accent
EYECARE

Dr Johnny Leung OD
Dr Thomas Casey OD
Dr Reza Rahmani DO

2498 S Rochester Rd
Rochester Hills MI 48307

P: 248 - 293 - 3399 F: 248 - 293 - 3380 www.accenteyecare.net

Please take a moment to fill out this form: ***Todays Date***_____

1. Patient Name: **Sex** **Date of Birth** **AGE**

_____ (M or F) _____/_____/_____ _____
(Please Circle)

Address: _____ HOME #_____

City: _____ State _____ Zip _____ CELL # _____

E-MAIL ADDRESS _____ WORK # _____

Occupation _____ Employer _____

2. Insurance Information:

Plan Name _____ Group _____

Insured Name _____ Relationship to Patient: □ Self □ Spouse □ Child

Insured ID# _____ Insured Date of Birth _____ Patient SS# ___-___-____
IF USED AS YOUR ID BY INSURANCE CO.

3. Reason for todays visit: _____ □ New Eyeglasses □ New Contacts □ Medical

Date of last eye exam? _____ How did you hear of us?_____

Name Eye Doctor _____ Name Medical Doctor _____ Last Medical exam_____

4. Do you or have you worn glasses? Yes No
If yes, for: □ Full Time □ Distance □ Reading

Have you worn contact lenses? Yes No
If yes, which BRAND?_____

Have you had eye surgery, injury, or infection? Yes No
Describe_____

Do you have frequent headaches, double vision, Yes No
Or sensitivity to bright light?
Do you see flashes of light, floaters, vision loss? Yes No
Describe_____

Please Circle Y or N	SELF	Relative
Diabetes	Y N	_____
High Blood Pressure	Y N	_____
Heart Disease	Y N	_____
Thyroid Disease	Y N	_____
Cataract	Y N	_____
Glaucoma	Y N	_____
Macular Degeneration	Y N	_____
Eye / Lazy Eye	Y N	_____
Other Medical	Y N	_____

Explain _____

5. List all medications _____ **List any allergies** _____

_____ _____

_____ _____

TO OUR PATIENTS

1. Dilated Eye Exam

This testing has been determined to be the most effective way to evaluate the health of the eyes. ***Because our mission is to always provide the highest level of care for your eyes, we strongly recommend this test to all of our patients every year.***

Procedure: Dilation eye drops are placed into each eye to enlarge the pupil size for examination.

Benefits of a Dilated Eye Exam: Early detection and treatment of eye problems and disease.

Risk of NOT having Dilated exam: Possibility of eye diseases going undetected and causing irreversible damage to the inside of the eye. (i.e. Retinal Detachments, Glaucoma, etc.)

Side effects of dilation: Increased sensitivity to sunlight and blurry near vision for up to 4 hours on average. Most patients have no problem with distance vision and driving. Disposable sunglasses are provided for you.

Fee: Dilation is covered by many, but not all insurances. Please inquire at front desk if you are unsure if your insurance covers this procedure. If not covered, cost of this procedure is $22.00

PLEASE CHECK ONE: _____ I accept Dilation _____ I decline the Dilation

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2. Visual Field Evaluation

A procedure that tests central and peripheral (side) vision. This test takes about 5 minutes and aids in the diagnosis of conditions such as glaucoma, retinal detachments, brain tumors, strokes, etc. This test is strongly recommended if you or any family members have any of the conditions mentioned

Fee: $22.00

PLEASE CHECK ONE: _____ I accept Visual Field Testing (Screening Test) _____ I decline

I have read and understand the information provided above.

SIGN NAME _____ **DATE** _____

(parent or legal guardian if under 18)

----------FOR OFFICE USE ONLY----------

Current Eyeglass Rx

OD

OS

Current CL Brand_____ BC_____

OD

OS

AUTHORIZATION AND ASSIGNMENT

I, _____, authorize Accent Eyecare to take any and all actions necessary to obtain payment from my insurance company, the Social Security Administration or other responsible party for any and all services provided to me by the doctor and staff of Accent Eyecare.

Further, I assign any and all payments due from my insurance company, the Social Security Administration or other responsible party directly to this office. I realize that in the event that my insurance company or other responsible party erroneously sends payments owed to Accent Eyecare directly to me, those payments legally belong to Accent Eyecare. I realize that I must forward those payments immediately to Accent Eyecare.

I understand that my signature below allows Accent Eyecare to release my confidential medical record to the insurance company, The Social Security Administration or other responsible party, in order to expedite payment of my claims.

I further understand that any co-pays or deductible amounts not paid by my insurance company, The Social Security Administration, or other responsible parties, do become my responsibility. In addition, I understand that I am fully responsible for any costs associated with that collection process.

I further understand that if after my claim has been submitted to my insurance company, Social Security Administration, or other responsible party, and it is then determined that I am not eligible; I am responsible for immediately paying the complete balance due. This authorization is effective for all appointments at Accent Eyecare.

HIPPA PRIVACY POLICY

By signing this acknowledgment of Receipt of Notice of Privacy Practices, I acknowledge and agree that I have received a copy of the Notice of Privacy Practices for review and to keep for my records on the date identified below. I understand that Accent Eyecare may use and disclose necessary personal health information to another party to permit us to perform its administrative duties, provide me with eye care services and products, process my vision benefit claims and communicate with me regarding vision care services provided by Accent Eyecare (for example, mailings of exam reminders or information about services/products provided by Accent Eyecare).

I can be assured that Accent Eyecare does not sell my personal health information to a third party for said party's own use. I acknowledge and agree that Accent Eyecare may submit my vision benefit claims to my health plan to receive reimbursement directly for the vision services and products that I have received.

_____ _____

Patient Signature Date