massucci vision plus
EYECARE + EYEWEAR

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Welcome to our office!

We're so glad you're here! The information and questions below will remain confidential, and are critical to the evaluation of your vision and eye health. Therefore it is very important that every question be answered in detail. Thank you.

Patient Information

TODAY'S DATE: _____

NAME: _____ DATE OF BIRTH: _____ AGE: _____ SEX: M F

ADDRESS: _____ SS#:_____
(Street) (City) (State) (Zip)

EMAIL: _____ HOME PHONE: _____DAY PHONE: Work/Cell:_____

NAME/ADDRESS OF **PRIMARY CARE PHYSICIAN**: _____DATE OF LAST EXAM: _____

NAME/ADDRESS OF LAST **EYE EXAM**: _____ DATE OF LAST EXAM: _____

EMPLOYER/SCHOOL: _____ OCCUPATION: _____

NAME OF SPOUSE/PARENT (Please Circle): _____

INSURANCE POLICY HOLDER (Please circle): SELF / SPOUSE

VISION INSURANCE: _____ MEDICAL INSURANCE: _____ FLEX SPENDING YES NO

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE: Name of Friend/Relative: _____

( ) Insurance Listing ( ) Social Media ( ) Another Doctor's Office recommendation
( ) Saw Sign/Building ( ) Flyer ( ) Web Page: Which website? _____
( ) Newspaper Ad ( ) Mailer ( ) Other _____

WHAT ARE THE MAIN REASONS FOR TODAY'S APPOINTMENT? (PLEASE CHECK ONE OR MORE)

( ) Contact lens discomfort	( ) Eye Pain or Soreness	( ) Frequent eyestrain	( ) Red eyes
( ) Distance blurred vision	( ) Eye Watering or Tearing	( ) Frequent headaches	( ) Seeing flashes of light
( ) Double vision	( ) Eyelids matted shut	( ) Mucous Discharge eyes	( ) Sudden loss of vision
( ) Near blurred vision	( ) Foreign matter in eyes	( ) Dry/Burning eyes	( ) Unusual Light Sensitivity
( ) Eye Itching or Allergies	( ) Floating spots in vision	( ) One eye turns in or out	( ) Other _____

ALLERGIES TO MEDICATIONS? ( ) NONE ( ) YES: Please List:
_____

CURRENT MEDICATIONS: ( ) NONE ( ) YES:
_____
Including prescription, over the counter, natural herbs, vitamins, and birth control. **Use space below if needed**.

DO YOU USE: *TOBACCO PRODUCTS? ( ) YES ( ) NO ( ) QUIT *DRINK ALCOHOL? ( ) YES ( ) NO *USE DRUGS? ( ) YES ( ) NO
IF YES, TYPE/AMOUNT/HOW LONG:_____

CHECK ANY **MEDICAL CONDITIONS** THAT APPLY TO **YOU** **( ) NONE :**

( ) Diabetes	( ) Vascular Disease/Stroke	( ) Cancer	( ) Skin Eczema/Rash
( ) High Blood Pressure	( ) Seizures	( ) Thyroid Disease	( ) Kidney/Bladder
( ) High Cholesterol	( ) Lung Disease/Asthma	( ) Arthritis	( ) Psychiatric
( ) Heart Disease	( ) Headaches/Migraines	( ) Weight Loss/Gain	( ) Autoimmune

CHECK ANY **EYE CONDITIONS** THAT APPLY TO **YOU** **( ) NONE :**

( ) Glaucoma	( ) Macular Degeneration	( ) Turned Eyes	( ) Eye Injury
( ) Cataracts	( ) Dry Eyes/Allergies	( ) Eye Surgery	( ) Other _____

CHECK CONDITIONS THAT ARE PRESENT IN OTHER FAMILY MEMBERS AND INDICATE WHO ( ) NONE :

( ) Glaucoma	( ) Retinal Detachment	( ) Cataracts	( ) Macular Degeneration
( ) Turned/Crossed Eyes	( ) Lazy Eye	( ) Blindness	( ) Diabetes
( ) High Blood Pressure	( ) Cancer	( ) Heart Disease	( ) Thyroid Disease

CONTACT LENS HISTORY

( ) I do not wear contact lenses
( ) I am interested in wearing contact lenses or would like to know more about them
( ) I currently wear contact lenses; If so, what type: Solution: _____Sleep in your lenses? YES NO
( ) I am not satisfied with the vision and comfort of my contact lenses

How often do you replace your contact lenses (use a new pair)? _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES

I acknowledge that I received a copy of Massucci Vision Plus LLC / Maura E. Massucci O.D., Notice of Privacy Practices.

Date: _____ Printed name: _____ Signature _____

CONSENT FORM

I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I authorize the Massucci Vision Plus LLC to receive assignment of benefits from my insurance company. Please be advised that if you are using insurance coverage for today's visit, this is a contract between you and your insurance company, not Massucci Vision Plus LLC. If your insurance company has not reimbursed our office in full within 90 days, you may be billed and your insurance company will then pay you directly. If by mistake your insurance company sends the payment check to us, we will of course sign over and forward the check directly to you. Please sign below acknowledging that you understand:

Date: _____ Printed name: _____ Signature _____

MASSUCCI VISION PLUS LLC FINANCIAL POLICY

The doctor and staff at Massucci Vision Plus LLC are pleased that you have chosen us for your eye care needs. Please review our financial policy and acknowledge it with your signature below.

1. Payment for professional services (eye examinations, specialty testing, office visits) is due the day services are provided. Payment for eyeglasses and contact lenses is due in full the day materials are ordered.

2. We are providers for a wide array of insurance plans and are happy to file those claims on your behalf. Payments for copays, deductibles, and items known not to be covered by your insurance is expected at the time of your visit. You are also ultimately responsible for all charges for which your insurance company denies payment when we receive your *Explanation of Benefits* statement from them. We ask patients with insurance for which we are not providers to make payment in full when services are rendered. If applicable, an itemized statement that can be submitted to your insurance company for reimbursement will be given to you at the time of your visit.

3. Both Established and New contact lens wearers are subject to a Corneal Evaluation and Fitting Fee. This fee varies by the complexity of the individual's prescription and is separate from the exam copays. This is a global fee that covers multiple visits until the prescription is finalized and is due at each annual eye exam. These fees are due on the date of service.

4. For those with Flex Spending accounts, payment in full for services rendered and materials ordered is expected. An itemized statement that can be submitted to your insurance company for reimbursement will be given to you at the time of your visit.

5. If payment from insurance company has not been received in 90 days, you will be responsible for paying your account balance in full.

6. Finance charges at the rate of 1.5%/month (18%APR) will accrue on all outstanding balances.
7. In some families, the question of who is responsible for a child's bill is uncertain. Since we are not party to any separation

agreement or court order, this is strictly a matter between parents. We must insist, therefore, that the parent who requests evaluation and treatment for the child will be responsible for all fees incurred.

8. A service charge of $30.00 will be applicable for all checks returned for any reason, including insufficient funds and stop payments.

9. If our office must take legal action to collect any unpaid charges, you will be billed the cost of attorney fees, courts costs and collection fees in addition to any unpaid balances.

** If you have any questions, please free to discuss them with us before services are rendered. We are always willing to work with you in any way possible. **

I acknowledge that I am responsible to pay for all charges associated with the services and materials provided by Massucci Vision Plus LLC. I understand that if I fail to make any payments, my account may be turned over to a collection agency.

Date: _____ Printed name: _____ Signature _____