HARVARD EYE ASSOCIATES

Patient Information Form

Last Name:_____ **First Name**:_____ **M.I.**:_____

Address – Street:_____

City:_____ **State**:_____ **Zip**:_____

Phone Numbers*: Home ☐:_____ Work ☐:_____ Cell ☐:_____

** Check box next to phone number(s) where we may leave a message*

Date of Birth:_____ **E-mail address**:_____

Gender: ☐ Female ☐ Male **Ethnicity**: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline to Specify

Race: ☐ Amer. Indian ☐ Asian ☐ White ☐ African-American ☐ Hawaiian ☐ Other Pac. Islander ☐ Decline

Employer Name:_____ **Occupation**:_____

How did you hear about Harvard Eye Associates? ☐ Internet ☐ TV Commercial ☐ Newspaper/Magazine

☐ Radio ☐ E-mail ☐ Drive-by ☐ Mail ☐ Health Event ☐ Family/Friend ☐ Employee

☐ Insurance ☐ Doctor Referral – First & Last Name:_____

Primary Physician's Full Name:_____ **Phone**:_____ **City**:_____

Optometrist's Full Name:_____ **Phone:**_____ **City:** _____

Pharmacy Name:_____ **Phone**:_____ **City**:_____

Primary Insurance: Insurance Co. Name:_____ ID#:_____ Group#:_____

Subscriber Name (if not self):_____ Subscriber's Date of Birth (if not self):_____

Secondary Insurance: Insurance Co. Name:_____ ID#:_____ Group#:_____

Subscriber Name (if not self):_____ Subscriber's Date of Birth (if not self):_____

Vision Insurance: Insurance Co. Name:_____ ID#:_____ Group#:_____

Subscriber Name (if not self):_____ Subscriber's Date of Birth (if not self):_____

Emergency Contact Information/Designated Individuals Release: Harvard Eye Associates (HEA) may release to, or discuss my personal health information (PHI) (except regarding treatment ☐, payment ☐, and/or administrative operations ☐), with the individuals listed below, verbally or in writing. I understand that HEA will make best efforts to verify the identity of the designated parties before disclosing PHI. I also understand that I may change any of the Emergency Contact Information/Designated Individuals Release information at any time in writing.

Name: _____ Relationship: _____ Ph#: _____

Name: _____ Relationship: _____ Ph#: _____

Your signature below indicates that the information provided above is accurate and complete to the best of your ability, and that you acknowledge you were advised of the Notice of Privacy Practices (NPP) for HEA. Our NPP provides information about how we may use and disclose your protected information. We encourage you to read it in full. Our NPP is subject to change. The NPP is available on our website at wwww.harvardeye.com and in our office. You may request a copy of the NPP. By providing your email address above, you are opting in to receive email communications from Harvard Eye Associates.

_____ _____

Signature of patient (if over 18) or patient's parent or legal guardian *Date*

_____

If signed by parent/legal guardian, name of legal guardian

HARVARD EYE ASSOCIATES

Medical History

Last Name: _____ **First Name:** _____ **Date:** _____

Date of Birth: _____ **Gender:** Male ☐ Female ☐

Reason for visit today: _____

Current Eye Conditions: (*Please check, circle, and write where appropriate*)

☐ Cataracts	☐ Retinal Detachment	☐ Glare / Light Sensitivity	☐ Glaucoma
☐ Retinal Tear / Hole	☐ Irritation or Redness	☐ Macular Degeneration	☐ Keratoconus
☐ Blurred or Double Vision	☐ Diabetic Retinopathy	☐ Loss of Vision	☐ Dry Eyes
☐ Flashes or Floaters	☐ Pterygium	☐ History of Eye Trauma	☐ Astigmatism
☐ Artery / Vein Occlusion	☐ History of Iritis	☐ Other: _____	

Previous Eye Surgeries: *(Please check, circle, and write where appropriate)*

☐ Cataract Surgery	☐ Radiation to Eye	☐ Glaucoma Surgery (ALT/SLT, stent, shunt, trabeculectomy)		
☐ LASIK	☐ YAG Capsulotomy	☐ Laser Iridotomy (YLPI)	☐ PRK	☐ Diabetes Laser (PRP)
☐ Vitrectomy	☐ Pterygium Excision	☐ Retinal Detachment Repair	☐ Corneal Transplant	
☐ Radial Keratotomy	☐ Retinal Tear Repair	☐ Macular Pucker / Hole Repair	☐ Other: _____	

Previous Surgeries (other than eye): _____

List current medications: _____

_____

Allergies to medications: ☐ No ☐ Yes **If yes, which ones:** _____

Current / Previous Medical Conditions: (*Please check, circle, and write where appropriate*)

Cancer

☐ Breast	☐ Skin	☐ Prostate	☐ Leukemia	☐ Lymphoma	☐ Multiple Myeloma	☐ Brain
☐ Colon	☐ Uterine	☐ Lung	☐ Cervical	☐ Thyroid	☐ Other: _____	

Cardiovascular

☐ Hypertension	☐ High Cholesterol	☐ Heart Attack (MI)	☐ Coronary Artery Disease	
☐ Arrhythmia	☐ Atrial Fibrillation	☐ Pacemaker / AICD	☐ Deep Vein Thrombosis	
☐ Peripheral Artery Disease	☐ Pulmonary Embolism	☐ Aneurysm	☐ Heart Failure (CHF)	☐ Stroke / TIA
☐ Valvular Disease (Aortic / Mitral Stenosis, etc.)		☐ Other: _____		

Endocrine / Metabolic

☐ Diabetes (Type 1 or 2)	☐ Thyroid (Hypo or Hyper)	☐ Pituitary Mass	☐ Other: _____

Respiratory

☐ Asthma	☐ COPD	☐ Emphysema	☐ Bronchitis	☐ Other: _____

Neurological

☐ Seizure Disorder	☐ Parkinson's Disease	☐ Myasthenia Gravis	☐ Multiple Sclerosis	☐ Migraines
☐ Bell's Palsy	☐ Diabetic Neuropathy	☐ Horner's Syndrome	☐ Other: _____	

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Rheumatologic

☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Fibromyalgia ☐ Polymyositis ☐ Temporal Arteritis
☐ Sjogren's Syndrome ☐ Ankylosing Sponylitis ☐ Sarcoidosis ☐ Scleroderma ☐ Gout
☐ Lupus ☐ Other: _____

Gastrointestinal

☐ Crohn's Disease ☐ Ulcerative Colitis ☐ Celiac Disease ☐ Ulcers ☐ Hernia
☐ Diverticulitis ☐ Reflux (GERD) ☐ Other: _____

Genitourinary

☐ BPH ☐ Kidney Disease ☐ On Dialysis ☐ Other: _____

Hematologic

☐ Anemia ☐ Bleeding Disorder ☐ Sickle Cell Anemia ☐ Receiving Blood Transfusions
☐ Other: _____

Psychiatric

☐ Anxiety ☐ Depression ☐ Bipolar Disorder ☐ Dementia ☐ Schizophrenia
☐ Other: _____

Infectious Diseases

☐ Hepatitis B / C ☐ HIV / AIDS ☐ Tuberculosis ☐ Toxoplasmosis ☐ Lyme Disease
☐ Syphilis ☐ Pneumonia ☐ Meningitis ☐ Herpes Simplex
☐ Herpes Zoster (Shingles) ☐ Other: _____

Family Medical History (*Please check appropriate boxes below*)

☐ High Blood Pressure ☐ Diabetes ☐ Cancer ☐ Other: _____

Family History of Eye Disease (*Please check appropriate boxes below*)

☐ Glaucoma ☐ Retinal Detachment ☐ Color Blindness ☐ Macular Degeneration
☐ Other: _____

Social History

Do you smoke? ☐ No ☐ Yes (If yes, how much?_____) ☐ Formerly
Do you drink? ☐ No ☐ Yes (If yes, how much?_____) ☐ Formerly

Contact Lenses/Glasses (*Please check appropriate boxes below*)

Do you currently wear glasses? ☐ No ☐ Yes If yes, how old are your glasses? _____
Do you currently wear contact lenses? ☐ No ☐ Yes If yes, for how long? _____

My signature below indicates that the information provided above is accurate and complete to the best of my ability.

_____ _____
Signature of patient (if over 18) or patient's parent or legal guardian *Date*

_____
If signed by parent/legal guardian, name of legal guardian

HARVARD EYE ASSOCIATES

Lifestyle Questionnaire

Name:_____ **Date of Birth:**_____ **Date:**_____

Are you interested in learning more about procedures like LASIK that can reduce your needfor glasses/contacts? Yes ☐ No ☐

How old are your current glasses?

Primary Pair: _____ Sunglasses: _____ Reading glasses: _____

Computer glasses: _____ Sport glasses: _____ Occupational glasses: _____

How much of a problem do you have with (please circle):	**None**					**Severe**
Glare from sunlight while driving	0	1	2	3	4	5
Glare around headlights in a car after dark	0	1	2	3	4	5
Difficulty reading street signs far away	0	1	2	3	4	5
Difficulty reading for long periods of time	0	1	2	3	4	5
Difficulty reading with your glasses in dim light	0	1	2	3	4	5
Difficulty with vision for sports (following golf ball, tennis ball)	0	1	2	3	4	5
Difficulty with hobbies requiring fine vision (sewing, carpentry)	0	1	2	3	4	5
Difficulty playing games like cards, bingo, etc.	0	1	2	3	4	5
Difficulty seeing small captions on the TV	0	1	2	3	4	5
Reading fine print (medicine bottles, telephone book, food labels)	0	1	2	3	4	5

Please answer the following questions by checking the appropriate boxes below:

Do you drive after dark? ☐ Often ☐ Sometimes ☐ Rarely/Never

Do you use a computer? ☐ Often ☐ Sometimes ☐ Rarely/Never

Do you do a lot of close detail work like sewing or building models? ☐ Often ☐ Sometimes ☐ Rarely/Never

Have you ever tried mono vision contact lenses (one eye near and one eyefor distance?) ☐ Yes ☐ No

If you had to wear glasses after surgery for one activity, for which activity would you be most willing to wear glasses?

☐ Reading fine print ☐ Computer ☐ Driving

Please place an "X" on the following scale to **describe your personality** as best as you can:

<...../.....>

Easy going Perfectionist

HARVARD EYE ASSOCIATES

Patient Questionnaire

Patient Name: _____ DOB: _____

Please fill out the information below:

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1. Are you interested in finding out if you're a candidate for **LASIK** or learning more about our **Cosmetic Services** (Botox®, fillers, brow lift, etc.)?

⬜ Yes ⬜ No

If yes, please select one or more of the following services you are interested in:

⬜ LASIK

⬜ Botox®

⬜ Filler

⬜ Eyelid Lift / Lower Lid Bags

⬜ Brow Lift / Facelift

A member of our team will reach out to you with more information.

What is the best phone number to reach you at? _____

2. Would you like to join our email list to receive **company updates**, **promotions**, and **eye care education**?

⬜ Yes ⬜ No

If yes, what is your email address? _____

_____ _____

Patient's Signature Date

HARVARD EYE ASSOCIATES

Financial Agreement and Lifetime Signature Authorization

Harvard Eye Associates (HEA) are privately-owned medical facilities that provide medical services on a fee-for-service basis. HEA relies solely on insurance reimbursement and patient payment(s) for services rendered in good faith. HEA receives no federal, state or other third-party funding; as such, HEA does not have provision for providing on-going indigent care. The following Financial Agreement is developed in accordance with Office of Inspector General (OIG) guidelines as well as all applicable State and Federal reimbursement guidelines.

Upon obtaining a copy of your insurance card(s), HEA will verify your eligibility and benefits including deductibles, copayments, coinsurance responsibility, etc. under your health insurance company, and HEA will submit claims for all medically necessary services to your health insurance company. Please note that payment is ultimately due from you in the event that your insurance company denies payment for any service(s); i.e. termination of coverage, coordination of benefits, non-payment of premium, etc.

Deductibles, coinsurances, and any non-covered services are the responsibility of the patient. To the extent possible and feasible, all patient financial responsibilities are payable at the time of service and / or prior to surgical procedures. Not all health insurance companies publish their (allowable) fee schedule; therefore coinsurance percentages cannot always be accurately calculated for pre-payment. A HEA statement will be sent to you after your health insurance has processed your claim(s); the balance due will compare to the Explanation of Benefits you will receive from your health insurance company. Should you dispute any amount on your Explanation of Benefits / statement, please contact your health insurance company member services for clarification of your benefits.

Copayment(s), as stipulated by your health insurance company, are due on the date of service.

Please note that OIG guidelines (FR Vol. 65, No. 194, Oct.5, 2000) relative to anti-kickback statutes, as well as contractual obligations to the health insurance companies from whom HEA will seek reimbursement for medical services, prohibit the routine discounting of published fees, “insurance-only billing” or waiver of any insurance-assigned charges otherwise due from the patient.

A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

Self-Pay: In the event that (1) you are uninsured, (2) HEA and / or its affiliated facilities does not have a participating relationship with your health insurance plan(s), or (3) you elect to have non-covered medical services (i.e. cosmetic or other services determined by your health insurance plan to be “not medically necessary”, etc.), HEA accepts self-pay patients with this signed agreement that payment is due on the day services are rendered or in the case of surgical procedures, payment is due prior to the surgical procedure(s).

HEA does not accept litigated cases and services are not provided on a contingency basis under any circumstances.

HEA is not a banking institution and does not assess finance charges to cover the operational cost of managing payments by installment; therefore, no internal financing options (i.e. budget or other installment plans) can be extended.

Eye Refractions: Typically, medical insurance plans do not pay for the refraction part of your comprehensive eye examination. Eye refractions are necessary not only for prescribing glasses and contact lenses but do also for determining whether you have eye disease. Even if you do not wish to receive new glasses, the refraction is an essential part of your complete eye examination.

For your convenience, HEA accepts cash, check, money order and credit cards. In addition, HEA offers financing options through third party vendors.

Consent to Contact: By providing us with your landline or cell phone number(s), you give your consent for us, our agents, and to our collection agents, to contact you at these numbers, or, at any number that is later acquired for you, and, to leave live, or pre-recorded messages regarding any accounts or services. For greater efficiency, calls may be delivered by an auto dialer.

I understand all of the terms defined above; I consent to receiving treatment under the stated terms and I agree to honor all of my financial obligations to Harvard Eye Associates. I hereby authorize this provider and its employees, agents and assignees to contact me via email, text messaging and to my cellular devices. My signature below constitutes my Financial Agreement and Lifetime Signature Authorization.

Patient Name Printed	**Date**	**Patient / POA Signature**
HEA Employee Name	**Date**	**HEA Employee Signature**

Failure to honor your financial obligations to HEA in accordance with this signed Agreement will result in your account being referred to Collections and termination of the treatment relationship in accordance with the regulations that govern ethical medical care. *K:\Clinic Forms\New Patient Forms\NEW PT FORMS\Word Document Version\HEA Financial Lifetime Signature Auth. 04/04/2025.docx*

HARVARD
EYE ASSOCIATES

Notice of the Open Payments Database

We are providing a notice to our patients in accordance with California law AB 1278. The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

Please sign and date below acknowledging you have received this notice

Print name:_____Signature:_____Date:_____