907 376-2020
Fax: 907 357-3937
4505 E Greenstreet Cir
Wasilla AK 99654

☐ Evan Wolf, MD PhD
☐ Kara Reynolds, OD
☐ Jacob Frank, OD

PATIENT HISTORY FORM

Name_________________________________ DOB _____________ Chart #_____________ Date ______________

Personal Medical History/Review of Symptoms: **Allergies/Current Medications:**

Do you *CURRENTLY* have any problems in the following areas? (CIRCLE ALL THAT APPLY)	**YES**	**NO**		**Please list all allergies to medications: Are you allergic to LATEX? □ YES □ NO**
1 **EYES** (poor vision, eye pain, tearing, redness, etc.)				
2. **GENERAL / COINSTITUTIONAL** (fever, weight loss or gain, heat stroke, unusually tired, other)				
3. **EAR / NOSE / MOUTH / THROAT** (hearing loss, stuffy nose, earache, dry mouth, other)				**Please list all medications you are taking, including eye drops:**
4. **CARDIOVASCULAR** (high blood pressure, racing pulse, other)				
5. **RESPIRATORY** (asthma, shortness of breath, wheezing, coughing, TB, other)				
6. **GASTROINTESTINAL** (stomach upset, diarrhea, constipation, hernia, ulcers, other)				
7. **GENITAL / KIDNEYS / BLADDER** (painful or frequent urination, impotence, yellow jaundice, other)				
8. **SKIN** (pimples, warts, growths, rashes, other)				
9. **MUSCLE / BONE / JOINTS** (joint pain, stiffness, swelling, cramps, arthritis, other)				
10. **NEUROLOGICAL** (numbness, headaches, seizures, paralysis, other)				
11. **BLOOD / LYMPH** (bleeding, cholesterolemia, anemia, problems related to blood transfusion, other)				
12. **FEMALES** (Are you pregnant? Nursing?)				
13. **ENDOCRINE** (thyroid problems, diabetes, other)				
14. **PSYCHIATRIC** (depression, anxiety, insomnia, other)				
15. **ALLERGIC / IMMUNOLOGIC** (sneezing, swelling, redness, itching, hives, lupus, other)				

FAMILY HISTORY – Has any member of your family had these diseases (CIRCLE ALL THAT APPLY):

	Yes	**No**	**UNKNOWN**
Blindness, Cataracts, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis, Other heritable disease:			

SOCIAL HISTORY –(CIRCLE ALL THAT APPLY):

	Yes	**No**
Does your vision limit any activities of daily living (driving, reading, sports, work, etc)?		
Have you ever had a blood transfusion?		
Do you drink alcohol? If YES, how much?_________		
Do you smoke? If YES, how much? _____How many years? ______		

CONTACT LENSES	**Yes**	**No**
Do your wear contact lenses now?		
I sleep in my contact lenses		
My lenses are ☐ soft ☐ rigid gas permeable		
I have worn contact lenses for ________ years		
My cleaning solution is:		
I dispose of contacts every ______weeks/days		

The information above is complete and accurate to the best of my knowledge.

____ ______________________________

PATIENT SIGNATURE **Date**

____________________ __________ ____________________ __________

Physician Signature **Date** **Technician Signature** **Date**

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PATIENT REGISTRATION

Welcome to our office. In order to serve you properly, we will need the following information. (Please Print)

Patient First Name Middle Initial Last Name	Sex Male ☐ Female ☐	Date of Birth	Marital Status (circle) S M W D
Mailing Address City State Zip		Home Phone:	Social Security #
Name of employer Address		Business Phone	Occupation
Name of Spouse/Parent	Date of Birth	Social Security #	Business Phone
Reason for visit	How were you referred to this office?		
Person to contact in case of emergency	Relationship to patient	Phone	

Primary Insurance Coverage

Primary Insurance Company	Address		
Subscriber Name	Subscriber birth date	Policy #	Group #
Is this insurance through your employer? Yes ☐ No ☐	Patient's relationship to insured Self ☐ Spouse ☐ Child ☐ Other ☐		

Secondary Insurance Coverage

Secondary Insurance Company	Address		
Subscriber Name	Subscriber birth date	Policy #	Group #
Is this insurance through your employer? Yes ☐ No ☐	Patient's relationship to insured Self ☐ Spouse ☐ Child ☐ Other ☐		

Medicare Patients Only, Read and Sign — Medicare Lifetime Signature

I request payment of authorized Medicare benefits to Wolf Eye Center for any service provided to me by the physician. I authorize any holder of medical information about me, to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that Medicare does not cover routine vision exams.

______________________________ ______________________________
Patient Signature **Date**

Please see reverse side for billing policy and signature.

Thank you for choosing Wolf Eye Center, Inc. as your eye care provider.

You'll See The Difference!

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BILLING POLICY & PROCEDURE

This document was prepared to assist patients with the financial policies of Wolf Eye Center, Inc. Please read and then sign in the space provided. Should you have further questions our staff will gladly assist.

Patients with Insurance

It is your responsibility to provide your insurance information. Without complete insurance information Wolf Eye Center, Inc cannot bill for services. Proof of insurance is required at the time of service. Insurance is a contract between you and your insurance company. We are NOT a party to this in most cases. We ARE a party to the following insurance companies and will handle claims according to our agreement with them; Aetna, Blue Cross, Medicare, Medicaid, Tricare and VSP. As a courtesy to you we will file your claim but you are ultimately responsible for all charges regardless of what your insurance does or does not pay. Your co-pay and any unmet deductible will be collected at the time of service. If you do not know what your co-pay is, we will collect 20% of the balance.

Patients without Insurance

All charges incurred at the time of service must be paid in full at the end of each appointment. For payment in full at time of service, we offer a discount. If you are unable to pay in full at the time of service you must establish an approved payment plan with Wolf Eye Center billing department. All payment plans must be paid in full within 120 days. A minimum of 20% of the balance is due at the time of service.

All Patients – Refractions

Refraction is a test that is performed to measure your best vision possible. Refraction is performed for several different reasons including (but not limited to):

1. Determining the correct prescription for glasses or contact lenses
2. Screening and monitoring of medical conditions such as diabetes, cataracts, glaucoma, and macular degeneration
3. During pre-operative care
4. During post-operative care

Federal guidelines require that the eye examination and the refraction are billed separately, but some insurance companies (i.e.: Medicare) do not pay for the refraction. Depending on your insurance benefits, you may be responsible for payment of this service. The current charge for the refraction is $45.00.

Delinquent Accounts

A statement of your account will be mailed to you at the beginning of each month if an outstanding balance exists. Payment in full is expected within 30 days after the insurance company has made its determination of payment or 90 days from the date of service whether or not insurance has responded. Failure to pay your account within 90 days from the date of service will result in collection proceedings. Should circumstances prevent you from paying your account in a timely manner prior to commencement of collection activity please contact our billing department to make other arrangements for payment. When accounts are submitted to Recovery Management Collection Agency a Collection Processing fee of 30% of the balance will be added to your account. Patients with delinquent accounts may be permanently discharged from our practice.

Returned checks for non-sufficient funds (NSF), will incur a $25.00 NSF fee.

I, the undersigned, authorize payment of medical benefits to Wolf Eye Center, Inc for any/all service provided to me by the physician. I understand that I am financially responsible for any amount not covered by my insurance plan. I authorize Wolf Eye center to release information concerning my health care, advice, treatment, and/or supplies to my insurance company and/or it's agents for the purpose of evaluating and administering claims. I understand that if I do not have insurance coverage payment is due in full at time of service unless an approved payment plan has been established.

____ ____________________

Patient, Parent or Guardian Signature (if child is under 18) Date

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NOTICE OF HEALTH INFORMATION PRACTICES

______(Initial) I give Wolf Eye Center, Dr. Wolf / Dr. Reynolds / Dr. Frank, permission to leave messages regarding appointments and test results on an answering machine or service if I am unavailable.

______(Initial) I give Wolf Eye Center, Dr. Wolf / Dr. Reynolds / Dr. Frank, permission to fax prescriptions to a pharmacy of my choice.

Communication with Family
______(Initial) I give Wolf Eye Center, Dr. Wolf / Dr. Reynolds / Dr. Frank, permission to use their best judgment, disclose to a family member, other relative, close personal friend, or any other person that I identify below, health information relevant to that person's involvement in my care. This includes information regarding payment related to my care.

Authorized individuals and phone numbers:

NAME	PHONE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, (Name of Patient)________________________________, acknowledge and agree that I have received a copy of Wolf Eye Center's Notice of Privacy Practices.

Patient Signature	Date
Patient's Legal Representative (if applicable)	Date
Print Name of Legal Representative	Relationship to Patient