Acknowledgement of Receipt of Notice

Pocatello Eye Care
John M. Fornarotto, M.D.   Ryan S. Johnson, O.D.
246 North 18th Avenue, Pocatello, ID 83201
(208) 234-4100 Office   (208) 234-4192 Fax

Yes No I would like to receive a copy of the Notice of Privacy Practice.

I understand this medical practices Notice of Privacy Practices.

If not signed by the patient, please indicate relationship:

- ☐ Parent or guardian of minor patient.
- ☐ Guardian or conservator of an incompetent patient.
- ☐ Beneficiary or personal representative of deceased patient.

Name of Patient: ______________________________

Signature: ______________________________

FOR OFFICER USE ONLY:

☐ Signed form received by: ______________________________

☐ Acknowlegement refused:
Efforts to obtain: ______________________________
____

Reasons for refusal: ______________________________
____

REFRACTION POLICY

1. **What is a refraction?**
   Refraction is the process of determining the eye's refractive error, or need for corrective glasses and/or contact lenses.

2. **Why is it sometimes necessary?**
   Refraction is sometimes necessary depending on the patient's diagnosis and/or complaints presented. **For example, if a patient is experiencing blurred vision or a decrease in visual acuity on the eye chart, a refraction would be needed to see if this is due to a need for glasses or due to a medical problem. A refraction is also necessary to prove to insurance the need for cataract surgery.** We must prove that your vision cannot be simply improved with a glasses prescription. As you can see, a refraction is an essential part of an eye exam; however, Medicare and most insurance companies DO NOT cover the charge for a refraction.

3. **Will I be notified in advance if I need it?**
   Yes, **ONLY** the doctor or a technician is qualified to tell you if this procedure is necessary. They will let you know if this procedure is necessary **BEFORE** it is done. You will be given the option to accept or decline this service.

   It is important to understand that if you decline we may not be able to determine the cause for your decrease in vision.

4. **How much is the procedure?**
   Our office policy is to charge $__25__ for this procedure in addition to the office visit co-pay and/or deductible. Payment is due at the time services are rendered. We will bill your insurance according to the individual contracted fee schedules. If your insurance pays the fee we will gladly refund you this prepaid $__25__ amount once we receive payment from your insurance.

NOTE: This fee is due and payable **whether or not** you receive a written glasses prescription. Sometimes the change in vision is not significant enough to warrant the cost of purchasing new glasses. However, the fee covers the doctor's and technician's time and effort in achieving this process.

ACKNOWLEDGEMENT

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service. I understand the co-pay and deductible are separate from, and not included in, the refraction fee.

______________________________ __________________

Patient Signature (Parent for Minor) Date

Review of Systems (considered mandatory by Medicare)

Do you currently have any problems in the following areas? If yes, please explain.

	YES	NO	Explanation of Problem
Constitutional Symptoms:			
Fever	☐	☐	______
Weight loss	☐	☐	______
Ears, nose, mouth, throat	☐	☐	______
Chronic cough	☐	☐	______
Cardiovascular (heart/blood vessels)	☐	☐	______
Respiratory (lungs/breathing)	☐	☐	______
Gastrointestinal (stomach/intestines)	☐	☐	______
Genitourinary (genitals/kidney/bladder)	☐	☐	______
Integumentary (skin and/or breast)	☐	☐	______
Neurological	☐	☐	______
Psychiatric	☐	☐	______
Endocrine (Thyroid)	☐	☐	______
Hematologic/Lymphatic	☐	☐	______
Allergic/Immunologic	☐	☐	______

Patient's Signature: ______________________ Date: __________

Doctor's Initials: ________ Date: __________

Medical and Ocular History-PFSH (considered mandatory by Medicare)

Name:__________________________________ **Date:**____________

Family Physician:________________________

Last Eye Exam:____________ **Done by:**________________________

Do you have a history of any of the following: (check if yes)

_____High Blood Pressure
_____Diabetes
_____Heart Disease
_____Heart Attack
_____Lung Disease/Asthma
_____Stroke
_____Cancer
_____Rheumatoid Arthritis
_____Thyroid Problems

_____Glasses/Contacts
_____Cataracts
_____Eye Surgery
_____Glaucoma
_____Retinal Detachment
_____Macular Degeneration
_____Strabismus (Crossed Eyes)
_____Amblyopia ("Lazy Eye")

_____Eye Trauma? If yes, please explain______________________________

_____Other? Please explain__________________________________

Surgical History:____

____

Current Medications:______________________________________

____

Medication Allergies:______________________________________

Are you taking ASPIRIN or any blood thinners? YES / NO (circle)

Is there a Family History of any of the following: (check if yes)

_____Cataracts
_____Retinal Detachment
_____Strabismus (Crossed Eyes)
_____Blindness

_____Glaucoma
_____Macular Degeneration
_____Amblyopia("Lazy Eye")

Do you smoke? YES / NO (circle) If yes, how often?______________

Do you use alcohol? YES / NO (circle) If yes, how often?______________

WOMEN- Are you?... Pregnant / Nursing / on Birth Control / None (circle)

▶Is there anything else that we have not asked you about concerning your eyes or your general health that you feel we should know? If yes, what?

____

____

____

POCATELLO EYE CARE

Please Complete All Information Requested Below

NAME: (Last, First, Middle) ______________________________

SEX: Male _____ Female _____ Date of Birth: ______________

ADDRESS: ______________________________

CITY, STATE, ZIP: ______________________________

HOME PHONE: ______________ OTHER: ______________

SS#: ______________

MARITAL STATUS: Single _____ Married _____ Widowed _____ Divorced _____

EMPLOYER: ______________ WORK PHONE: ______________

OCCUPATION (If retired, former): ______________________________

SPOUSE'S NAME: ______________

PERSON(S) RESPONSIBLE FOR BILLING – Check here if patient is responsible ☐

NAME: ______________ RELATION: ______________

ADDRESS: ______________________________

CITY, STATE, ZIP: ______________________________

HOME PHONE: ______________ OTHER: ______________

SS#: ______________ DATE OF BIRTH: ______________

EMPLOYER: ______________ WORK PHONE: ______________

(1) INSURANCE COMPANY: ______________________________

POLICY #: ______________ GROUP #: ______________

ADDRESS: ______________________________

PHONE #: ______________

INSURED: ______________ RELATION: ______________

(2) INSURANCE COMPANY: ______________________________

POLICY #: ______________ GROUP #: ______________

ADDRESS: ______________________________

PHONE #: ______________

INSURED: ______________ RELATION: ______________

***Please Note:** The Federal Government is now requiring Medical Providers to enter your race/ethnicity and primary language spoken. You may decline to answer these.*

Please check:

Race
- ☐ American Indian/ Alaskan Native
- ☐ Asian
- ☐ African American/Black
- ☐ Caucasian/White
- ☐ Other
- ☐ Pacific Islander
- ☐ Declined

Ethnicity
- ☐ Hispanic
- ☐ Non-Hispanic
- ☐ Declined

Language
- ☐ English
- ☐ Spanish
- ☐ Other
- ☐ French
- ☐ German
- ☐ Japanese
- ☐ Korean

I authorize payment of medical benefits to the physician or suppler for the care and services rendered. I acknowledge and understand that I am responsible for all of the charges for all of the services rendered to me or any family member. I understand that it is my responsibility to make sure the bill is paid within 30 days. All collection costs and attorney fees are incurred by the patient if not paid as agreed.

SIGNATURE: ______________________ DATE: ______________