SURE VISION℠ Eye Centers

Thank you for trusting SureVision with your eye care needs! Part of being able to take good care of our patients includes making sure we have current information on file. We ask that all of our patients complete this paperwork once a year. Returning the completed forms to us at least one week (sooner would be better) prior to your appointment will decrease your wait time before seeing the doctor. We have enclosed a self-addressed stamped envelope for your convenience. You may also return the completed paperwork via fax to (314) 838-9536 or via e-mail to medicalrecords@surevision.us. Be sure to write down all of the medications you are currently taking.

If you are unable to return your forms prior to your appointment, please bring the completed forms with you to your appointment and arrive 15 minutes earlier than your scheduled time.

Please bring all medical and vision insurance cards as well as a photo ID with you to your appointment. If your insurance requires a referral from your primary care doctor, we must receive it prior to your appointment date or your appointment will be rescheduled. If you're unsure if a referral is required, call your insurance company to inquire about it at least four days prior to your appointment date. It sometimes takes 3 or 4 days to obtain referrals.

We require payment of all estimated patient expenses when you arrive for your appointment and check in at the front desk. This includes co-payments plus any deductible you might owe. Our staff confirms insurance benefits prior to your visit. They will give you an estimate of how much needs to be paid when you are called to be reminded of your appointment. That amount will be collected prior to seeing the doctor. We accept cash, checks, MasterCard, Visa, Discover and American Express. As well, we offer Care Credit patient financing.

If you have any questions or if you need to reschedule your appointment for any reason, please call one of our offices at the numbers listed below. We are looking forward to seeing you!

SureVision Eye Centers

Appointment Date_____ Time_____ Doctor_____

☐ 7934 North Lindbergh Blvd., Hazelwood, MO 63042	(314) 921-2020	(866) 305-2044
☐ 2127 Bluestone Drive – Suite 202, St. Charles, MO 63303	(636) 949-3924	(866) 305-2044
☐ 1 Professional Drive – Suite 260, Alton, IL 62002	(618) 465-2020	(866) 443-6192
☐ 1 Park Place, Belleville, IL 62226	(314) 921-2020	(866) 305-2044

Vision like you've never seen before.℠

SURE VISION Eye Centers

(*Office Use Only*) MRN: _____

NAME		DATE
STREET ADDRESS	APT. #	SOCIAL SECURITY #
CITY, STATE, ZIP		

RACE
☐ AMERICAN INDIAN
☐ ALASKAN NATIVE ☐ BLACK OR AFRICAN AMERICAN
☐ WHITE ☐ DECLINE
☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER

SPECIAL NEEDS
☐ WHEELCHAIR
☐ HEARING IMPAIRED ☐ WALKER
☐ TRANSLATOR ☐ OTHER

PREFERRED LANGUAGE	BIRTH DATE	AGE	ETHNIC ORIGIN	SEX
			☐ HISPANIC OR LATINO ☐ NON- HISPANIC OR LATINO ☐ DECLINE	☐ M ☐ F

HOME PHONE	WORK PHONE	MARITAL STATUS
		☐ S ☐ M ☐ D ☐ W
EMPLOYER NAME/ADDRESS		POSITION/DEPARTMENT
SPOUSE'S NAME		SPOUSE'S WORK PHONE ( )
EMERGENCY CONTACT – NAME AND PHONE NUMBER		YOUR E-MAIL ADDRESS

BILLING

GUARANTOR (FINANCIALLY RESPONSIBLE PERSON) NAME_____ SOCIAL SECURITY # – –	RELATIONSHIP TO PATIENT ☐ SELF ☐ PARENT ☐ SPOUSE ☐ OTHER
STREET ADDRESS	BIRTH DATE PHONE / / ( ) -
CITY	STATE ZIP

SEND WORKERS COMP BILL TO	AUTHORIZED BY NAME PHONE ( ) -

REFERRAL

WHOM MAY WE THANK FOR TELLING YOU ABOUT OUR PRACTICE? PHONE ( )	☐ FRIEND/FAMILY ☐ NEWSPAPER ☐ M.D. ☐ RADIO ☐ OPTOMETRIST ☐ TELEVISION ☐ YELLOW PAGES ☐ OTHER

STREET ADDRESS	CITY	STATE	ZIP CODE
PRIMARY CARE DOCTOR	PHONE ( ) -		
STREET ADDRESS	CITY	STATE	ZIP CODE

Continued on back ➔

Agreement of Responsibility

I understand that professional services are rendered to the patient and the patient is responsible for charges incurred for these services. Payment for annual deductibles and co-insurance may be collected at the time of service. I understand that I am financially responsible for charges not covered by my insurance company.

Consent to Treat

I voluntarily consent to such care and treatment as prescribed by the physician as is necessary in his/her medical judgment.

Release of Information/Assignment of Benefits

I authorize use of this form on all my insurance submissions and authorize release of information needed to process a claim to all my insurance companies. I permit a copy of this authorization to be used in place of the original. I authorize the provider to act as my agent in helping me obtain payment from my insurance companies. I understand the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement on disputed claims. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand I will receive a monthly statement for any balance due by me.

This Agreement is in effect until revoked in writing by the patient.

Signature: _____ Date: _____/_____/_____

Medicare Authorization Medicare No. _____

I request payment of authorized Medicare benefits be made on my behalf to SureVision Eye Centers – Midwest, LLC for any services furnished me by that physician/supplier. I authorize the holder of medical information about me to release to Medicare and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and the uncovered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Medigap Authorization Insurance Co._____

Policy No._____

Fill out if you have a Medigap insurance policy for which you wish to assign benefits. A Medigap or Medicare Supplemental policy is a health insurance policy or other health benefit plan, offered by a private company, to those entitled to Medicare benefits. It is designed to pay certain costs that Medicare does not pay. By law, this excludes a policy or plan offered by an employer to employees or former employees, as well as a policy or plan offered by a labor organization to members or former members.

SURE VISION Eye Centers

Patient Name:_____

DOB:_____

(Office Use Only) MRN:_____

Health & History Information

Primary Care Physician			**Referring Physician**
Address:			Address:
City, State:		Zip:	City:
Telephone: ( )			State: Zip:
	Please Circle		Telephone: ( )
Do you Wear contact lenses?	Yes	No	If Yes, What Kind? Soft lenses Hard lenses
Do you have vision insurance?	Yes	No	If yes, What Insurance Company?
Do you have any medication allergies?	Yes	No	If yes, What Medications?
Do you have seasonal Allergies?	Yes	No	
Do you smoke?	Yes	No	If yes how much? How long?
Recreational drug use?	Yes	No	Needle use? Yes No
Do you consume alcohol?	Yes	No	Amount Frequency
Do you consume caffeine?	Yes	No	Amount Frequency

Please List all Medications you take Below		
Medication	**Dose**	**Condition**

CONTINUED ON REVERSE SIDE…

Preferred Pharmacy?		Phone #
Pharmacy Address		
Do you have Diabetes?	Yes No (Type I Type II)	How long?
Do you have a family history of any of the following:		
Diabetes	Yes No	Family Member?
Crossed eyes	Yes No	Family Member?
Glaucoma	Yes No	Family Member?
Corneal Disease	Yes No	Family Member?
Retinal Disease	Yes No	Family Member?

EYE HISTORY - Disease or surgery of the EYE

Date	Diagnosis or Surgery	Doctor	Location

Procedure	OTHER SURGERIES	Year

Patient Signature:_____

Date:_____

Tech Initials:_____

SURE VISION Eye Centers

(*please print*) Patient Name: _____

Date Of Birth: _____

(*Office Use only*) MRN: _____

Have you or do you currently have any of the following medical Problems?	**YES**	**NO**	**If yes, please explain**
Heart Issues (heart attack, high blood pressure, congestive heart failure, pacemaker, heart surgery, high cholesterol, etc)			
Dermatologic (acne, rosacea, eczema, psoriasis, etc.)			
Gastrointestinal (Crohn's disease, colitis, inflammatory bowel disease, GERD, Ulcer, etc)			
Genitourinary (enlarged prostate, endometriosis, ovarian cyst, current pregnancy, etc)			
Ear, Nose, and Throat (chronic sinus diseases, deafness, tonsillitis, etc)			
Hematologic (sickle cell anemia, leukemia, lymphoma, etc)			
Immunologic (Sjogren's syndrome, rheumatoid arthritis, seasonal allergies, lupus, myasthenia gravis, etc)			
Infectious dieseases (Hepatitis B or C, HIV, AIDS, etc)			
Endocrine (Diabetes-Type I or II, hypothyroidism, Hypethyroidism, pituitary tumor, etc)			
Muscoloskeletal (Osteoarthritis, fibromyalgia, osteoporosis, etc)			
Cancer (Skin cancer, bladder cancer, breast cancer, chemotherapy, radiation, etc)			
Neuropsychiatric (Cluster headaches, migraine headaches, multiple sclerosis, Alzheimer's, dementia, depression, mood swings, etc)			
Pulmonary (asthma, emphysema, cystic fibrosis, COPD, etc)			

Other Medical Problems:

_____

_____

_____

Patient Signature: _____ Date: _____

Tech Initials: _____

SURE VISION Eye Centers

(*Office Use Only*) MRN: _____

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.
By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

This Consent was signed by: _____
Printed Name – Patient or Representative

Relationship to Patient (if other than patient): _____

Date:_____/_____/_____ Witnessed by: _____
Printed Name – Patient or Representative

I agree to have my health information disclosed to the following person(s):

_____ Name

_____ Relationship to Patient

_____ Name

_____ Relationship to Patient