*****PATIENT INFORMATION*****

ACCOUNT #: DATE:

Name: DOB: AGE:

Address:

Town: ST: ZIP:

HOME PHONE: Can we contact you at this number? Y N

Cell Phone: _____ Can we contact you at this number? Y N

WORK #:_____ Can we contact you at this number? Y N

EMPLOYER:_____

Email:_____

Marital Status:_____

EMERGENCY CONTACT: _____

Phone #:_____Relationship:_____

NAME OF LOCAL PHARMACY: _____MAIL ORDER:_____

PRIMARY CARE PHYSICIAN: _____

****

PRIMARY INS: SUBSCRIBER:

CERTIFICATE #: GROUP #: SUB DOB:

SECONDARY INS: SUBSCRIBER:

CERTIFICATE #: GROUP #:

****

Responsible Party Information:

Last Name:_____First:_____

Address:_____

Phone #:_____ Relationship:_____

Preferred Language: __English ___Spanish ___French ___German ___Other

Ethnicity:__US/American ___African American ___Asian ____English ___Dutch ___Other

Race:__White ___African American ___Latino/Hispanic ___Asian ___Native American ___Prefer not to answer

CONSENT: I authorize Mid Coast Vision Care and its health care practitioners, staff, and other individuals involved in my care to examine me and perform any tests, procedures and/or treatments that may be helpful to care for my injury or illness. I understand that the health care practitioner responsible for this care will explain any proposed procedure or treatment, including their usual and most frequent risks and hazards. I also understand that I have the right to refuse any proposed procedure or treatment.

RELEASE: I authorize Mid Coast Vision Care, to release my health care information, to the extent necessary, to my insurance carriers and their reviewers or others paying for this care. This authorization is effective until final payment is received or 30 months (whichever is sooner) Mid Coast Vision Care may make future disclosures of these records to the same individuals or facilities during this time period.

PAYMENT: I understand that I am responsible for paying all costs associated with my evaluation and care. If I have health insurance, I understand that I am financially responsible in the event that all or some payment is denied by my insurance carrier or other third party who is responsible for payment. I am also responsible for those charges not covered by my insurance such as deductibles, copays or evaluations or treatment that are not included as an insurance benefit, I AUTHORIZE my health insurance carrier(s) or other third parties who are responsible for paying for my health care to pay the costs associated with my evaluation and care directly to Mid Coast Vision Care, or any of his professional employees.

I UNDERSTAND THAT: I CAN revoke all or part of this authorization at any time by notifying Mid Coast Vision Care, in writing, subject to the rights of anyone who disclosed or received information prior to receiving my revocation. I CAN refuse to disclose all or some of the information in treatment records. A refusal or revocation to release some/all information may result in improper diagnosis or treatment, denial of insurance coverage or a claim for a health benefits or other adverse consequences. I CAN request a copy of this form. I CAN cross out any provision in this form with which I do not agree.

DISMISSAL: I understand that should I fail to comply with the physicians recommendations for follow up and/or treatment, I risk being dismissed from the doctor's care after appropriate and routine notification has been given as per policy.

_____ _____ _____

Witness Patient or Authorized Representative Date

MID COAST VISION CARE

LYNDON W. MORGAN, M.D.
Ophthalmology
Serena A. Morrison, M.D.
Ophthalmology
ROBERT A. POOLE, O.D.
Optometry

158 Northport Avenue
Belfast, Maine 04915
(207) 338-2571

96 Maverick Street, Suite 2
Rockland, Maine 04841
(207) 596-6074

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT

Patient Name:

Date of Birth:

I have received and understand this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of this Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controled by, this practice. If changes to the policy occur, this practice will provide me with a revised Notice of Privacy Practices upon request.

Signature: _____

Date:_____
Relationship to patient (if signed by a personal representative)

Mid Coast Vision Care

PATIENT HISTORY QUESTIONNAIRE

Name: Date of Birth:

Medical History:
□ Blood pressure □ Heart attack □ Chest pain/angina □ Irregular heart beat
□ Congestive heart failure □ Cholesterol
□ Asthma □ Emphysema
□ Fever □ Weight Gain/Loss
□ Thyroid problem □ Diabetes / diagnosis date _____ / last HGBA1C _____
□ Acid Reflux □ Ulcers/Bleeding
□ Urinary tract disorder
□ Chronic Cough □ Hearing Loss
□ Anemia □ Hemophilia □ Immune deficiency disease
□ Breast disease □ Skin disease
□ Arthritis
□ Anxiety □ Depression
Other:
_____

Current Medications (including eye drops and vitamins):
_____ _____ _____ _____
_____ _____ _____ _____
Allergies (including latex)_____

Surgical History: _____

Eye History

□ Cancer	□ Double vision	□ Glare	□ Trauma/injury
□ Cataract(s)	□ Eyelid problems	□ Glaucoma	□ Other: _____
□ Contact lenses	□ Flashes	□ Lazy eye	_____
□ Crossed eye(s)	□ Floaters	□ Retinal problems	

Past Eye Surgery
Date(s) _____ Operations(s) _____
_____ _____
Social History
□ Alcohol □ Smoke tobacco x _____years. Year quit _____.
Employment/Hobbies _____

Family History (list those blood relatives living or deceased diagnosed with the following)
□ Age related macular degeneration _____ □ Glaucoma _____
□ Diabetes _____ □ Cataracts _____

FINANCIAL POLICY

Thank you for choosing Mid Coast Vision Care as your healthcare provider. We are committed to providing you and your family with the best available medical care. In our ongoing process to make sure that all your medical needs are met, our billing department will be available to discuss our fees and this policy with you.
We ask that all responsible parties read and sign our financial policy as well as complete the patient information forms prior to seeing the provider.

Payments for all services will be due at the time services are rendered. In order to serve you better, we accept cash, check, Visa, MasterCard and Discover. As a courtesy to you, it is the policy of Mid Coast Vision Care to bill your insurance carrier, although you are ultimately responsible for the entire bill. As the responsible party, please understand :(PLEASE INITIAL THE FOLLOWING)

_____ 1. Your insurance policy is a contract between you, your employer, and the insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company. We will not become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance and "usual and customary" charge. As your medical provider, we will only supply factual information to facilitate claim processing.

_____ 2. Fees for services, which include unpaid balances, deductibles and co-payments, are due at the time of service. Returned check fee and unpaid balances may be subject to collection placement and collection fees. Credit of over $25 will be reviewed quarterly at a minimum and returned to the patient at the address on file. Requests for credits under $25 will need to be initiated by the patient. Credits will not be released if open claims are on file, family balances exist, or the patient account has a balance in collections. Your outstanding balance must be paid prior to receiving more services.

_____ 3. All charges are your responsibility regardless of how or if any insurance company responsible for your services adjudicates a claim. If your insurance carrier does not remit payment within sixty days, the balance will be due in full from you. If any payment is made directly to you for services billed by Mid Coast Vision Care, you recognize an obligation to promptly remit payment to Mid Coast Vision Care.

_____ 4. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, after such default and upon referral to a collection agency or attorney by Mid Coast Vision Care, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

_____ 5. The above does not apply for those patients that are considered Workers' Compensation. However, be advised that as a compensation patient you may be help responsible for charges in the event that your claim is controverted.

At Mid Coast Vision Care, we understand that financial problems may affect timely payment, so we encourage you to communicate any such problems to us, so that we may assist you in keeping your account in good standing. If you have any questions, please call (207)338-2571.

I UNDERSTAND THE ABOVE INFORMATION AND WILL BE RESPONSIBLE FOR THE PATIENT LISTED BELOW

Printed Name of Patient: _____ Account#: _____

_____ _____

Signature of Patient or Responsible Party Date