



# PATIENT HEALTH HISTORY

PLEASE CIRCLE YES OR NO Name: \_\_\_\_\_ Date: \_\_\_\_\_

FAMILY (blood relatives) HEALTH HISTORY					
Cataract	.....No	Yes	Diabetes	.....No	Yes
Glaucoma	.....No	Yes	High Blood Pressure	.....No	Yes
Macular Degeneration	.....No	Yes	Heart Problems/Stroke	.....No	Yes
Blindness	.....No	Yes	Thyroid Problems	.....No	Yes
Retinal Detachment	.....No	Yes	Cancer	.....No	Yes
Other	.....		Arthritis	.....No	Yes

List any other Health Problems that run in your Family \_\_\_\_\_

SELF - OCULAR HISTORY				Date of previous eye exam: _____	
Cataract	.....No	Yes	Injury to Eye or Head	.....No	Yes
Glaucoma	.....No	Yes	Ocular Foreign Body Removed	.....No	Yes
Macular Degeneration	.....No	Yes	Explain	.....	
Blindness	.....No	Yes	Amblyopia (Lazy Eye)	.....No	Yes
Retinal Detachment	.....No	Yes	Strabismus (Eye Turn)	.....No	Yes

Eye Infections .....No Yes

Other \_\_\_\_\_

Eye Surgery .....No Yes

Explain \_\_\_\_\_

SELF - HEALTH HISTORY / ROS		Name of Regular Physician: _____
<input type="checkbox"/> Constitutional Symptoms		<input type="checkbox"/> Genitourinary
Developmental Disability .....No Yes		Urinary Tract Infections .....No Yes
Recent Weight Change .....No Yes		Kidney Problems .....No Yes
Fever .....No Yes		STD's (HIV, Herpes, Chlamydia) .....No Yes
Fatigue .....No Yes		Onset Date: _____
Shortness of Breath .....No Yes		Comment: _____
Date: _____		<input type="checkbox"/> Endocrine
Comment: _____		Non-insulin Dependent Diabetes .....No Yes
<input type="checkbox"/> Ears / Nose / Mouth / Throat		Insulin Dependent Diabetes .....No Yes
Chronic Sinus Problems .....No Yes		Thyroid Problems .....No Yes
Hearing Loss .....No Yes		Onset Date: _____
Onset Date: _____		Comment: _____
Comment: _____		<input type="checkbox"/> Musculoskeletal
<input type="checkbox"/> Respiratory		Arthritis .....No Yes
Asthma/Bronchitis .....No Yes		Fibromyalgia .....No Yes
Emphysema .....No Yes		Muscular Dystrophy .....No Yes
Onset Date: _____		Onset Date: _____
Comment: _____		Comment: _____
<input type="checkbox"/> Hematologic / Lymphatic		<input type="checkbox"/> Neurological
Anemia .....No Yes		Multiple Sclerosis .....No Yes
Leukemia .....No Yes		Epilepsy .....No Yes
Large Volume Blood Loss .....No Yes		Onset Date: _____
Onset Date: _____		Comment: _____
Comment: _____		<input type="checkbox"/> Psychiatric
<input type="checkbox"/> Cardiovascular		Depression .....No Yes
Heart Problems .....No Yes		Nervousness/Panic Disorder .....No Yes
High Blood Pressure .....No Yes		Schizophrenia .....No Yes
Stroke .....No Yes		Onset Date: _____
Onset Date: _____		Comment: _____
Comment: _____		<input type="checkbox"/> Allergic / Immunologic
<input type="checkbox"/> Gastrointestinal		HIV/AIDS .....No Yes
Crohn's Disease .....No Yes		Lupus .....No Yes
Ulcer .....No Yes		Cancer .....No Yes
Onset Date: _____		Environmental/Food Allergy .....No Yes
Comment: _____		Onset Date: _____
		Comment: _____

PATIENT DRUG ALLERGIES OR SENSITIVITIES



## PATIENT SERVICE AGREEMENT

Thank you for choosing us as your eye health care provider. Prior to receiving care, read and sign the following.

### OUR COMMITMENT TO YOU:

- Personalized Eye Health Care
- Patient Education
- Exceptional Service with Infinite Accuracy
- Controlling Costs

- Full payment is due at the time of service.
- A minimum of half down is required when ordering glasses and/or contact lenses, with full payment due at time of delivery.
- We accept cash, checks, Visa, or MasterCard.

### **INSURANCE**

- Your insurance is a contract between you and your insurance company. We are not a party to that contract. We will pre-certify your coverage at the time of your visit. During pre-certification, every insurance company states, "This is not a guarantee of benefits". It is your responsibility to know your insurance benefits and what is covered at date of service.
- As a courtesy, we may accept assignment of insurance benefits and we will file your insurance claim for you. Be aware that some, perhaps all, of the services provided may be deemed non-covered services by your insurance company.
- If your insurance requires you to have a prior-authorization or referral, it is your responsibility to request and obtain the needed information. If you do not have one, treatment may be denied. On the date of service, our office must receive authorization within 30 days or you will be responsible to pay for these services.
- The maximum we will wait for insurance reimbursement is 90 days, after which the insurance amount is then payable by you.
- Regarding insurance plans in which we are participating providers, all co-pays and deductibles are due the day service is provided, per your insurance company. You may lose privileges if you do not comply. If we are non-participating providers, you are responsible for the balance.

### **USUAL AND CUSTOMARY RATES**

- You are responsible for payment regardless of your insurance company's arbitrary determination of usual and customary fees.

### **MINOR PATIENTS**

- The adults accompanying a minor and the parents (or guardians of the minor) are responsible for fully payment. For unaccompanied minors, treatment may be denied unless pre-authorized by parent or guardian in writing with means of payment. It is not possible for us to do split billing between accounts.

### **INTEREST**

- We reserve the right to charge a late fee in the amount of 1% as provided by state law for any unpaid patient balance remaining after 60 days of service.
- Collection proceedings will begin on any outstanding balance in non-compliance with this policy.

### MEDICAL AND/OR VISION ASSIGNMENT RELEASE

I request that payment of authorized Medical and/or Vision benefits be made to me or on my behalf to Richard F. Rule OD PC for services furnished to me by the physician. I understand my signature request that payment be made and authorize release medical information necessary to pay the claim. In medical and/or vision carrier as the full charge, and the patient is responsible only for deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge of the assigned Medical and/or Vision carrier. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES IF UNINSURED OR NOT COVERED BY MY INSURANCE.**

X

Signature on Patient and/or Guardian

Date