



## Signature On File/Assignment of Benefits/Financial Agreement

\_\_\_\_\_  
Name (*Print*)

**1. MEDICARE LIFETIME ASSIGNMENT/SIGNATURE ON FILE:** I request that payment of authorized Medicare benefits be made on my behalf to Cortland Eye Center (CEC), for services furnished to me by CEC. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand 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, my signature authorizes releasing the information to the insurer or agency shown. CEC accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

**2. MEDIGAP:** I understand that if a Medigap policy of other health insurance is indicated in item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to CEC, if possible, otherwise to me.

**3. NOTICE OF PRIVACY PRACTICES:** Notice of Privacy Practices has been provided.

**4. OTHER INSURANCE:** I understand that CEC maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. I understand that CEC has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by CEC if I belong to a plan that does not appear on the above mentioned list.

**5. NON-COVERED SERVICES:** I understand that CEC's contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services that are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services that are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with CEC to obtain all necessary health care service plan authorizations.

**6. FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by CEC, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to CEC for payment. If my account is delinquent and requires collection services, I agree to pay all collection expenses, attorney fees, and/or court costs. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, and any other party liable to the patient, is hereby assigned to CEC. I understand and agree that any unmet deductibles are my responsibility. **I understand and agree that my insurance co-pay is due at the time of service and if not paid to CEC at the time of service, I will be charged and agree to pay a \$15.00 billing fee. I also understand that there will be a service fee applied for all payments I make that are not honored by my banking or credit/debit card institution (bounced checks, etc.).**

**7. TERM OF AUTHORIZATION:** This authorization shall remain in effect until I choose to revoke it.

\_\_\_\_\_  
Beneficiary Signature Patient or Authorized Party

\_\_\_\_\_  
Date

***Note: Must Be Signed To Bill All Insurance Companies***

Cortland Eye Center
PATIENT HISTORY RECORD

Name: Age: Date:

Drug or food allergies? Yes No If YES, please list:

Have you ever been treated for any medical conditions (such as diabetes, high blood pressure, arthritis, etc.)? Yes No If YES, explain:

Have you had any eye disease/eye injuries/eye surgery (such as glaucoma, cataract, "lazy" eye, retinal detachment, etc.)? Yes No If YES, explain:

Have you ever had any other surgery? Yes No If YES, provide date & procedure:

Do you use any eye medications? Yes No If YES, please list:

Do you take any other medications? Yes No If YES, please list:

Review of Systems

Table with 4 columns: Question, Yes, No, If Yes, please explain:
Do you currently have any of the following problems:
Eyes (poor vision, eye pain, tearing, dry eye, redness, etc)
Constitutional (Chronic fever, unexpected weight loss/gain, fatigue)
Ear/nose/throat problems (hearing loss, sinus problems, sore throat, etc)
Cardiovascular/Heart problems (high BP, chest pain, irreg. heart beat, etc)
Respiratory problems (shortness of breath, wheezing, cough, etc)
GI problems (heartburn, abdominal pain, diarrhea, vomiting, hernia, ulcers, etc.)
Urinary/Kidney/Bladder problems (pain, discomfort, blood in urine, etc)
Females (Are you pregnant? Nursing?)
Musculoskeletal (Muscle aches, joint pain, swollen joints, arthritis)
Skin Problems (rashes, excessive dryness, growths, etc)
Neurological (numbness, weakness, headaches, seizures, paralysis)
Psychiatric problems (depression, anxiety, insomnia, etc)
Endocrine problems (Diabetes, thyroid problems, etc.)
Blood/Lymphatic problems (anemia, leukemia, bleeding tendencies, swollen glands, etc.)
Allergic/Immunologic problems (lupus, severe allergies, HIV, immunosuppressed etc)

Family & Social History: (Blood relatives only - Mother, Father, Grandparent, Sibling)
Circle any conditions that run in your family: Diabetes, High Blood Pressure, Blindness, Glaucoma, Macular Degeneration, Crossed/Lazy eye(s), Thyroid Disease, Other eye disease/conditions:
Who?

Never Smoked Occasionally Smokes Quit Current Smoker x Years How much?
No Alcohol Consumption Yes Drinks Alcohol? How much?

Name: \_\_\_\_\_

Date: \_\_\_\_\_

In order to serve your eye care needs: Are you having any of the following eye problems or symptoms?

	Yes	No	Explanation of Problem
Loss of vision or blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	.....
Flashes and/or floaters	<input type="checkbox"/>	<input type="checkbox"/>	.....
Distorted vision (halos)	<input type="checkbox"/>	<input type="checkbox"/>	.....
Loss of side vision (peripheral)	<input type="checkbox"/>	<input type="checkbox"/>	.....
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	.....
Dryness of eyes	<input type="checkbox"/>	<input type="checkbox"/>	.....
Mucous discharge of eyes	<input type="checkbox"/>	<input type="checkbox"/>	.....
Redness	<input type="checkbox"/>	<input type="checkbox"/>	.....
Sandy or gritty feeling	<input type="checkbox"/>	<input type="checkbox"/>	.....
Itching and/or burning sensation	<input type="checkbox"/>	<input type="checkbox"/>	.....
Foreign body sensation	<input type="checkbox"/>	<input type="checkbox"/>	.....
Excessive tearing/watering	<input type="checkbox"/>	<input type="checkbox"/>	.....
Glare/Light sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	.....
Eye pain or soreness	<input type="checkbox"/>	<input type="checkbox"/>	.....
Chronic infection of eye or lid	<input type="checkbox"/>	<input type="checkbox"/>	.....
Sties, Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	.....
Fluctuating vision acuity (vision)	<input type="checkbox"/>	<input type="checkbox"/>	.....
Problems with night vision or driving	<input type="checkbox"/>	<input type="checkbox"/>	.....

*To assist us in appropriately prescribing and fitting your eyewear, please check the proper responses:*

**Work environment:**  office setting  fluorescent lighting  industrial setting/construction work

**Computer use:** Hours/day spent on computer at work \_\_\_\_\_ at home use \_\_\_\_\_

**Driving:**  day  night  bothered by brightness/glare  bothered by headlights or halos

**Hobbies:**  needlework/sewing  musician  pilot/shooter/marksman  avid reader  
 stamp/coin collector, etc.  woodworking  gardening  other \_\_\_\_\_

**Sports:**  golf  racquet sports  skiing  fishing/hunting  other \_\_\_\_\_

use more than 1 pair glasses  happy with current glasses  problems with current glasses

**FOR OFFICE USE ONLY**

Changes + Updates to this information are noted on the exam notes.

Updated: \_\_\_\_\_  
\_\_\_\_\_