Great Lakes Eyecare

Dr. James Bozic
Dr. Jenna Bayer

Patient Information

Last Name: _____ First Name: _____
Date of Birth: _____/_____/_____ Cell Number: (_____)_____
Employer: _____ Occupation: _____
How did you hear about our office? _____

[ ] Diabetes Type 1 [ ] Type 2 [ ] [ ] High Blood Pressure [ ] High Cholesterol
[ ] Thyroid Conditions [ ] Seasonal Allergies [ ] Autoimmune Conditions

Other Medical Conditions:
_____

Current Medications:
_____

Medication Allergies:
_____

Primary Care Physician: _____ Date of Last General Exam: _____

Family Medical & Ocular History
[ ] Diabetes [ ] High Blood Pressure [ ] Macular Degeneration
[ ] Glaucoma [ ] Retinal Detachments

Ocular History
Date of Most Recent Eye Exam: _____ History of Eye Injury or Surgery: _____
_____ Date of Injury/Surgery: _____
Current Concerns About Your Vision or Eyes: _____
[ ] Blurry Vision [ ] Macular Degeneration [ ] Glaucoma [ ] Retinal Detachments
[ ] Cataracts [ ] Dry Eyes [ ] Lazy Eye

Vision Correction
Do you wear glasses? [ ] Yes [ ] No Age of Glasses: _____
Do you wear contact lenses? [ ] Yes [ ] No
Type of Lenses [ ] Daily [ ] Biweekly [ ] Monthly [ ] Hard/RGP
Do you sleep in your lenses? [ ] Yes [ ] No
Brand (if known): _____
Prescription (if known): _____

Pupil Dilation Consent
If necessary to complete today's exam, may we dilate your pupils? [Yes] [No]

Signature: _____ **Date:** _____

Insurance Information

Name of ***Vision*** Insurance:_____ Name of ***Medical*** Insurance:_____

Policy Holder's Name: _____ Policy Holder's Name:_____

Policy Holder's Birthdate:_____ Policy Holder's Birthdate:_____

Policy Holder's ID or SSN:_____ Policy Holder's ID or SSN:_____

Assignment of Benefits

In order to accommodate the needs and requests of our patients, we are a direct provider for several insurance programs. While we are pleased to provide this service to you, it is extremely difficult for us to track the individual requirements of each plan. On occasion, some medically necessary procedures and materials may not be covered by insurance. ***Patients are responsible for all charges not covered by insurance***, including copayments and deductibles. Payment for professional services is due at the time of the examination, and balances on materials must be ***paid in full*** before glasses and/or contact lenses can be ordered. ***Professional fees are non-refundable***. We will do our best to assist you in submitting your insurance claim to your insurance carrier(s).

Contact Lens Patients

To receive a contact lens prescription in addition to that for glasses, a patient is required to pay a contact lens evaluation fee. This fee may not be covered by all insurance plans. The fee is for the additional testing and measurements necessary to be successfully fitted with contact lenses, as well as any contact lens-related follow-up visits scheduled within 60 days of the evaluation. Contact lens-related follow-up appointments beyond this 60-day period are subject to office visit charges and/or additional contact lens evaluation fees.

I authorize payment of benefits on my behalf to Great Lakes Eyecare and assume responsibility for all charges.

Signature of Responsible Party:_____ Date: _____

Group Number:_____ Group Number:_____

Relation to Policy Holder: (Self) (Spouse) (Child) Relation to Policy Holder: (Self) (Spouse) (Child)

NOTICE OF PRIVACY PRACTICES

This notice describes how your medical information may be used and disclosed and how you can get access to this information. Please review it carefully. We are required by law to:

- Maintain the privacy of your protected health information (PHI)
- Provide you with notice of our legal duties and privacy practices
- Follow the terms of the notice currently in effect

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

Treatment
We may use or disclose your health information to provide, coordinate, or manage your eye care. This may include:

- Comprehensive eye examinations
- Contact lens evaluations and fittings
- Diagnosis and management of ocular disease
- Referrals to ophthalmologists or other healthcare providers
- Communication with your primary care physician or specialists when medically appropriate

Payment
We may use and disclose your information to bill and collect payment from:

- Vision insurance plans
- Medical insurance plans
- Secondary insurers
- You or a responsible party

This may include determining eligibility, submitting claims, and responding to requests for documentation.

Healthcare Operations
We may use your information for standard business operations, such as:

- Quality assurance and patient safety activities
- Staff training
- Practice management and administrative purposes
- Compliance and auditing activities

Optical and Contact Lens Services
Your information may be shared internally to:

- Fabricate, dispense, adjust, or repair eyeglasses
- Order and dispense contact lenses
- Communicate with optical laboratories and contact lens manufacturers when necessary

As Required by or Permitted by Law
We may disclose your information when required by law, including for public health activities, legal proceedings, or law enforcement purposes.

Signature: _____ Date: _____