MOA MEDICAL OPTOMETRY AMERICA℠

NEW PATIENT MEDICAL & OCULAR HISTORY FORM

Date: _____/_____/_____

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Social Security #: _____ Marital Status: _____ Sex: _____

Date of Birth: _____ Age: _____

Address: _____ Apt./Suite #: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email (for appointment reminders and office news): _____

Occupation: _____ Employer/School: _____

How Did You Hear About Us? _____

EMERGENCY CONTACT

Last Name: _____ First Name: _____ MI: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____ Relationship to Patient: _____

INSURANCE INFORMATION

If Insurance Policy is held by someone other than you, the patient:

Policy Holder Name: _____ Policy Holder Date of Birth: _____

*Please be sure to provide us with a copy of your medical insurance card

PRIMARY CARE PHYSICIAN and REFERRING PHYSICIAN

Primary Care Physician Name: _____ Phone Number: _____

Referring Physician Name: _____ Phone Number: _____

PHARMACY

Pharmacy Name: _____ Phone: _____

Address: _____ City: _____ State: _____

ACCOUNT FINANCIAL RESPONSIBILITY

❑ Check the box if the patient is financially responsible for this account. Otherwise, list responsible party below:

Last Name: _____ First Name: _____ MI: _____

Address: _____ Apt./Suite #: _____

City: _____ State: _____ Zip Code: _____

Social Security #: _____ Date of Birth: _____

Relationship to Patient: _____

OCULAR HISTORY

Please describe any concerns you have regarding your eyes, vision, ocular health, or disease prevention:

_____

_____

Date of Last Eye Exam: _____ Doctor/Location: _____

Do You Currently Use or Wear: Eyeglasses: ❑ No ❑ Yes
Contact Lenses: ❑ No ❑ Yes

Ocular History	Self	Family	Relation		Self	Family	Relation
Lazy Eye	❑	❑	_____	Retinal Detachment	❑	❑	_____
Eye Turn/Wandering	❑	❑	_____	Blindness	❑	❑	_____
Color "Blind"	❑	❑	_____	Cataracts	❑	❑	_____
Light Sensitivity	❑	❑	_____	Glaucoma	❑	❑	_____
Eyestrain	❑	❑	_____	Eye Injury/Surgery	❑	❑	_____
Dry Eyes	❑	❑	_____	Macular Degeneration	❑	❑	_____
Floaters/Spots	❑	❑	_____				

Other History Not Listed: _____

MEDICAL HISTORY

Medical History	Self	Family	Relation
High Blood Pressure	❑	❑	_____
Cholesterol	❑	❑	_____
Diabetes	❑	❑	_____
Thyroid	❑	❑	_____
Arthritis	❑	❑	_____
Gastrointestinal	❑	❑	_____
Respiratory	❑	❑	_____
Cancer	❑	❑	_____
Headaches/Migraines	❑	❑	_____
Head Trauma	❑	❑	_____
Stroke	❑	❑	_____
Neurological Disorder	❑	❑	_____

Please list all medications you are currently taking and why (*e.g.*, Lipitor for cholesterol):

_____

_____

_____

Surgical History:

_____

_____

_____

Are You:

Allergic to Medication: ❑ No ❑ Yes (if yes, please list below)

_____

_____

Pregnant or Nursing: ❑ No ❑ Yes If yes, please list your due date: _____

Being Treated for: ❑ HIV ❑ Hepatitis ❑ Gonorrhea ❑ Syphillis

❑ Other: _____

SPEED QUESTIONNAIRE

Name: _____ Date: ____/____/____

Sex: M F (Circle) DOB: ____/____/____

Please answer the following questions by checking the box that best represents your answer. Select only one answer per question.

1. Report the FREQUENCY of your symptoms using the rating list below (check one box for each symptom):

Symptoms	Never 0	Sometimes 1	Often 2	Constant 3
Dryness, Grittiness or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

2. Report the SEVERITY of your symptoms using the rating list below:

Symptoms	No Problems 0	Tolerable 1	Uncomfortable 2	Bothersome 3	Intolerable 4
Dryness, Grittiness or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

3. Do you use eye drops for lubrication? YES NO If yes, how often? _____

CONSENT TO TREATMENT:
By signing below, I do hereby voluntarily consent for MOA to provide eyecare services including diagnostic procedures and treatments deemed necessary in the judgment of the optometrist. I acknowledge that no guarantees have been or can be made to me as a result of such procedures and treatments. I also authorize the release of insurance information and payment of medical/vision benefits if I choose to use an insurance plan for which the doctors are providers.

_____ _____ _____/_____/_____
Patient Name (Printed) Patient Signature Date

_____ _____ _____/_____/_____
Parent/Guardian Name (Printed) Parent/Guardian Signature Date

PATIENT FINANCIAL POLICY

Thank you for choosing MOA for your eyecare needs. Because MOA is committed to providing you with the highest level of patient care to ensure your experience with our practice is seamless and amazing, this financial policy has been developed to assist in answering your questions regarding patient and insurance responsibility for services rendered. Your understanding of, and compliance with, our patient financial policy is important. As such, please thoroughly review the policy below, let us know if you have any questions or concerns, and then please sign and date as indicated. The original signed policy will be maintained in your patient file and a copy may be provided to you upon your request. Please promptly notify our practice of any changes to your insurance policy at time of service so that we can perform our duties accurately.

CO-PAYMENTS, DEDUCTIBLES, & CO-INSURANCE

Patients are expected to pay on the date of service for all amounts that are not covered by their insurance company. These amounts may include all co-payments, deductibles, co-insurance, and/or past-due balances. Payments may be made by cash, check, and/or major credit card (MasterCard, Visa, Discover, American Express). Patients who are unable to pay their non-covered fees and/or past-due balances at the time of service may be asked to reschedule their visit.

INSURANCE POLICY

Your insurance policy is a contract between you and your insurance provider. In order for MOA to properly file your claims with your insurance provider, you are responsible for providing our practice with the correct insurance information at the date of service or you may be responsible for the charges in full. If any balance remains after your insurance provider has processed your claim, or should they fail to pay the insurance claim for services rendered, you will be responsible for all charges submitted which will be due upon receipt of your statement. If your insurance provider fails to pay a claim for services rendered, we recommend that you follow-up with your insurance provider directly.

REFERRALS

Some patients will be required by their insurance provider to obtain a referral from their Primary Care Physician (PCP) authorizing their visit to MOA. It is the patient's responsibility to obtain this referral and ensure this referral is communicated to MOA prior to the patient's visit. A patient without a required referral will be asked to sign a waiver by which he/she agrees to pay all charges generated by their visit at the date of service. In this case, if a referral is ultimately received after the patient's visit and the insurance provider submits reimbursement to MOA, a refund will be sent to the patient. However, patients are reminded that many physician offices will not provide a retroactive referral. Patients without a required referral and who do not agree to sign a waiver will be asked to reschedule their appointment.

SELF-PAY PATIENTS

Self-pay patients (*i.e.*, patients with no health insurance) or insurance we are not contracted with are expected to pay for all charges generated by their visit at the date of service.

OUTSTANDING BALANCES

MOA greatly appreciates your prompt payment in full for any outstanding balances. Patients with outstanding balances from previous visits will be required to pay the full balance at the time of the next visit. Patients who are unable to pay the outstanding balance may be asked to reschedule their visit. If you are unable to pay a balance in full, please notify our billing department immediately and we will try to work out a payment plan or discuss alternative payment options with you. Patients may be asked, in these circumstances, to provide financial income details or other information which MOA can use in determining an appropriate and fair payback schedule.

COLLECTIONS

Outstanding balances on patient accounts which have not been paid for 90 or more days since the date the balance becomes due may be subject to Collection efforts. MOA is authorized to retain the services of an attorney and/or collection agency to assist with the collection of any outstanding balance(s). Any expenses incurred by such actions, including but not limited to reasonable attorneys' fees, court filing fees, and/or other reasonable costs of collection efforts, shall become an additional liability for which the patient is responsible in addition to the account balance.

RETURNED CHECKS

Any payment made by check that does not clear your bank account will result in a $35.00 returned check fee for insufficient funds. This fee will be added to your account for each returned check.

MISSED APPOINTMENTS

MOA requests that you keep your scheduled appointment, however, we understand that life happens, and appointments need to be canceled or rescheduled from time-to-time. Because we are unable to fill no show appointments, please provide at least 24-hours' notice if you need to cancel or reschedule your appointment. Missed Appointments and appointments canceled or rescheduled less than 24 hours prior may be subjected to a $35.00 cancellation fee.

MINORS

For patients who are minors, the parent(s) or legal guardian(s) are responsible for full payment and will receive the billing statements for any minors receiving services. A signed release for treatment will be required for unaccompanied minors.

We greatly appreciate your choosing us for your medical eye care needs and we remain committed to providing you with an exceptional and unparalleled patient experience. If you have any questions or would like further clarification on any of the above policies or procedures, please do not hesitate to reach out to us at your earliest convenience.

Your signature below indicates that you have read, understand, and agree with the above financial policies and procedures. MOA reserves the right to amend these policies from time to time.

_____	_____	____/____/____
Patient Name (Printed)	Patient Signature	Date
_____	_____	____/____/____
Parent/Guardian Name (Printed)	Parent/Guardian Signature	Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand that by signing this consent, I am acknowledging and have been informed of, as well as given the right to review and secure a copy of MOA's Notice of Privacy Practices. The notice contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA.

I understand that MOA may use and disclose my protected health information to carry out:

- Treatment (this includes all providers and other healthcare offices involved in my treatment plan)
- Obtaining payment from third-party payers (*e.g.*, my insurance company)
- The day-to-day healthcare operations of MOA

I understand that MOA reserves the right to change the terms of this notice from time to time and that I may contact MOA at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that MOA is not required to agree to these requested restrictions. However, if MOA does agree, then they are bound to comply with the restrictions.

_____ _____/_____/_____

Signature of Patient or Legally Authorized Representative Date — Date

_____ _____

Printed Name of Patient or Legally Authorized Representative — Relationship to Patient

OFFICE USE ONLY

I attempted to obtain the patient's signature on this Notice of Privacy Practices Acknowledgement, however, was unable to do so as document below:

Date:	Staff Member:	Reason:

PATIENT HIPAA COMMUNICATION FORM

Patient Name: _____ Date of Birth: _____

FAMILY & FRIENDS: It is the policy of MOA not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friends into the exam room, we will assume, unless you object, that the person is entitled to receive information regarding your treatment, (iv) in emergency situations, or (v) as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If you anticipate that you will need or want your medical information to be provided to family members, friends, or caregivers, please INDICATE THAT BELOW, so that we may best serve you. By signing below, you authorize the following persons to receive information, as requested, regarding your care and treatment. **UPDATES to this form must be made in person.**

Name	Relationship	Phone #
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALTERNATIVE COMMUNICATION: I wish to be contacted in the following manner (check all that apply):

Home Phone_____

_____ Okay to leave message with details

_____ Leave a call back number only

Cell Phone_____

_____ Okay to leave message with details

_____ Leave a call back number only

Work Telephone_____

_____ Okay to leave message with details

_____ Leave a call back number only

Written Communication

_____ Okay to mail to home address

_____ _____/_____/_____

Signature of Patient or Legally Authorized Representative Date — Date

_____ _____

Printed Name of Patient or Legally Authorized Representative — Relationship to Patient

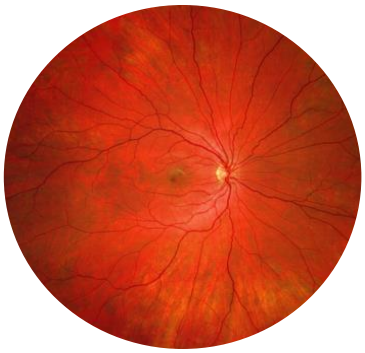
MOA ANNUAL EYE PHYSICAL

Ocular Imaging Package

To optimize your Annual Eye Physical, it is recommended that you receive a set of additional, specialized ocular images to thoroughly evaluate your eye health. These images are critical to help detect diseases at their earliest stages and track changes over time. The following two diagnostic imaging tests are highly recommended for you by your Medical Optometrist:

RETINAL PHOTOGRAPHY

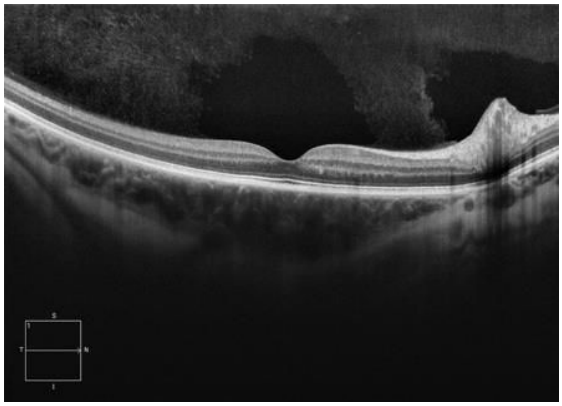
Wide field retinal images are captured utilizing the latest technology to provide direct and detailed imaging of your circulatory system. This is a critical step to establish a baseline for your eye health. The image is taken in a few seconds with no contact and allows you to see what the doctors see.



- Photos facilitate early protection from sight threatening diseases or blindness.
- Besides eye diseases, this test can help with the early detection of life-threatening diseases like cancer, stroke, and cardiovascular disease.
- Retinal photos are especially important during COVID-19 as they greatly reduce the face-to-face time needed for your exam.

OCT

This retinal ultrasound imaging examination allows for views into the layers of the retina and is an important diagnostic tool for mature eyes. This aids in the early diagnosis of vision threatening diseases such as macular degeneration and diabetic eye disease.



There is an additional charge of $89 for the MOA Annual Eye Physical Ocular Imaging Package.

- ❑ I elect the MOA Annual Eye Physical Ocular Imaging Package
- ❑ I wish to defer imaging at this time

Patient/Guardian Signature: _____ Date: _____