GREAT RIVERS COMMUNITY EYE CARE

PATIENT REVIEW OF SYSTEMS

We are pleased to welcome you to our practice! Please take a few minutes to fill out this form to the best of your ability. Let us know if you have any questions and we will gladly help you.

PATIENT INFORMATION

Today's Date: _____

Patient's Name: _____

Patient's SSN: _____

Phone: _____

Email: _____

Date of Birth: _____

Sex: ☐ Male ☐ Female

How would you like us to contact you?

☐ Phone Call ☐ Text ☐ Email

Tobacco Use: ☐ Yes ☐ No ☐ Smokeless

Alcohol Use: ☐ No ☐ Social ☐ Daily

Primary Doctor: _____

EMERGENCY CONTACT

Name: _____

Relationship: _____

Phone: _____

ETHNICITY

☐ Hispanic or Latino
☐ Native Hawaiian/Pacific Islander
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ White
☐ Declined to Specify

MEDICAL AND FAMILY HISTORY

Please list the family member(s) when applicable. If you have no changes since your last visit, please sign at the end.

Please list any OTC or Prescription meds:

_____

_____

Please list any medication or other allergies:

_____

_____

CONDITION	YOU	FAMILY
Constitutional	☐	☐
Developmental Disability	☐	☐
Cancer	☐	☐
Fatigue Syndrome	☐	☐
Other: _____	☐	☐
ENT		
Hearing Loss	☐	☐
Sinusitis	☐	☐
Dry Mouth	☐	☐
Laryngitis	☐	☐
Other: _____	☐	☐
Neurological		
Multiple Sclerosis	☐	☐
Epilepsy	☐	☐
Cerebral Palsy	☐	☐
Tumor	☐	☐
Migraine	☐	☐
Autism	☐	☐
Other: _____	☐	☐

CONDITION	YOU	FAMILY
Psych		
Depression	☐	☐
ADD/ADHD	☐	☐
Anxiety Disorder	☐	☐
Bipolar Disorder	☐	☐
Other: _____	☐	☐
Cardiovascular		
Hypertension	☐	☐
Stroke/CVA	☐	☐
Heart Disease	☐	☐
Vascular Disease	☐	☐
Congestive Heart Failure	☐	☐
Other: _____	☐	☐
Respiratory		
Smoker	☐	☐
Asthma	☐	☐
Bronchitis	☐	☐
Emphysema	☐	☐
Chronic Obstruction	☐	☐
Sleep Apnea	☐	☐
Other: _____	☐	☐
Gastrointestinal		
Crohn's Disease	☐	☐
Ulcer	☐	☐
Acid Reflux	☐	☐
Celiac Disease	☐	☐
Other: _____	☐	☐

CONDITION	YOU	FAMILY
Genitourinary		
Kidney Disease	☐	☐
Prostate Disease/Cancer	☐	☐
STD-Herpetic/Chlamydia	☐	☐
Prostate Hypertrophy	☐	☐
Pregnant	☐	☐
Nursing	☐	☐
Other: _____	☐	☐

CONDITION	YOU	FAMILY
Musculoskeletal		
Arthritis	☐	☐
Osteoarthritis	☐	☐
Fibromyalgia	☐	☐
Muscular Dystrophy	☐	☐
Ankylosing Spondylitis	☐	☐
Osteoporosis	☐	☐
Gout	☐	☐
Other: _____	☐	☐
Integumentary		
Eczema	☐	☐
Rosacea	☐	☐
Psoriasis	☐	☐
Cold Sores	☐	☐
Shingles	☐	☐
Other: _____	☐	☐

CONDITION	YOU	FAMILY
Endocrine		
Diabetes Type 1	☐	☐
Diabetes Type 2	☐	☐
Thyroid Dysfunction	☐	☐
Hormonal Dysfunction	☐	☐
Other: _____	☐	☐
Hematologic/Lymphatic		
Anemia	☐	☐
Large Volume Blood Loss	☐	☐
Hypercholesterolemia	☐	☐
Other: _____	☐	☐
Allergy/Immunologic		
Drug Allergies	☐	☐
Environmental Allergies	☐	☐
Rheumatoid Arthritis	☐	☐
Sjögren's Syndrome	☐	☐
Other: _____	☐	☐

Signature: _____ Date: _____

GREAT RIVERS COMMUNITY EYE CARE

NOTICE OF PRIVACY PRACTICES & COMMUNICATION CONSENT

We are committed to protecting your personal health information and maintaining your privacy.
Please read the information below and sign at the bottom.

1 PRIVACY PRACTICES

The law requires us to protect your personal health information. This Notice explains how we may use and share your information and your rights.
You have the right to read this Notice before signing.

2 INFORMATION RELEASE

By signing below, you authorize us to release your personal health information to the following individuals:

Name: _____

Relationship to Patient: _____

Name: _____

Relationship to Patient: _____

3 COMMUNICATIONS

We may contact you by phone, email, or text to share appointment reminders, test results, and information about your care.

☐ I authorize the use of these methods to communicate with me.

☐ I do not authorize the use of these methods to communicate with me. Please contact me another way.

These methods are not secure and may not guarantee privacy.

4 INSURANCE AUTHORIZATION

By signing below, you authorize us to release information, including diagnosis and records of treatment or examination, to your insurance company. I request payment of benefits to be made directly to this office. I understand I am responsible for any charges not covered by my insurance. Providing correct insurance information is my responsibility.

By signing below, I acknowledge that I have read and understand this Notice of Privacy Practices and Communication Consent.

Patient/Guardian Name: _____

Signature: _____ Date: _____

Questions? Please ask any team member. We are happy to help.

GREAT RIVERS COMMUNITY EYE CARE

Advanced Beneficiary Notice (ABN) & Financial Responsibility Agreement

This form explains situations where your insurance may not pay for certain services, materials, or procedures provided during your visit.

Our goal is to help you understand your financial responsibility before services are performed.

1. WHEN THIS FORM MAY APPLY

You may be responsible for charges when:

- You do not have vision or medical insurance
- Your insurance is out-of-network with our office
- Your deductible has not been met
- Your insurance does not cover a specific service, procedure, test, or material
- Your insurance does not cover refractions (glasses prescription checks)
- Your insurance denies payment for services provided
- Medicare does not cover certain services or materials
- Your insurance company sends payment directly to you instead of our office

2. IMPORTANT INFORMATION ABOUT REFRACTIONS

- A refraction is the part of the exam used to determine your eyeglass prescription.
- Many medical insurance plans and Medicare do not cover refractions, even when performed during a medical eye exam.
- If your insurance does not cover this service, you will be responsible for payment.

  Refraction fee: $45

3. YOUR FINANCIAL RESPONSIBILITY

By signing below, you understand and agree that:

- Your insurance coverage does not guarantee payment
- You are responsible for any charges not covered by your insurance
- You are responsible for providing current and accurate insurance information
- Any unpaid balance remains your responsibility

This agreement applies to services, testing, procedures, and materials provided by Great Rivers Community Eye Care.

4. PATIENT ACKNOWLEDGEMENT

I understand that some services or materials may not be covered by my insurance plan and that I may be financially responsible for those charges.

Patient/Guardian Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

GREAT RIVERS COMMUNITY EYE CARE

VISION VS. MEDICAL INSURANCE ACKNOWLEDGEMENT

At Great Rivers Community Eye Care, we understand that insurance coverage for eye care can sometimes be confusing. This form is designed to help explain the difference between vision insurance and medical insurance, and how each may apply to your visit.

VISION INSURANCE

Vision plans are intended for routine eye care and may include benefits for:

- Routine eye examinations
- Updating eyeglass or contact lens prescriptions
- Glasses and contact lenses
- Preventive vision care

Examples include VSP, EyeMed, Spectera, Davis Vision, and similar plans.

Vision insurance is generally used when:

- You are having a routine exam
- You are not experiencing medical eye symptoms
- No medical eye condition is being evaluated or treated

MEDICAL INSURANCE

Medical insurance is used when your visit involves the diagnosis, treatment, monitoring, or management of a medical eye condition or symptom.

Examples include, but are not limited to:

- Diabetes
- Cataracts
- Glaucoma
- Dry eye syndrome
- Macular degeneration
- Eye infections or allergies
- Eye pain, redness, flashes, or floaters
- Double vision
- Headaches related to vision
- High blood pressure affecting the eyes
- Medication monitoring
- Eye injuries or foreign body removal

Medical insurance may also be billed if the doctor discovers a medical condition during a routine exam that requires additional testing, diagnosis, or treatment.

IMPORTANT INFORMATION

- Our doctors determine which insurance is appropriate to bill based on:
  - Your reason for visit
  - Symptoms reported
  - Examination findings
  - Testing performed
  - Final diagnosis
- A routine vision exam may become a medical visit if medical concerns are addressed during the appointment.
- Vision and medical insurance typically cannot both be billed for the same examination on the same day.
- In certain situations, coordination of benefits may allow both vision and medical insurance to be used appropriately. For example, medical insurance may be billed for the medical portion of care while eligible vision benefits may still apply toward glasses or contact lenses. Not all insurance plans allow coordination of benefits, and coverage varies by plan.
- Some services, including refraction (the portion of the exam used to determine your eyeglass prescription), may not be covered by medical insurance.
- Insurance coverage does not guarantee payment. You are responsible for any copays, deductibles, refractions, non-covered services, or balances not paid by your **insurance company.**

REFRACTION NOTICE

A refraction is used to determine your eyeglass prescription. Many medical insurance plans do not cover this service.

Refraction Fee: $45.00

PATIENT ACKNOWLEDGEMENT

I understand the difference between vision insurance and medical insurance and authorize Great Rivers Community Eye Care to bill the appropriate insurance based on my visit and the doctor's findings.

Patient/Guardian Name: _____

Signature: _____ Date: _____

Thank you for helping us provide the best possible care for your eyes!

GREAT RIVERS COMMUNITY EYE CARE

Your eyesight is priceless and we are here to protect it!

Vision threatening diseases such as glaucoma, macular degeneration, and diabetic retinopathy often have no outward signs or symptoms in early stages, so **Dr. Gerson** has begun using state-of-the-art technology to assess the health of your eyes.

The Wellness Exam with Fundus Photography is a quick, non-invasive scan that allows our doctor to see both the surface and beneath the surface of your retina. This unique technology can help our doctors detect vision threatening and systemic diseases in their very early stages, when they are most treatable.

As part of your pre-exam testing, our technician will perform the Wellness Exam with Digital Fundus Photography which your doctor will review with you during your exam today.

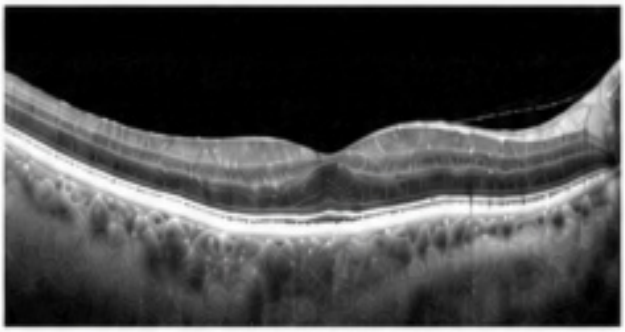
The **$39.00** charge is typically not covered by your vision or medical insurance, so this **will be added into the cost of your visit today.**

Any questions you have about the Wellness Exam or Fundus Photos and the results of the test can be discussed with the doctor during your exam.

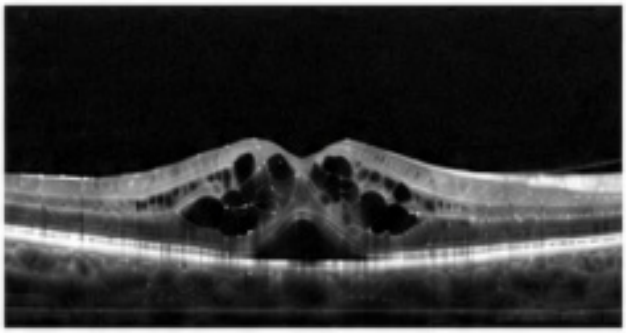
Wellness Package Exam: _____

OR

Refusal of Wellness Exam: _____



Healthy Retina



Unhealthy Retina invisible to photos