ALABAMA COAST EYE CLINIC
FELBER & ASSOCIATES, LLC
Dr David R Felber

TODAY'S DATE: _____

Have you ever had an eye exam here before? _____

LAST NAME: _____ FIRST NAME: _____ M.I._____

BIRTHDATE: _____ MALE_____ FEMALE_____

SSN: _____

MARITAL STATUS: SINGLE _____ MARRIED _____ DIVORCED _____ WIDOWED _____

PHYSICAL ADDRESS: _____

MAILING ADDRESS: _____

CITY/STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL: _____

EMPLOYER: _____

RESPONSIBLE PARTY INFORMATION (if different)

NAME: _____ RELATIONSHIP: _____ DOB: _____

ADDRESS IF DIFFERENT: _____

PHONE NUMBER_____ EMPLOYER: _____

SSN: _____

WHEN WAS YOUR LAST EYE EXAM? _____

DO YOU WEAR GLASSES NOW? _____

DO YOU WEAR CONTACT LENSES? _____ DO YOU WANT AN EXAM FOR CONTACTS TODAY? _____

WHAT KIND/BRAND DO YOU WEAR? _____

HEALTH INFORMATION: CHECK IF YOU HAVE A HISTORY OF:

____ High Blood Pressure
____ Heart Disease
____ Heart Attack
____ High Cholesterol

____ Diabetes
____ Thyroid Disease

____ Stroke
____ Seizures
____ Epilepsy

____ Kidney Disease
____ Prostate Problems

____ Stomach Problems
____ Ulcers
____ Weight Loss/Gain

____ Ear Problems
____ Sinus/Allergy Problems
____ Headaches
____ Migraines

____ Anemia
____ Hepatitis/Jaundice
____ Sickle Cell or Trait
____ Cancer

____ Arthritis
____ Back Problems
____ Neck Problems

____ ADHD
____ Alcoholism
____ Drug Addiction
____ HIV

____ Asthma
____ Emphysema

____ Skin Cancer
____ Rosacea

PLEASE TURN PAGE OVER

PHARMACY NAME/LOCATION: _____

MEDICATIONS ALLERGIC TO: _____

ARE YOU PREGNANT / NURSING? _____

SOCIAL HISTORY: Do you use: Tobacco: Y___ N___ Illegal Drugs: Y___ N___ (REQUIRED BY INSURANCE)

FAMILY HISTORY: (List any conditions that run in your family) _____

_____

INSURANCE INFORMATION

HEALTH Insurance Carrier: _____/_____

Policy/Contract/SS Number: _____/_____

Policy Holders LEGAL Name: _____/_____

Policy Holders Date of Birth: _____/_____

Policy Holders Employer: _____/_____

Policy Holders Address: _____
(If Different than Responsible Party)

VISION Insurance Carrier: _____/_____

Policy/Contract/SS Number: _____/_____

Policy Holders LEGAL Name: _____/_____

Policy Holders Date of Birth: _____/_____

Policy Holders Employer: _____

Policy Holders Address: _____
(If Different than Responsible Party)

The above information is true to the best of my knowledge. Fees for professional services and materials are due at the time of service or when materials are ordered. Payment from my insurance is to be paid directly to Felber and Associates LLC. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company. Final determination can only be made after the claim is processed. My signature below also acknowledges that I have been offered/read Felber and Associates Privacy Notice. I also understand that I am ultimately responsible for any charges incurred today, including those charges that my insurance company may deny. I authorize Felber and Associates LLC or my insurance company to release any information required to process my claims.

_____ DATE: _____

SIGNATURE OF PATIENT OR GUARDIAN

HIPAA Medical Information Release Form

Patient Name: _____ Date:_____

Privacy regulations require us to have a release form signed by our patients so we may speak with family members, friends, and other relations regarding your medical treatment and financial information. Each person you would like to have access to your information must be listed below.

Please print the name and relationship for each person you are authorizing access to your medical information and account balances.

Please choose one option below **AND** sign when done.

____ "The person(s) listed below have access to my private information":

_____ _____
Name Relationship

_____ _____
Name Relationship

OR

____"I choose not to release my private information with anyone."

Patient Signature: _____

RETINAL SCANNING

We have a state of the art device in our office that will scan the eye and the structures underneath. This is a non-invasive scan (OCT scan) that allows our doctor to see below the surface of the retina. This technology can allow us to see problems in the eye up to 10 years earlier than can be seen with a normal eye exam and dilation. In most cases this scan will replace the need for dilation. This procedure provides a permanent scan and image that can be reviewed and compared from year to year and track any changes in health.

The doctor strongly recommends that all patients have this procedure performed.
If you choose not to have the scan, then you must be dilated.

This scan is **NOT** covered by your health or vision insurance.

_____ I choose the scan and agree to pay $25.00 to have this procedure done.

_____ I do not want to have this procedure performed. I prefer to be dilated.

_____ _____

Signature Date

Contact Lens Exam Agreement

The contact lens exam is an additional fee not included in your comprehensive examination cost. Depending on your vision insurance some plans cover the contact lens fitting in full, require a copay, or give a discount. **The fee includes the initial visit, contact lens training, and all follow ups for a 90 day period.** This exam applies to both new, and established patients.

Policies:

- Charges for fitting fees are due in full at the time of the exam
- All follow-ups extending past the 90 days are subject to normal office visit rates
- We will be happy to confirm your insurance benefits in relation to the contact lenses and fitting costs.
- Any non-covered expenses become the patient's responsibility.
- All fees are nonrefundable.
- All prescriptions are valid for one year.
- You are responsible for keeping all follow-up appointments to finalize your prescription.
- If you do not keep your follow-up appointments and have exceeded the 90 day period, you will be responsible for normal office visit rates.

This does not include routine eye exam, co-pays, or other fees.

I understand and comply with the above policies and fee schedule.

Patient Name: _____

Patient or Guardian Signature: _____ Date: _____