NEW PATIENT FORM

Patient's Name: _____

Appointment Date: _____Time: _____Location: _____

PLEASE ARRIVE 15 MINUTES PRIOR TO YOUR APPOINTMENT TIME

Please complete the forms and bring them with you the day of your appointment.

PLEASE BRING THE FOLLOWING:

Medical insurance card(s)
Photo identification
List of medications

HMO INSURANCE

If you have an **"HMO"** insurance that requires an "authorization" from your insurance company and a "referral form" from your primary care physician, *it is your responsibility to obtain this information PRIOR to your appointment.*

WORK INJURY OR AUTO ACCIDENTS

If your appointment is related to a "work injury" and/or "auto accident", it is your responsibility to obtain proper "**authorization in writing**" from your employer and/or insurance carrier in order to receive treatment.

We will need the following information in writing, ON COMPANY LETTERHEAD, from your agent or employer:

Date of injury
Insurance company name and billing address
Claim number

IF THIS INFORMATION IS NOT OBTAINED, YOUR APPOINTENT WILL NEED TO BE RESCHEDULED.

CANCELLATION POLICY

We request 24 hour notice for rescheduling or cancellation of an appointment so that we may schedule another patient on our waiting list. Failure to cancel or reschedule your appointment within 24 hours of scheduled appointment will be considered a "no show" and a $25.00 fee will be charged. You are required to pay this fee before another appointment can be made. Three consecutive "no shows" will result in a discharge of care.

Please Initial Here _____

Blue Water Eye Care Associates, P.C.

Kevin D. Johnson, M.D.
Carol Allen, O.D.
2609 Electric Ave., Suite A, Port Huron, MI 48060

Dear Patient,

We are delighted that you have chosen our practice for your medical eye care and we look forward to your visit.

Your first visit may take up to 2 hours, depending on the complexity of your medical eye problems and any following visits may take up to 1 hour. Be sure you have allowed enough time for your visit(s).

In order to expedite our check-in process, please complete the enclosed paperwork prior to your appointment. When you arrive at our office for your appointment, please present your completed paperwork, proper identification, such as driver's license and all insurance cards.

If you have an insurance plan that requires a referral, you will need to contact your primary care physician and have them forward a referral to our office. We cannot see you if a referral is not on file with our office by the scheduled appointment date.

For your convenience, we accept cash, Master Card, Visa, and/or personal checks for payment of your co-pay, co-insurance or deductible amount.

We have several policies we would like for you to know about before you are examined. These policies are designed to safeguard our patients and our practice.

Sincerely,

Kevin D. Johnson, M.D.

Kevin D. Johnson, M.D.
Board Certified Ophthalmologist

I

OFFICE POLICIES & PROCEDURES

INSURANCE & FINANCIAL POLICY
All office visit co-payments, deductibles and co-insurance for professional services are due at the time of service. Please let us know immediately if you have a financial question or problem because we do not wish to cause embarrassment or hardship for any patient.

As a courtesy to our patients, we will be happy to bill your health plan if you provide us with the necessary information. If your health plan has changed since your last visit, it is YOUR responsibility to inform our staff of the change, to ensure proper resolution when processing your claims.

Please contact your health plan if you are unsure about what is covered or not-covered.

Please note that any balance unpaid by your insurance carrier will become your financial obligation. If your health plan has not paid your claim within 45 days, you may be billed. If you have an insurance plan that requires referral, you will need to contact your primary care physician and have them forward a referral to our office. We cannot see you if a referral is not on file with our office by the scheduled appointment date, unless you decide to pay out to pocket.

RETURNED CHECKS
If you pay by check and your check is being returned to us due to "insufficient funds" or for whatever reason, there will be a $30.00 service fee. We will no longer receive check payments from you and all future payments must be paid in Cash or by Credit Card only.

APPOINTMENTS
Office hours are by appointment only. Our staff and physicians will make every effort to accommodate urgent add on requests. Patients arriving early for their appointment may not be taken until the scheduled time, to avoid delaying other patients unnecessarily. Patients arriving late for their appointment may need to be rescheduled.

MISSED APPOINTMENTS
We reserve your appointment exclusively for you. We require 24 hour notice for rescheduling or cancellation of an appointment so that we may schedule another patient on our waiting list. Failure to cancel or reschedule your appointment within 24 hours of scheduled appointment will be considered a "no show" and result in a $25.00 office fee, the second time the fee will be $50.00. Three (3) consecutive "no shows" will result in a discharge of care.

PATIENT INSTRUCTIONS FOR MEDICATION REQUESTS

The medication questions and requests for additional medications from our patients are important issues that are taken very seriously by our physicians and staff. Please consider the following policies so that we may better serve you.

1. Please provide 72 hours notice for refill request. Please **call your pharmacy** to send us a request for your refill. Authorized refills will be sent to your pharmacy. If denied, you will be notified by our clinical staff.
2. If you contact our office for a medication refill after 11:00 am on Friday your request will be addressed the following Monday.
3. Medications will not be refilled on the weekends or holidays.

MEDICAL RECORDS

There will be no charge when records are sent directly to a medical provider for continuing care. There will be a charge of $30.00 for medical records when sent to any party other than a medical provider, including when given to patient.

PRIMARY CARE PHYSICIAN

It is very important for you to have a primary care doctor (family doctor, internist, pediatrician, etc.) to coordinate your healthcare. Please provide name, address and phone number of your physician.

EYEGLASS PRESCRIPTION

Eyeglass prescriptions are valid for 1 (one) year. We cannot guarantee the accuracy of the prescription after that.
Please be sure to have your glasses checked, if having problems with them, within one month of the purchase date.

CELL PHONE

Please be courteous in using your cell phone in the waiting room and please **turn off** your cell phone during your examination.

Blue Water Eye Care Associates, P.C.
PATIENT HISTORY QUESTIONNAIRE

Date _____

Name _____ Birthdate _____

REVIEW OF SYSTEMS: DO *YOU CURRENTLY* HAVE ANY PROBLEMS IN THE FOLLOWING AREAS:

YES	NO	Constitutional symptoms
☐	☐	Fever
☐	☐	Weight changes (loss or gain)
☐	☐	Night sweats, fatigue, excessive thirst
		Eyes
☐	☐	Loss of vision
☐	☐	Floaters / Light Flashes
☐	☐	Distorted vision (halos)
☐	☐	Loss of side vision
☐	☐	Double vision
☐	☐	Dryness
☐	☐	Mucous discharge
☐	☐	Redness
☐	☐	Sandy or gritty feeling
☐	☐	Itching
☐	☐	Burning
☐	☐	Foreign body sensation
☐	☐	Excess tearing/watering
☐	☐	Occasional tearing
☐	☐	Glare/light sensitivity
☐	☐	Eye pain
☐	☐	Chronic infection of eye or lid
☐	☐	Sties, Chalazion
☐	☐	Tired eyes
☐	☐	Other _____
		Ears, nose, mouth, throat
☐	☐	Sinus congestion
☐	☐	Tonsils
☐	☐	Chronic cough
☐	☐	Dry throat/mouth
☐	☐	Hearing impairment
		Head
☐	☐	Headache
☐	☐	Fainting
☐	☐	Dizziness
☐	☐	Neck pain/stiffness
		Hematologic/Lymphatic
☐	☐	Blood disease
☐	☐	Anemia
☐	☐	Swollen lymph nodes
		Endocrine
☐	☐	Diabetes
☐	☐	Thyroid

YES	NO	Cardiovascular (heart/blood vessels)
☐	☐	Difficult or labored breathing
☐	☐	Slow/rapid heart rate or palpitations
☐	☐	Irregular heart beat
☐	☐	Chest pains
☐	☐	Hypertension (high blood pressure)
		Respiratory (lungs/breathing)
☐	☐	Shortness of breath
☐	☐	Chronic cough
☐	☐	Asthma
☐	☐	Emphysema
		Gastrointestinal
☐	☐	Stomach pain
☐	☐	Bowel habits change
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Ulcers
☐	☐	**Genitourinary (genitals/kidney/bladder)**
☐	☐	**Reproductive organs**
☐	☐	Are you pregnant?
		Musculoskeletal (muscle/joint/bones)
☐	☐	Weakness
☐	☐	Pain
☐	☐	Arthritis
		Integumentary (skin or breast)
☐	☐	Masses
☐	☐	Tumors
☐	☐	Pigmented lesions
☐	☐	Rash
		Neurological
☐	☐	Weakness
☐	☐	Numbness
☐	☐	Tingling
☐	☐	Tremors
☐	☐	Speech problem
☐	☐	**Psychiatric**
		Allergic/immunologic
☐	☐	Head allergy symptoms
☐	☐	Seasonal allergies
☐	☐	Hay fever symptoms
☐	☐	**Cancer** (site) _____
☐	☐	**Other Problems** (list)_____

CURRENT EYE MEDICATIONS: _____

CURRENT OTHER MEDICATIONS: _____

CONTINUED ON REVERSE

Social History

Occupation _____

Do you ☐ live alone ☐ with a spouse ☐ other_____

☐ Single ☐ Married ☐ Divorced ☐ Widow

Next of Kin Name_____

(not living with you) Phone #_____

YES	NO	
☐	☐	Do you drink alcohol?
☐	☐	Do you smoke?
☐	☐	Do you use drugs?

HAVE *YOU HAD* ANY OF THE FOLLOWING:

YES	NO	**Past Medical History:**
☐	☐	Diabetes ☐ Insulin ☐ Non-insulin
☐	☐	Hypertension (high blood pressure)
☐	☐	Coronary artery disease
☐	☐	Heart problem
☐	☐	Congestive heart failure
☐	☐	Arrythmia
☐	☐	Stroke
☐	☐	Pulmonary disease (lung/breathing)
☐	☐	Gastrointestinal (stomach/bowel/liver)
☐	☐	Arthritis
☐	☐	Genitourinary organs
☐	☐	Cancer (site) _____
☐	☐	Infectious disease (hepatitis/AIDS/tuberculosis)
☐	☐	**Previous Surgery** (other than eyes): Date
☐	☐	Tonsillectomy _____
☐	☐	Gallbladder _____
☐	☐	Hysterectomy _____
☐	☐	Appendectomy _____
☐	☐	Hernia _____
☐	☐	Bypass surgery _____
☐	☐	Other surgery _____

If yes, list_____

_____

_____

☐ ☐ **Allergies to Medication:**

If yes, list_____

_____

For office use only: PFSH & ROS Updated			
Date	Initials	Date	Initials

YES	NO	**Family History**
☐	☐	Diabetes_____
☐	☐	High Blood Pressure_____
☐	☐	Heart disease_____
☐	☐	Stroke_____
☐	☐	Cataracts_____
☐	☐	Glaucoma_____
☐	☐	Retinal Problems_____
☐	☐	Blindness_____
☐	☐	Eye Disorders_____

YES	NO	**Previous Eye History**
☐	☐	Eye injury(ies)
☐	☐	Blindness
☐	☐	Glaucoma
☐	☐	Ocular Hypertension (increased eye pressure)
☐	☐	Cataract
☐	☐	Retinal Problem
☐	☐	Iritis
☐	☐	Eye Infections
☐	☐	Ocular Herpes
☐	☐	Macular Degeneration
☐	☐	Other Eye Problems (If yes, list)_____

_____

_____

_____

_____

☐ ☐ **Previous Eye Surgery or Laser Treatment:**

If yes, list_____

_____

_____

_____

_____

☐ ☐ **Previous Hospitalizations** (other than surgery)

If yes, list_____

_____

_____

☐ ☐ **Previous Anesthesia Problems:**

☐ ☐ Local anesthesia

☐ ☐ General anesthesia

If yes, explain_____

_____

_____

_____

PATIENT INFORMATION

Date: _____

Patient's Name: _____

Address: _____
(street) (City) (State & Zip Code)

Home Phone: _____ Cell Phone: _____

Social Security #: _____ Birth Date: _____ Female __ Male __

Patient's Employer: _____ Phone: _____

Employer's Address: _____

Occupation: _____

IF CHILD

Parent's Name: _____ D.O.B.: _____

Social Security #: _____

Employer: _____ Phone: _____

Employer Address: _____

EMERGENCY CONTACT – OTHER THAN HOME PHONE

Name: _____Relationship: _____ Phone: _____

CONTACT PREFERENCE

___Mail ___Phone ___Fax _____ ___Email _____

FAMILY DOCTOR

NAME: _____ **PHONE:** _____

ADDRESS: _____

Who referred you to us? _____

PHARMACY (Where you have your prescriptions filled)

NAME: _____ **PHONE:** _____

CONSENT FOR TREATMENT

DUE TO LAWS ENACTED BY CONGRESS, WE ARE REQUIRED TO HAVE YOU SIGN THIS CONSENT FORM PRIOR TO RECEIVING TREATMENT

Do you consent to medical examination and any other procedures or tests deemed necessary while you are receiving medical care from our office: ___ Yes ___No

Do you consent to our staff releasing medical and insurance information to a third party? (Specialist Insurance Verification, Prior Authorization, Research Purpose only) ___ Yes ___ No

Do you consent to our office mailing bills to your home? ___ Yes ___ No

Do you consent to our staff leaving messages on an answering machine or voice mail system regarding appointment and/or test results? ___ Yes ___ No

Do you consent to our staff releasing information about appointments and/or test results to the person(s) assigned on your list? ___ Yes ___ No

Please list the Name(s) of the person(s) to whom we can discuss your medical information with:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Your Name Printed: _____ Date: _____

Signature: _____

Initial here ___ if you wish this consent to be effective indefinitely or until you revoke it.
(If not initialed, you will have to sign a new form every time)

Initial here___ if you DO NOT give permission to release your medical information to anyone but yourself.

You may revoke this consent at any time. By revoking this consent, you will receive no further medical care from Blue Water Eye Care Associates, P.C. Revoking consent for further treatment does not relieve you from any financial obligations which occurred during the period this consent was effective.

REFRACTION SERVICE AND FEE

A refraction is an essential part of an eye examination to determine what your best vision is and if eyeglasses will help to correct your vision. It is a necessary measurement in order to write a prescription for glasses or contact lenses. Without a refraction, it is not possible for the doctor to advise you whether you need glasses or if you need to update your current glasses. Unless we do a refraction to determine what your best vision is, it is not possible for the doctor to give you definitive advice about any medical treatment you may need to improve your vision. Our physicians recommend a refraction at the time of your annual, dilated exam.

Medical insurance does not cover the cost of a refraction. Only vision insurance contributes to the expense of this test. Our fee for a refraction is $35.00. If you do not have an insurance policy that we anticipate will provide for the full amount of the refraction, this fee is due at the time of check-in for your examination.

I have read the information above and understand the $35 refraction fee is due at the time of service.

_____

Patient signature

Date_____

CANCELLATION POLICY

We request 24 hour notice for rescheduling or cancellation of an appointment so that we may schedule another patient on our waiting list. Failure to cancel or reschedule your appointment within 24 hours of scheduled appointment will be considered a "no show" and a $25.00 fee will be charged. Two (2) consecutive "no shows" the second will be charged at $50.00. You are required to pay this fee **before** another appointment can be made. Three (3) consecutive "no shows" will result in a discharge of care.

Signature Date

Blue Water Eye Care Associates, P.C.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION AND ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

With my consent, Blue Water Eye Care Associates, P.C. may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Blue Water Eye Care Associates, P.C.'s Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Blue Water Eye Care Associates, P.C. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Blue Water Eye Care Associates, P.C. Privacy Officer at 2609 Electric Ave., Ste. A, Port Huron, MI 48060, and/or each time you visit the office you may request a copy of the current Notice in effect.

With my consent, Blue Water Eye Care Associates, P.C. may call my home or other designated location and leave a message on voice mail, answering machine, or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Blue Water Eye Care Associates, P.C. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request that Blue Water Eye Care Associates, P.C. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Blue Water Eye Care Associates, P.C.'s use and disclosure of my PHI to carry out TPO, and I acknowledge that I have received a copy of this office's Notice of Privacy Practices Form.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Blue Water Eye Care Associates, P.C. may decline to provide treatment to me.

Signature of Patient or Parent/Legal Guardian	Witness Signature
Patient's Name (Printed)	Witness Signature
Parent/Legal Guardian Name (Printed)	Date