that I will need to pay in full for surgery prior to the surgery date.
- **Forms Fees:** I understand that I will be required to prepay for Orion Eye Center to complete forms, copying medical records, notarizing, or for extra written communication by the doctor. Orion Eye Center will have 30 business days in which to copy my records before making them available for me to pick up. A list of possible charges are as follows:
    - There is no charge for last 1 year of records or last chart note if <10 pages.
    - Complete medical record or >10 pages to be printed and mailed by Orion Eye Center to another office - $30.00
    - Complete medical record or >10 pages to be printed for pick-up - $25.00
    - Expedited fees (If needed before 7 days) - $ 5.00
- **Billing Office:** If I have any questions regarding any of my billing statements, I will call the accounts receivable staff at Orion Eye Center at 541-548-7170 for assistance.
- **Cancellations or Missed Appointments:**
    - *General Clinic* **-** If I do not cancel my appointment at least 24 hours in advance, or if I **no-show**, I will assess a $20.00 missed appointment fee.
    - *Surgery* - If I do not cancel my surgery appointment at least 24 hours before my scheduled surgery, or if I no-show, I will be assessed a $ 250.00 missed surgery fee.
- **Assignment of Insurance Benefits:** I herby assign, transfer, and set over directly to **Orion Eye Center** sufficient monies and /or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said clinic. I authorize Orion Eye Center to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Orion Eye Center. I authorize Orion Eye Center to release all medical information requested by my health insurance carrier, Medicare, other physicians or providers and any other third-party payers.
- **Release of Information:** I hereby authorize and direct **Orion Eye Center** to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.
- **Collections:** I understand that in the event my account is placed in collection status, any additional fees incurred due to this action will be added to my outstanding balance. This includes, but is not limited to, late fees, collection agency fees, court costs, interest and fines. I understand that these additional fees will be my personal responsibility to pay in full. I understand that I will be discharged as a patient and will not be seen for any future medical visits.
- **Divorced Parents of Patients:** By signing below, the adult who signs for a minor child into our practice on the day of service accepts responsibility for payment. This office does not promise to send bills or records to the other parent/guardian for issues of payment or communication. We will communicate about treatment and payment with the parent who signs in that day. Parents are responsible between themselves to communicate with each other about the treatment and payment issues.

Responsibility for Payment: I understand that I, personally, am financially responsible to **Orion Eye Center** for charges not covered by my insurance benefits.

I have read the practice's financial policy and I agree to bind by its terms. I also understand and agree that such terms may be amended by the practice periodically.