



Montague Eye Center

PLEASE PRINT AND COMPLETE CAREFULLY (THIS INFORMATION WILL ENSURE PROPER CLAIMS PROCESSING)

PATIENT'S Last Name _____ First Name _____ Middle Initial _____

Name you prefer to be called (If different from above): _____

Mailing Address: _____ City _____ State _____ Zip _____

Primary Phone #(____) _____ Texting ok Secondary Phone #(____) _____ Texting ok

Sex: Male Female Date of Birth _____ Social Security # _____

Marital Status: Married Single Divorced Widowed Email Address _____

Preferred Language: _____ Race: Hispanic White Other Ethnicity: _____

Emergency Contact Person _____ Phone Number _____ Family Doctor _____

Who may we thank for referring you:

Friend/Family _____ Doctor _____ Phonebook Internet Other

RESPONSIBLE PARTY AND BILLING INFORMATION:

Person Responsible for Bill: Last Name _____ First Name _____ Middle Initial _____

Social Security # _____ Date of Birth _____ Relationship to patient _____

Address: Apt/Street _____ City _____ State _____ Zip _____

Home Phone (____) _____ Work Phone (____) _____ Extension _____

Employer _____ City _____ State _____ Zip _____

Primary Insurance Company Name

Insurance Company Name _____ Insurance Id Number _____

Policy Holder (Subscriber) Last Name _____ First Name _____ Middle Initial _____

Policy Holder: Date of Birth _____ Sex: Male Female Social Security # _____

Additional Authorization:

- I authorize payment of any medical benefits to Montague Eye Center, LLC rendered on my behalf. It is our policy for patient to pay for service when rendered unless other arrangements are made.
- I understand that if my account becomes delinquent with Montague Eye Center, LLC, and requires placement with an outside collection agency, I will be charged a 35% collections fee, in addition to the amount owed.
- All professional services are charges to the patient. I am responsible for all fees regardless of insurance coverage. I understand that Montague Eye Center, LLC will file my insurance as a courtesy. Any amount not paid by insurance within 45 days will be turned back over to patient.
- I understand that eye drops are routinely used during eye exams and will cause the pupils to dilate. The eye drops will cause blurred vision and light sensitivity that may impair my ability to drive, walk, or operate hazardous machinery. The effects of the drops usually will be gone in a few hours, but in rare instances may last several days. This office and staff has advised me to have someone drive me home or assist me in any way necessary while my vision is blurred from the eye drop medication.

Signature _____ Date _____
Patient or Responsible Party



Dr. Jennifer R. Lippens
Optometrist

Signature on file, Assignment of Benefits, and Financial Agreement:

It is the policy of Montague Eye Center that the patient has the ultimate responsibility for payment on his or her account. Payment in full is due and required at the time of service.

Insurance – I request that payment of authorized Insurance benefits be made on my behalf to Montague Eye Center, LLC, for services furnished to me by Montague Eye Center, LLC. In an effort to accommodate the needs of our patients, we have contracted with Medicare and various insurance carriers. The specifics of your plan that govern how claims are paid are outlined in the policy booklet you received when you joined the insurance plan you elected. It is your responsibility to read and understand your insurance plan's provisions and requirements. If we are not contracted with your current insurance it will be necessary for you to pay in full for your visit at the time of service. We will provide you with an itemized receipt to file with your insurance company for them to reimburse you.

If your exam includes a Refraction you will be responsible to pay the **\$40 charge as well as your co-pay**. **A refraction** is necessary for your glasses and contact lens prescription. **Medical insurance companies do not cover the refraction.**

Specialist co-pay- A patient with a medical diagnosis is required to pay the specialist co-pay, this is not an option. If you cannot pay your co-pay, be prepared to reschedule your appointment. It is also a requirement that cost not covered by insurance, coinsurance and deductibles be paid at the time of service.

If you do not have your insurance card with you at the time of your visit, be prepared to pay in full for the visit, or to reschedule your appointment. If you need assistance or have questions about your insurance card please contact your insurance company directly.

Self Pay Patients are required to pay the entire cost of visit when services are rendered. No payment plans are available.

Montague Eye Center delinquent policy

*If your account becomes delinquent for noncompliance to our financial policy, and we feel it is necessary to involve a third party in the collection effort, we reserve the right to add a collection fee to your balance. A list of charges will be furnished upon request. *

I have read, understand and agree to Montague Eye Center financial/payment policy.

I understand that charges not covered by my insurance company, as well as applicable co-payment, deductible and out-of-network fees are my responsibility. In the event my account becomes delinquent I understand and agree to pay the collection fees and or attorney fees associated with the collection process. Failure to follow our policy may result in discharge from our practice.

Print Name: _____ **Date:** _____

Date: _____

Signature of Patient (Parent or Legal Guardian if a Minor)



Dr. Jennifer R. Lippens
Optometrist

Authorization to Release Information

I authorize the release of medical information and the records concerning my treatment to Medicare, Medgap and/or other insurance companies and assign my claim for medical benefits to Montague Eye Center to the extent permitted under applicable law or insurance agreements. I agree to allow Montague Eye Center to request or release my information from or to other physicians or medical institutions as it deems necessary for my medical care and I further authorize the release of my medical records by such parties for such purpose. I agree to allow Montague Eye Center to use my medical information and photography anonymously for the purpose of teaching or publication.

Consent to Treatment

I authorize the physician of Montague Eye Center, their associates, technical assistants and other health care providers under their direction to provide diagnostic evaluations and treatment. I agree to pupil dilation for the purpose of examination and have been advised not to drive. I understand that no guarantee has or will be made to me regarding any possible result or cure based on my examinations, and/or treatment.

Release of Health Information

I authorize the person(s)/parties listed in the box below to receive all health information about appointments, treatment, payment information, and/or other information regarding my healthcare until I sign a new form voiding this form.

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Notice of Privacy

I have been given the opportunity to read in full the Privacy Notice provided by Montague Eye Center. I release Montague Eye Center for all legal responsibility or liability that may arise from the above authorizations and agreements.

Appointments

Montague Eye Center strives to provide our patients with the best care possible but are unable to render that care if appointments are missed or not scheduled according to your physicians' recommendation. Please be advised that failure to show for appointments or neglecting to schedule or reschedule an appointment can result in discharge from this practice.

Print Patient Name Date

Signature of Patient or Legal Guardian (relationship to patient) Date



Montague Eye Center – Health History

PATIENT'S NAME _____ Date _____

Patient's Primary Medical Doctor _____

Personal Medical History - Select all which you have or ever had problems with, if none select none in each category

Allergies

- Drug Allergies
- Food Allergies
- Seasonal Allergies
- Other
- None

Cardiovascular

- Heart Attack/Stroke
- Vascular Disease
- High Blood Pressure
- High Cholesterol
- Other
- None

Constitutional

- Weakness
- Weight Loss/Gain
- Other
- None

Endocrine

- Diabetes
- Thyroid
- Pituitary
- Other
- None

Gastrointestinal

- Reflux
- Cancer
- Ulcer
- Other
- None

Genitourinary

- Ovarian Cancer
- Kidney Disease
- Prostate Cancer
- STD
- Other
- None

Head

- Hearing Loss
- Sinus Congestion
- Chronic Cough
- Runny Nose
- Dry Throat/ Mouth
- Other
- None

Hematologic/Lymphatic

- Anemia
- Bleeding Problems
- Leukemia
- Other
- None

Immunologic

- AIDS
- HIV Positive
- Herpes Zoster
- Other
- None

Integumentary/skin

- Acne
- Rosacea
- Skin Cancer
- Other
- None

Bones/Joints Muscles

- Arthritis
- Muscle Pain/Weak
- Joint Pain
- Other
- None

Neurological

- Headaches
- Migraines
- Seizures
- Head Injury
- Other
- None

Psychiatric

- Attention Disorder
- Anxiety
- Depression
- Other
- None

Respiratory

- Asthma
- Chronic Bronchitis
- Emphysema
- Lung Cancer
- Other
- None

Social History

- Do you use/drink*
- Tobacco Products
 - Alcohol
 - Illegal Drugs

List all medications you are currently taking:

Please use back of page if more space is needed

List all medications you are allergic to:

Please use back of page if more space is needed

Are you pregnant or nursing: Yes No

Personal Ocular History - Select all which you have or ever had problems with

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Sudden Loss of Vision (not blur) | <input type="checkbox"/> Styes or Chalazion | <input type="checkbox"/> Flashes of Light | <input type="checkbox"/> Floaters in Vision |
| <input type="checkbox"/> Chronic Infection of Eye or Lid | <input type="checkbox"/> Itching | <input type="checkbox"/> Tired Eyes | <input type="checkbox"/> Lasik Surgery |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Burning | <input type="checkbox"/> Redness | <input type="checkbox"/> Cataract Surgery |
| <input type="checkbox"/> Distorted Vision | <input type="checkbox"/> Computer Strain | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Other Eye Surgery |
| <input type="checkbox"/> Double Vision | <input type="checkbox"/> Excess Tearing/ Watering | <input type="checkbox"/> Mucous Discharge | |
| <input type="checkbox"/> Dryness | <input type="checkbox"/> Glare/ Light Sensitivity | <input type="checkbox"/> Cataracts | |
| <input type="checkbox"/> Sandy/ Gritty Feeling | <input type="checkbox"/> Eye Pain or Soreness | <input type="checkbox"/> Macular Degeneration | |
| <input type="checkbox"/> Other – Please describe: _____ | | | |

Do you wear contacts: Current Never Wore in the Past

Are you interested in the latest developments in Contact Lenses: Yes No

Family Medical and Ocular History - Select all which apply to your family

- | | | |
|---|---|--|
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Crossed Eyes | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Retinal Disease |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> None |
| <input type="checkbox"/> Other – Please describe: _____ | | |

Signature _____

Date _____

Patient or Responsible Party