



www.Eye1st.net

Financial Responsibility Statement

➤ To our patients using their Medical Insurance Benefits:

We will be happy to help you file your insurance claim forms or take assignment on your vision benefits as designated by the third party plan of which you state you are a member. This service will be provided without additional charge to you. We will do all that we can to help you receive maximum benefits.

However, in the event that the Plan Sponsor determines that:

- 1) You are not eligible at the time of the claim;
- 2) You are eligible at the reduced level of coverage;
- 3) Insurance company fails to remit a payment on your behalf within 60 days of service;

I hereby agree to be financially responsible for any and all of the charges incurred by me and not paid by my insurance plan. Including, but not limited to co-payments, co-insurance, and deductibles. For reimbursement, I authorize my insurance plan to pay the provider directly.

➤ To our patients not using their Medical or Vision Insurance Benefits:

I decline the option of using my insurance benefits for the services rendered today. I agree to pay for all fees at the time of service. My method of payment will be: (Please circle one)

Cash Check CreditCard DebitCard

3) I HAVE READ AND UNDERSTAND THE FINANCIAL RESPONSIBILITY POLICY.

Patient Signature

Date



At Eye1st Vision & Laser we give our patients the highest level of comprehensive eyecare using the latest equipment and technology available. This includes a thorough examination for eye diseases such as corneal disease, dry eye disease, glaucoma, cataracts, diabetic retinopathy, macular degeneration, and other retinal diseases. We perform a dilated internal ocular exam and utilize digital photography of the retina on every patient. Additionally, we perform a careful determination of vision correction (refraction).

In order to provide this level of care, all patients are charged a \$30 annual photography fee that will be collected on the date of the exam.

We thank you for choosing Eye1st Vision & Laser as your eyecare provider.

Signature

Date

Annual Health History

Patient: _____ DOB: _____ Date: _____

Yes	No	
		Lung disease/asthma _____
		Kidney disease _____
		Arthritis _____
		Diabetes _____ #of Yrs _____
		Neurological disease _____
		Migraines _____
		Psychiatric disorder _____
		Nervous disorder _____
		Heart disease _____
		Gastrointestinal disease - type _____
		High blood pressure _____ #ofYrs _____
		Scarring/keloids _____
		Allergic to Latex or Rubber? _____
		Cancer _____
		Thyroid - Hyper / Hypo _____
		High Cholesterol _____
		Currently pregnant or nursing _____

Medications: _____

Eye Drops: _____

Surgeries: _____

Allergies (Meds/Environmental, Seasonal) _____

Eye injury or surgeries: _____

Has any family member (mother, father, sisters, brothers, or grandparents) been treated for the following:

Yes	No	
		Glaucoma _____
		Cataracts _____
		Macular degeneration _____
		Diabetic retinopathy _____
		Diabetes _____
		Stroke _____

Yes	No	
		Retinal detachment _____
		Corneal disease _____
		Retinitis pegmentosa _____
		Other eye problems _____
		Heart disease _____
		Other health conditions _____

- _____ Dr. James A. Stewart
- _____ Dr. George D. Shida
- _____ Dr. Julie A. Wolf
- _____ Dr. Dennis C. Matzkin
- _____ Dr. George O. Waring
- _____ Dr. Julia Bond

Patient Signature _____

Doctor Signature _____