

**Allure Eye & Aesthetic Laser Center**  
Patient Information Sheet

**PATIENT INFORMATION**

**Today's Date:** \_\_\_\_\_

Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Single Married Other

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Alternate Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Whom may we contact in case of emergency? \_\_\_\_\_ Phone: \_\_\_\_\_

**INSURANCE SUBSCRIBER INFORMATION (required for billing purposes)**

**Primary Insurance:** \_\_\_\_\_ ID#: \_\_\_\_\_

Group #: \_\_\_\_\_ Insurer Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Social Security: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

*Do you have any other insurance? If yes please provide information below:*

**Secondary Insurance:** \_\_\_\_\_ ID#: \_\_\_\_\_

Group #: \_\_\_\_\_ Insurer Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Social Security: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Who is Responsible for this Bill? \_\_\_\_\_

Co-payments and non-covered services are due at time of service. I will be paying today by:

Cash       Check       Credit Card

**PATIENT RIGHTS, PRIVACY and RESPONSIBILITIES**

You have a right to access and review your medical records at any time. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations.

You have the right to review our Notice of Patient Rights prior to signing this form. You have the right to restrict the uses of your information but the Practice does not have to agree to those restrictions. You may revoke, in writing, at any time and all future disclosures will then cease. The Practice may condition treatment upon execution of this Consent.

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above questions. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information. If it's applicable, I pre-authorize the office to charge my credit card the balance due.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent (if minor) \_\_\_\_\_

Date: \_\_\_\_\_

# Allure Eye & Aesthetic Laser Center

Catherine Pham, M.D.

## Our Financial Policy and Your Insurance Benefits

Thank you for choosing Allure Eye & Aesthetic Laser Center as your vision care provider. The following is a statement of our Financial Policy and Your Insurance Benefits which we require you to read and sign prior to your treatment.

You may be fortunate to have healthcare insurance that will cover a portion of your care. It is best you have an idea of what the expenses are likely to be. As a courtesy, we call your insurance plan and make the effort to understand your insurance benefits in advance of any service(s). We obtained the information below from your insurance company. The insurance agent told us that they do not guarantee payment until they receive a claim and review it. It is a good idea for you to check the information below, yourself, by calling your insurance representative.

As a courtesy to you we will bill your group insurance including Medicare insurance. Also, as a courtesy to you, we will bill your secondary insurance. Please be aware that some or perhaps all of the services provided may be “non-covered” services and not considered reasonable or necessary under your medical insurance and/or the Medicare program. Payment for these services must be paid separately by you.

### For example:

- **During a complete eye examination the refraction which is the examination for glasses, is generally not covered by any insurance plan other than VSP and will cost \$70.00.**
- **Evaluation and fitting of contact lenses is not part of a routine eye examination, therefore, a separate charge will be made for this. Please refer to the contact lens policy sheet for cost.**

## INSURANCE BENEFITS

Patient Name: \_\_\_\_\_ SSN# \_\_\_\_\_ DOB \_\_\_\_\_

Patient Phone: \_\_\_\_\_ Reason for visit: \_\_\_\_\_

Insurance Co: \_\_\_\_\_ Subscriber ID: \_\_\_\_\_

Phone #: \_\_\_\_\_ Group # \_\_\_\_\_

Effective Date: \_\_\_\_\_ Authorization or referral needed Yes or No

**Ind. Deductible** \$ \_\_\_\_\_ Met\$ \_\_\_\_\_ **Family Deductible** \$ \_\_\_\_\_ Met \$ \_\_\_\_\_

**Office Visit** Co-pay \$ \_\_\_\_\_ Deductible applies Yes OR No

**Procedure** Co-Pay \$ \_\_\_\_\_ Deductible applies Yes OR No

**Out of Pocket** \$ \_\_\_\_\_ Met \$ \_\_\_\_\_ **Refraction Covered** (92015) Yes OR NO

Appointment date: \_\_\_\_\_

I understand the benefits as described above. I understand that the office reserves the right charge a \$10.00 late fee and/or 1.5% interest on my overdue amount.

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date

ALLURE EYE & AESTHETIC LASER CENTER

PATIENT HISTORY QUESTIONNAIRE

Today's date: \_\_\_\_\_

IMPORTANT: This questionnaire is to be reviewed at each appointment. Please answer all questions.

Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_

EYE HEALTH HISTORY

- Do you have any eye conditions or problems? Yes/No Type \_\_\_\_\_ Date \_\_\_\_\_
Have you had any eye operations? Yes/No Type \_\_\_\_\_ Date \_\_\_\_\_
Have you had an eye injury? Yes/No Type \_\_\_\_\_ Date \_\_\_\_\_
Do you have glaucoma? Yes/No Cataracts? Yes/No
Dry eyes? Yes/No Macular degeneration? Yes/No
Retinal detachment? Yes/No Blurred vision? Yes/No
Do you wear glasses? Yes/No Contact lenses? Yes/No Type \_\_\_\_\_

MEDICAL INFORMATION

Any major medical problems?

Do you have problems with any of these systems? (Please circle yes or no.)

Table with 6 columns: System Name, Yes/No, System Name, Yes/No, System Name, Yes/No. Rows include Gastrointestinal, Nervous, Endocrine, Ears/Nose/Throat, Urinary, Blood/Lymph, Cardiovascular, Muscles/Bones, Allergies/Immunologic, Respiratory, Headaches, Mental, High Blood Pressure, Eyes, Integumentary (skin).

Please explain \_\_\_\_\_

Diabetes Yes/No Type \_\_\_\_\_ Date of diagnosis \_\_\_\_\_

Other health problems \_\_\_\_\_

Current medication(s) \_\_\_\_\_

Drug Allergies? Yes/No Which? \_\_\_\_\_ Reactions? \_\_\_\_\_

Have you had any surgeries? Yes/No Kind? \_\_\_\_\_ When? \_\_\_\_\_

Name of primary care doctor \_\_\_\_\_

Date of last visit \_\_\_\_\_ Date of last tetanus shot \_\_\_\_\_

FAMILY HISTORY

- High Blood Pressure Yes/No Relation \_\_\_\_\_ Macular Degeneration Yes/No Relation \_\_\_\_\_
Diabetes Yes/No Relation \_\_\_\_\_ Retinal Detachment Yes/No Relation \_\_\_\_\_
Glaucoma Yes/No Relation \_\_\_\_\_ Cataracts Yes/No Relation \_\_\_\_\_

DOCTOR USE ONLY

- Reviewed by \_\_\_\_\_ No changes Date \_\_\_\_\_
Reviewed by \_\_\_\_\_ No changes Date \_\_\_\_\_
Reviewed by \_\_\_\_\_ No changes Date \_\_\_\_\_