PATIENT DEMOGRAPHICS

Eyecare Medical Group

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.
☐ Rev. ☐ Sr. ☐ Jr. ☐ _____

Last Name | First Name | Middle Initial

/ / Date of Birth | Preferred Name | Ethnicity (Optional)

Address | Apt. # / Unit # | Primary Language

City | State | Zip

Preferred method of contact for appointment reminders: ☐ Email ☐ Text ☐ Call

Email | ( ) - Cell Phone | ( ) - Home Phone

Employer | Position

Optometrist | Optometrist City / State

Primary Care Provider / Other | Primary Care Provider / City / State

EMERGENCY CONTACT INFORMATION

Emergency Contact | Relation to Patient | ( ) - Preferred Phone

GUARDIAN INFORMATION

Name of Parent / Guardian / Power of Attorney | Relationship to Patient

Email | ( ) - Cell Phone | ( ) - Home Phone

Billing Address: If different from Patient

Address | Apt. # / Unit #

City | State | Zip

PATIENT MEDICAL HISTORY

Eyecare Medical Group

Patient Name _____ Date of Birth ___/___/___

MARK ALL THAT APPLY

GENERAL

- ☐ Sudden Weight Gain
- ☐ Sudden Weight Loss
- ☐ Insomnia
- ☐ Cancer
- ☐ Malignant Hyperthermia

SKIN / COMPLEXION

- ☐ Eczema
- ☐ Masses / Tumors
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Rashes

EARS / NOSE / THROAT

- ☐ Loss of Hearing
- ☐ Loss of Sense of Smell
- ☐ Post Nasal Drip

RESPIRATORY

- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ Emphysema / COPD
- ☐ Frequent Cough
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Utilizes CPAP
- ☐ Current Smoker
- ☐ Former Smoker

CARDIOVASCULAR

- ☐ Chest Pain
- ☐ Elevated Cholesterol
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Arrhythmia / A-Fib
- ☐ Cardiac History

_____
Cardiologist

_____
Date of Last Visit

GASTROINTESTINAL

- ☐ Diverticulitis
- ☐ Heartburn / Acid Reflux
- ☐ Ulcers

GENITOURINARY

- ☐ Kidney Stones
- ☐ Prostate Disease
- ☐ Recurrent UTI
- ☐ Urinary Frequency

MUSCULOSKELETAL

- ☐ Injury
- ☐ Ankylosing Spondylitis
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis

NEUROLOGICAL

- ☐ Headaches
- ☐ Stroke
- ☐ Parkinson's Disease
- ☐ Multiple Sclerosis
- ☐ Paralysis
- ☐ Numbness / Tingling
- ☐ Restless Leg Syndrome

ENDOCRINE

- ☐ Liver Disease
- ☐ Hypothyroid
- ☐ Hyperthyroid
- ☐ Diabetes

_____
Endocrinologist

_____
A1C & Date

LYMPHATIC

- ☐ Anemia
- ☐ Leukemia
- ☐ Other

PSYCHIATRIC

- ☐ Anxiety
- ☐ Depression
- ☐ Claustrophobia
- ☐ Needle Phobia
- ☐ PTSD

PATIENT MEDICAL HISTORY

Eyecare Medical Group

FAMILY HISTORY

- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Disease
- ☐ Diabetes
- ☐ Lazy Eye
- ☐ Cancer

MISC.

COVID Vaccinated? Y / N

Do you drive? Y / N

Do you live alone? Y / N

Mobility Issues? Y / N

Require Wheelchair? Y / N

Recent Glasses Rx? _____
Date

Do you take blood thinners or aspirin? Y / N

Please Specify: _____

Reason for Use: _____

Latex allergy? Y / N

Reaction Type: _____

MEDICATIONS / VITAMINS	DOSE	FREQUENCY

ALLERGIES

SURGERY & YEAR

☐ **I have completed my medication list on the back of this form.**

☐ **I have attached my medication list to this form.**

Patient Initials: _____

Date: ___/___/___

Tech Initials: _____

Date: ___/___/___

CATARACT ASSESSMENT:
Patient Questionnaire

Eyecare Medical Group

Patient Name: _____ ___/___/___
Date of Birth

EMG Physician: _____

4: No Difficulty 3: A Little Difficult 2: Moderately Difficult 1: Very Difficult 0: Unable NA: Not Applicable

Do you have difficulty, even with glasses, with the following?	Check the Applicable Box					
1) Reading small print, such as labels on medicine bottles, telephone books, or food labels?	4	3	2	1	0	NA
2) Reading a newspaper or book?	4	3	2	1	0	NA
3) Reading a large-print book, large-print newspaper, or large numbers on a telephone?	4	3	2	1	0	NA
4) Recognizing people when they are close to you?	4	3	2	1	0	NA
5) Seeing steps, stairs, or curbs?	4	3	2	1	0	NA
6) Reading traffic signs, street signs, or store signs?	4	3	2	1	0	NA
7) Doing fine detail work like sewing, knitting, crocheting, carpentry, painting, or photography?	4	3	2	1	0	NA
8) Writing checks or filling out forms?	4	3	2	1	0	NA
9) Playing games such as bingo, dominos, or card games?	4	3	2	1	0	NA
10) Taking part in sports like bowling, handball, tennis, or golf?	4	3	2	1	0	NA
11) Cooking?	4	3	2	1	0	NA
12) Watching television?	4	3	2	1	0	NA
13) Other: _____	4	3	2	1	0	NA

Have you been bothered by:	Check the Applicable Box					
1) Poor night vision?	4	3	2	1	0	NA
2) Seeing rings or halos around lights?	4	3	2	1	0	NA
3) Glare caused by headlights or bright sunlight?	4	3	2	1	0	NA
4) Hazy and/or blurry vision?	4	3	2	1	0	NA
5) Not seeing well in poor or dim light?	4	3	2	1	0	NA
6) Poor color vision?	4	3	2	1	0	NA
7) Double vision?	4	3	2	1	0	NA

CATARACT ASSESSMENT:
Patient Questionnaire

Patient Name: _____ ____/____/____
Date of Birth

1) Have you ever driven a car? YES (continue) NO (Skip to *)

2) Do you currently drive a car? YES (skip to 4) NO (complete 3)

3) When did you stop driving?

Less than 6 months ago 6-12 months ago More than 1 year ago

4) How difficult is driving DURING DAYTIME because of your vision?

No difficulty Moderately Difficult

A Little Difficult Very Difficult

5) How difficult is driving AT NIGHT because of your vision?

No Difficulty Moderately Difficult

A Little Difficult Very Difficult

* Cataract surgery can almost always be safely postponed until you feel you need better vision. If stronger glasses no longer improve your vision, and if the only way to help your vision is with surgical intervention, do you feel comfortable moving forward with cataract surgery?

YES NO

_____ ____/____/____
Patient Signature Date

_____ ____/____/____
Reviewed with Patient by Date

Clinical Staff to complete:

Date of Surgery:_____

Surgical Eye: RIGHT / LEFT

Staff Initials:_____ Date:_____

CATARACT SURGERY:
Intraocular Lens (IOL) Information

ADVANCED TECHNOLOGY LENS OPTIONS

Not all patients will medically qualify for these lens.

MULTIFOCAL LENS

- Will provide you with good **distance AND near** vision without the aid of glasses.
- Astigmatism correction will be included with this lens.
- Low powered reading glasses may still be required for detailed work or fine print.
- Insurance WILL NOT cover the additional costs for this lens.
- $2,480 per eye will be due seven (7) days prior to the surgery date.

TORIC LENS

- Will correct your astigmatism. However, some residual astigmatism may remain. Any post surgery correction will be minimal and often times corrective glasses or contacts are only necessary for fine detailed work.
- This lens will allow you to see at **distance OR near**, but not both.
- You will need reading glasses or distance glasses depending on the focal point that was addressed.
- Insurance WILL NOT cover the additional costs for this lens.
- $1,500 per eye will be due seven (7) days prior to the surgery date.

STANDARD LENS OPTION

MONOFOCAL LENS

- Will help alleviate your dependence on glasses for either distance vision or near vision.
- Glasses WILL BE required for whichever focal point you are not corrected for with the IOL.
- This lens WILL NOT correct for any astigmatism (this will require you to wear glasses or contacts even after surgery).
- In most cases, insurances will cover the full cost of this lens.

Around 30% of those that undergo cataract surgery develop a haze post surgery. This "secondary cataract" is simply the body's response to the surgery and is easily corrected with a minimally invasive laser procedure called a YAG capsulotomy. This procedure is not included in the cost of a standard or advanced technology lens but will be billed to your insurance.

GENERAL CONSENT AND ACKNOWLEDGMENT FORM

Patient Name: _____ ____/____/____
Date of Birth

1) GENERAL CONSENT TO TREATMENT

By signing below, I authorize the health care providers at Eyecare Medical Group to conduct examinations and diagnostic tests and procedures to assess my health care conditions, and to provide care, services, or therapies necessary to effectively diagnose and treat me. I understand that it is the responsibility of my treating health care provider(s) to explain to me the nature of the proposed care, treatment, services, prescribed medications, suggested interventions, or procedures. Before I undergo particular procedures or tests, my provider(s) will explain the potential benefits, risks, and/or side effects including potential unexpected outcomes or complications that might occur during my recovery. They will also discuss the likelihood of achieving certain goals, any reasonable alternatives, as well as the relevant risks, benefits, and side effects related to the alternatives, and including the possible results of not choosing to undergo the recommended treatment. I acknowledge that the practice of medicine is not an exact science and that no guarantees will be made to me as to the results of treatments and examinations at Eyecare Medical Group.

A. RIGHT TO REFUSE TREATMENT

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy, or medication recommended or deemed medically necessary by my treating health care provider(s).

B. MEDICAL EDUCATION AND PARTICIPATION OF STUDENTS AND TRAINEES

I understand that Eyecare Medical Group is dedicated to medical education, and that authorized, appropriately supervised students and trainees may observe and/or assist in my diagnosis, treatment, and care unless I expressly object to their participation in my health care.

2) RESPONSIBILITY FOR PAYMENT AND/OR ASSIGNMENT OF BENEFITS

By signing below, I understand and acknowledge that I am financially responsible for paying all costs associated with the health care services I receive from Eyecare Medical Group. I understand that I may be financially responsible for such costs even if I have health insurance, depending on the benefits and coverage limitations of my health insurance policy. I understand that I am also financially responsible for charges not covered by my health insurance, including deductibles and co-payments. I understand that health information about me, including (if applicable) information related to HIV/AIDS, substance abuse, and mental health treatment may be shared with my health insurance carrier(s) or other third party payers responsible for paying for my health care. I understand that I may choose to pay privately in full for particular services if I do not wish certain sensitive health information to be disclosed to my third party payer.

GENERAL CONSENT AND ACKNOWLEDGMENT FORM

Patient Name: _____ ____/____/____
Date of Birth

By signing below, I authorize Eyecare Medical Group to share this information, including specially protected information such as mental health, substance abuse, and/or HIV/AIDS information about me with health insurers in order to be paid for the services they have provided. I agree that the patient named in this form is covered by the insurer(s) that I have shared with Eyecare Medical Group, and that I have received no notice of discontinuation of benefits. I authorize such health insurers or other third party payers including Medicare, MaineCare (Medicaid) and TRICARE to pay the costs associated with my health care directly to Eyecare Medical Group or its contracted agents.

3) Dependent

If you are a dependent who consents to health care services on your own behalf, but utilize your parent's or guardian's insurance policy to pay for your services, please know that your parent or guardian will receive an Explanation of Benefits describing the nature of the services provided and, as a result, these services will no longer be confidential. Please speak with our staff if you wish to pay for your services in another manner.

4) Notice of Privacy Practices

I understand and acknowledge that Eyecare Medical Group is obligated to keep my health information confidential, but legally may use my health information for purposes of treating me, getting paid for services provided to me, or for the internal operations of the practice such as improving care and treatment services. I understand that a detailed list of permissible uses and disclosures is included in Eyecare Medical Group's Notice of Privacy Practices. I understand that a copy of Eyecare Medical Group's Notice of Privacy Practices is available to me at www.eyecaremed.com, in the waiting room at Eyecare Medical Group, and that I have the right to a complete copy upon request.

By signing below, I acknowledge that I have been offered the Notice of Privacy Practices. I have (check box that applies):

ACCEPTED ☐ REFUSED ☐

A copy of Eyecare Medical Group's Notice of Privacy Practices

GENERAL CONSENT AND ACKNOWLEDGMENT FORM

I acknowledge that I have read the above information. I understand and agree to the above statements and have been given the opportunity to have my questions about this form answered. I have also been given the opportunity to have my questions about the Notice of Privacy Practices answered.

Patient Name (Printed)

Date of Birth

Patient Signature

Date

I hereby sign on behalf of the patient listed above. I acknowledge that I have read the above information. I understand and agree to the above statements and have been given the opportunity to have my questions about this form answered. I have also been given the opportunity to have my questions about the Notice of Privacy Practices answered.

Authorized Representative Name (Printed)

Authority (PoA, Guardian, etc.)

Authorized Representative Signature

Date

Eyecare Medical Group complies with applicable Federal Civil Rights Laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Eyecare Medical Group respecte les lois fédérales en vigueur relatives aux droits civiques et ne pratique aucune discrimination basée sur la race, la couleur de peau, l'origine nationale, l'âge, le sexe ou un handicap.

Eyecare Medical Group cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

PATIENT FINANCIAL RIGHTS AND RESPONSIBILITIES

Thank you for choosing Eyecare Medical Group (EMG) to serve your eye care needs. We are committed to providing you the best care possible. Your clear understanding of financial responsibilities is important to our professional relationship. Please let us know if you have any questions or concerns about our financial policy.

As a patient at EMG, you have the right to, upon request:

- Receive, prior to treatment, a reasonable estimate of charges for medical care.
- Receive a copy of a reasonably clear and understandable itemized bill, and to have the charges explained.
- Full information, and necessary counseling on the availability of known financial resources for your care.

PAYMENTS

We accept cash, checks, all major credit cards, and Care Credit Financing. Co-payments are due at the time of service unless you have established a payment plan with the Patient Accounts Department. You will also be billed for any coinsurance and deductible amounts as well as non-covered services.

If you are being seen for a related service during a **postoperative period** (typically a short period of time following a procedure, often referred to as the "global period"), we will not collect a co-payment for the related postoperative visit. However, tests and medical supplies provided within a global period or an unrelated visit/service are separately billable and any balance after the insurance processes your claim will be **your responsibility**.

INSURANCE

We are a participating provider with most major insurance carriers. We will file a claim to your insurance company for services rendered by EMG. You are expected to present an insurance card at each visit. Failure to provide valid and complete insurance information at the time of service may result in you being responsible for payment for services usually covered by an insurance plan. If you provide health insurance information after the insurance company's time guidelines for filing a claim, you will be responsible for payment of services denied for timely filing by your insurance company. Additionally, it is **your responsibility** to communicate any changes to insurance or demographic information to EMG in a timely manner.

If your insurance plan requires a referral for specialist services, it is **your responsibility** to contact your Primary Care Physician (PCP) to obtain a referral. You may be financially responsible for any visits denied due to no referral.

NON-PARTICIPATING INSURANCE PLANS

As a service and courtesy to our patients, non-participating medical insurance plans will be billed as a non-assigned claim. Full payment is expected at the time of your visit.

EMG does not participate with any vision plans and they will not be billed. Any balances are the responsibility of the patient. A detailed receipt of payment can be obtained from the Patient Accounts Department for you to submit to these plans for possible reimbursement.

NON-COVERED SERVICES

This office offers some services and procedures that are deemed "not covered" by insurance companies. You will be given advanced notice of non-coverage before the services are provided. You will be responsible for payment in full prior to services being rendered. Non-covered services may include but are not limited to specialty lenses, refractive procedures, and dry eye treatments.

SELF-PAY ACCOUNTS

If you have no medical insurance coverage, full payment is expected at the time of service. Uninsured patients will receive a 25% discount off our standard fees with an additional 5% prompt pay discount applied to the discounted balance if paid in full at the time of service. A Patient Accounts Specialist will contact you to discuss a payment plan if you are unable to pay your balance in full.

PAYMENT PLAN

If you need to establish a payment plan, you are expected to make monthly payments of at least 10% of the balance. All payment plans must be reviewed and approved by a Patient Accounts Specialist. If for any reason you are unable to make a monthly payment, please contact the Patient Accounts Department at (207) 828-2020 ext. 4006 to setup an alternative temporary arrangement.

PATIENT COLLECTIONS POLICY

Your outstanding balance will be considered past due 30 days from the first statement. If you are unable to pay the balance in full within the 30 days, please call the Patient Accounts Department at (207) 828-2020 ext. 4006 to establish a payment plan. A past due outstanding balance may be sent to our collection agency and may also impact access to further appointments. EMG reserves the right to discharge a patient from the practice for non-compliance if a balance is sent to EMG's collection agency.

FINANCIAL ASSISTANCE

If you do not have insurance and need assistance paying for services, you may apply for Financial Assistance. Financial Assistance paperwork must be completed and submitted within 14 days of the initial visit. Once the information is received by EMG, it will be reviewed, and a determination will be made on eligibility for Financial Assistance.

WORKERS' COMPENSATION CASES

It is your responsibility to provide information to EMG with the M-1 form including date of injury, claim number, insurance company address, phone number, and name of adjuster prior to your appointment. You will be asked to provide your personal health insurance information in addition to your workers' compensation information. If your workers' compensation claim is denied, EMG will bill your health insurance. If you should receive a Notice of Controversy (NOC), please provide a copy when checking-in for services.

If you have filed a workers' compensation claim and you have a managed care plan (HMO), you will need to make sure to contact your PCP for a referral prior to your appointment.

POWER OF ATTORNEY

If the patient has a power of attorney (POA), this must be identified on the EMG General Consent and Acknowledgement Form, and the POA must sign and accept the terms of this document. A POA is defined as a legal document giving one person (the agent or attorney-in-fact) the power to act for another person (the principal). The agent can have broad legal authority or limited authority to make legal decisions about the principal's property, finances, or medical care.

MINOR CHILDREN/CHILD CUSTODY CASES

Services for minor children will be billed to the insurance company on file. The adult who signs the consent forms accepts full responsibility for payment for services rendered. We will not split bill between parents at any time. Statements for outstanding balances will be sent to the adult who signed the consent for treatment.

PATIENT FINANCIAL RIGHTS AND RESPONSIBILITIES ACKNOWLEDGMENT

I hereby acknowledge that I have read the Patient Financial Responsibilities form, understand its content, and have been given the opportunity to have my questions addressed.

_____ _____/_____/_____

Patient Name (Printed) Date of Birth

_____ _____/_____/_____

Patient Signature Date

I hereby sign on behalf of the patient listed above. I acknowledge that I have read the Patient Financial Responsibilities Form, understand its content, and have been given the opportunity to have my questions addressed.

_____ _____

Authorized Representative Name (Printed) Authority (PoA, Guardian, etc.)

_____ _____/_____/_____

Authorized Representative Signature Date

APPOINTMENT CANCELLATION:
No Show Policy

Thank you for trusting Eyecare Medical Group with your eye care . When you schedule an appointment with EMG, we set aside enough time to provide you with the highest quality care.

Should you need to cancel or reschedule an appointment, please contact our office as soon as possible but no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

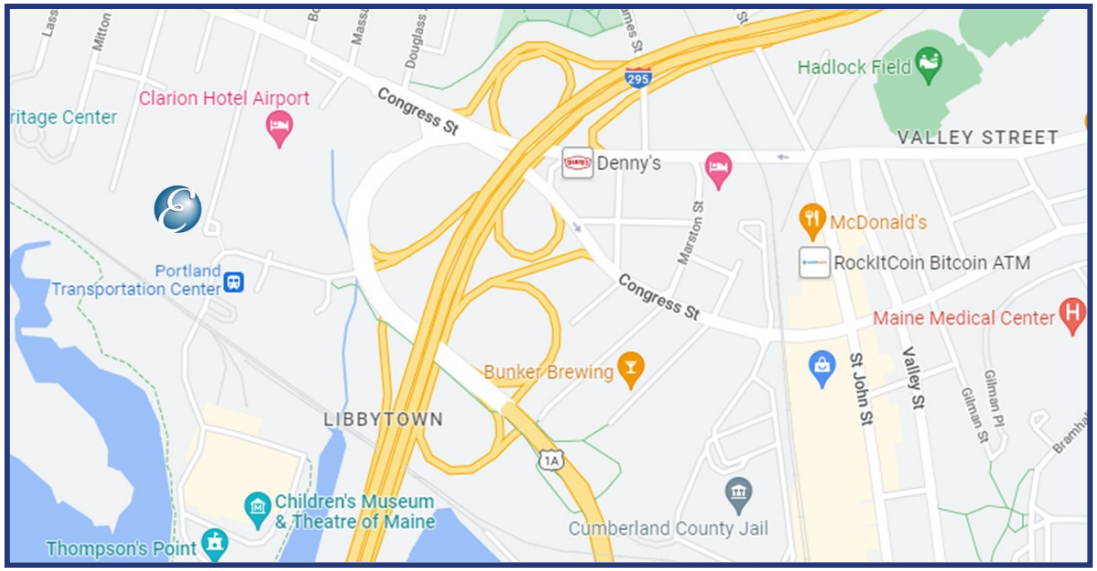
- Any established patient who fails to show or to cancel/reschedule an appointment 24 hours in advance will be considered a No Show.
- Any established patient who fails to show or to cancel/reschedule an appointment 24 hours in advance a second time within a 12-month period, will receive a No-Show letter as a reminder of this policy.
- If a patient fails to show or to cancel/reschedule an appointment 24 hours in advance a third time within a 12-month period, the patient may be dismissed from Eyecare Medical Group. **You will be notified by letter if the dismissal was approved.**
- Any new patient who fails to show for their initial visit may not be rescheduled.
- As a courtesy, we make reminder calls for appointments. If, for some reason, you do not receive a reminder call or message, the above Policy will remain in effect.

We understand there may be times when illness or transportation issues occur and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our office as soon as possible. You may contact EMG 24 hours a day, 7 days a week at the numbers below. Should it be after regular business hours you may leave a message with our answering service.

Eyecare Medical Group

207.828.2020 or 1.888.374.2020

Portland Location Directions



MAINE TURPIKE

From South:

I-95 heading North.

Take Exit 46.

After the tollbooth, turn right at the light toward Route 9.

At the next light, take a left onto Route 9 East.

Route 9 joins Route 22 and becomes Congress Street.

Remain on Congress Street to Sewall Street (@ 2.5 miles)

Take a right onto Sewall Street to Eyecare Medical Group (last building on right).

From North:

I-95 heading South.

Take Exit 46.

After the tollbooth, turn right toward Route 9.

Go through the first set of lights and at the second light turn left onto Route 9 East.

Route 9 joins Route 22 and becomes Congress Street.

Remain on Congress Street to Sewall Street (@2.5 miles).

Take a right onto Sewall Street to Eyecare Medical Group (last building on right).

I-295

From South:

I-295 heading North.

Take Exit 5.

Following the signs for Route 22 West, bear right and immediately bear right again.

Go through the first light and take a left at the second light onto Route 22 West.

Pass through an additional set of lights.

Sewall Street is on the left at the next light.

Turn left onto Sewall Street to Eyecare Medical Group (last building on the right).

From North:

I-295 heading South.

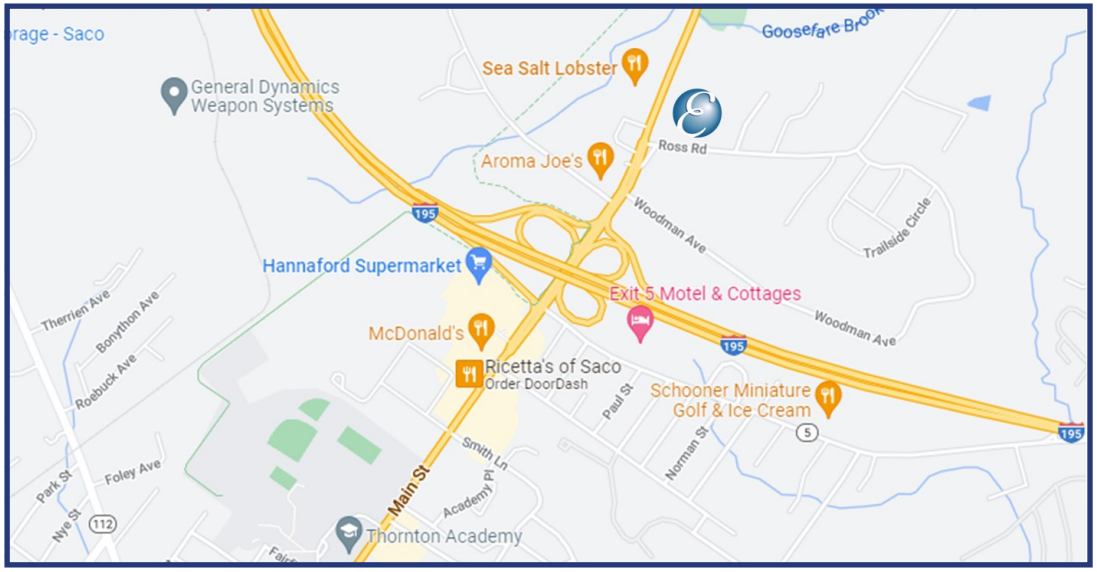
Take Exit 5B.

At the light, bear right onto Route 22 West.

Pass through an additional set of lights.

At the next set of lights, take a left onto Sewall Street. Eyecare Medical Group (last building on the right).

Saco Location Directions



***Navigational Device Use: 5 Ross Rd., Saco ME**

From South on I-95:

I-95 North and head toward Augusta / Portland.

At Exit 36, head right on the ramp for I-195 East toward Old Orchard Beach / Saco.

At Exit 2B, head right on the ramp for US-1 North toward Portland Rd / Saco.

Arrive at US-1 N / Main Mt.

The last intersection before your destination is Ross Rd.

Eyecare Medical Group 655 Main St, Saco, ME.

From North on I-95:

I-95 South heading toward Scarborough.

At Exit 36, head right on the ramp for I-195 East toward Old Orchard Beach / Saco.

At Exit 2B, head right on the ramp for US-1 North toward Portland Rd / Saco.

Arrive at US-1 N / Main St.

The last intersection before your destination is Ross Rd.

Eyecare Medical Group 655 Main St, Saco, ME.

From North on I-295:

I-295 South heading toward Portland.

Take the ramp for I-95 South

At Exit 36, head right on the ramp for I-195 East toward Old Orchard Beach / Saco.

At Exit 2B, head right on the ramp for US-1 North toward Portland Rd / Saco.

Arrive at US-1 N / Main St.

The last intersection before your destination is Ross Rd.

Eyecare Medical Group 655 Main St, Saco, ME.