Insurance Coverage and Our Patient

Many patients have medical insurance to help pay for the cost of requested medical services. This contract is between you, the patient, and the insurance carrier of your choice. Each insurance contract is different, therefore: patients are responsible for knowing and understanding the provisions of their coverage.

Dr. Michael E. Rom's office will submit an insurance form to the insurance carrier we have on file for you at the time of your visit. It is your responsibility to assure we have the proper insurance coverage each time you are seen in the office. A COPY OF YOUR ACTIVE INSURANCE CARD WILL BE REQUESTED AT EACH VISIT. If your coverage has been terminated or not active at the time of your visit, you will be expected to pay for the visit prior to being seen.

Your contract with your insurance carrier, requires you to pay all co-pays, deductibles, and/or co-insurance amounts for each medical service received. Your insurance carrier determines the amount of each co-pay, deductible and/or co-insurance based on your contract. Dr. Michael E. Rom's office is required, by your insurances carrier, to collect all amounts designated as co-pays, deductibles, and/or co-insurance. Your insurance carrier provides you with an EOB (explanation of Benefits) which lists what the carrier has paid and the amounts determined to be co-pays deductibles, and/or co-insurance. YOU ARE RESPONSIBLE FOR PAYING THE AMOUNTS LISTED AS PATIENT RESPONSIBILITY.

If you are scheduled for a surgical procedure, you may be asked to pay a portion of your deductible, as determined by your insurance carrier, prior to scheduling the procedure. This will be discussed with you at the time of surgical scheduling.

Dr. Michael E. Rom's office has an obligation to notify insurance carriers of any patient not meeting their financial responsibility for co-pays, deductibles, and/or co-insurance. We will notify insurance carriers of any patient delinquent in meeting their financial responsibility.

By my signature below, I certify that I have read, understand, and agree to the information provided above.

Date:______________ **Signature**____

INSIGHT
EYE CENTER

Patient Name:________________________ **Date of Birth**:___________

Address:____

Home Telephone:___________________ **Cell Phone**:_______________

Email Address:____

SSN:________________________ **Sex**: (Please Circle) Female/Male

Emergency Contact Information:

Name:_______________________ **Relationship**:_________________

Home Telephone:________________ **Cell Phone**:__________________

Pharmacy:____

Current Medical Insurance:____________________________________

Subscriber Name:________________________ **Date of Birth**:________

What is your Occupation:________________ **Employer:**____________

How did you hear about Dr. Rom:______________________________

I certify that I,and/or my dependant(s), have insurance coverage with those listed above and assign directly to Insight Eye Center, Dr. Michael E. Rom, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named practice may use my health care information and my disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable to related services. I acknowledge that I understand the Privacy Policies of this office. (A copy of the Notice of Privacy Practices is available upon request.)

Patient Signature:____

Medical History Questionnaire

Patient Name:_____________________________ Date of Birth:________________

Please answer the following question to best assist the doctor.

1. **Who performed your last eye exam:_________________________**

   Date of last eye exam:_________________________________

2. **Do you or any family member have the following:**

Glaucoma Y/N if so, who__________________

Macular Degeneration Y/N if so, who__________________

3. **Regarding your medical history, have you ever had:**

High Blood Pressure	**Y/N**	**Congestive heart failure**	**Y/N**
Diabetes	**Y/N**	**Rheumatoid arthritis**	**Y/N**
Asthma	**Y/N**	**Thyroid disease**	**Y/N**
Stroke	**Y/N**	**Cancer**	**Y/N**
Anxiety	**Y/N**	**Depression**	**Y/N**

   Other medical conditions:__________________________________

4. **Have you ever had an eye operation or serious injury (explain)____**

5. **Are you allergic to any medications/food? YES NO**
   If yes, please list:____
   Do you smoke? Y/N If so, how many packs per day?__________
   Do you drink alcohol? Y/N if so, how much?_________________
   Do you use any recreational drugs? Y/N if so, what?__________

Please list any Prescription Medications that you are currently taking:

Please list any Over the Counter Medications:

Vitamins:

Michael E. Rom, M.D.
Pre-Surgical Cataract Patient Questionnaire

Patient:____________________________ Eye being Evaluated: RIGHT LEFT

VISUAL FUNCTIONING:

Do you have difficulty, even with glasses, with the following activities:

1. Reading small print, such as labels on medicine bottles, telephone books, or food labels. YES NO
2. Reading a newspaper or book? YES NO
3. Reading a large-print book, or large-print newspaper, or large numbers on a telephone? YES NO
4. Recognizing people when they are close to you? YES NO
5. Seeing steps, stairs, or curbs? YES NO
6. Reading traffic signs, street signs, or store signs? YES NO
7. Doing fine handwork like sewing, knitting, crocheting, or carpentry? YES NO
8. Writing checks or filling out forms? YES NO
9. Playing games such as bingo, dominos, or card games? YES NO
10. Taking part in sports like bowling, handball, tennis, or golf? YES NO
11. Cooking? YES NO
12. Watching television? YES NO

SYMPTOMS:
Have you been bothered by:

1. Poor night vision? YES NO
2. Seeing rays or halos around lights? YES NO
3. Glare caused by headlights or bright sunlight? YES NO
4. Hazy and/or blurry vision? YES NO
5. Seeing well in poor or dim light? YES NO
6. Poor color vision? YES NO

1. Have you ever driven a car?
   YES NO

2. Do you currently drive a car?
   YES NO

3. How much difficulty do you have driving **during the day** because of your vision?
   € No difficulty A little difficulty € A moderate amount of difficulty € A great deal of difficulty

4. How much difficulty do you have driving **at night** because of your vision?
   € No difficulty € A little difficulty € A moderate amount of difficulty € A great deal of difficulty

5. When did you stop driving?
   € Less than 6 months ago € 6-12 months € More than 1 year ago

Cataract surgery can almost always be safely postponed until you feel you need better vision. If stronger glasses won't improve your vision any more, and if the only way to help you see better is cataract surgery, do you feel your vision problem is bad enough to consider cataract surgery now?

YES NO

Patient Signature:___________________________ Date:______________