Eugene Eye Clinic, LLC

Jason Gross, M.D. & Kent Reynolds, O.D.
2460 Willamette Street, Eugene, OR 97405
Phone (541) 683-3744 Fax (541) 683-6672
www.eugeneeyedoctors.com

Welcome to the Eugene Eye Clinic

________________________________ **is scheduled for an appointment on** ____________________

with Dr. Gross / Dr. Reynolds. Please arrive at __________________ **to check in.**

The office is located on the corner of 24th Place and Willamette Street. Patients may park in our private lot on either side of the building. The office suite is located on the lower level and can be accessed via the stairs or ramp.

- **Please complete all the included forms and bring with you to your appointment to help expedite the registration process.**

- Please remember to bring your insurance cards and photo identification. By providing your correct insurance information, your benefits can be verified and billed correctly. Please refer to the enclosed "Medical vs. Vision Waiver" for explanation of different exam options.

- **Your eyes may or may not be dilated, depending on your specific needs. Most patients are able to drive themselves after dilation, while others may need a driver to accompany them.**

- Please allow up to 2 hours for your initial exam.

- Bring your most recent pair of eyeglasses and a list of your current medications.

- **If you wear contact lenses, wear them to your appointment. Your lenses must be worn for at least 2 hours prior to your appointment. Please bring your contact lens RX information, i.e. written RX or packaging.**

- Co-payments and fees for non-covered services are collected at time of check-in. Our office accepts cash, check and Visa/American Express/MasterCard/Discover.

The Spectacle Shop is conveniently located in our office for your eyewear needs.
The Spectacle Shop is open Monday - Friday 8:00am - 5:00pm.
Phone Number is (541) 683-3746.

Eugene Eye Clinic, LLC
2460 Willamette Street
Eugene, OR 97405
(541) 683-3744
Fax (541) 683-6672
The Spectacle Shop
(541) 683-3746

Jason P. Gross, M.D.
Kent D. Reynolds, O.D.

To Our Valued Contact Lens Wearers,

Drs. Gross, and Reynolds' desire is to exceed the standards set for safe and healthy contact lens wear. For our patients an Annual Contact Lens Evaluation ***is needed to meet these standards.***

A prescription for contact lenses is good for 12 months from your last exam. An ***Annual Contact Lens Evaluation*** is needed to continue to prescribe contact lenses. The fee for this service is $75. Should a change in contact lens material be warranted, additional fee will apply. This evaluation will be performed at your complete vision exam and is a separate charge from the exam itself. If you are only in need of a new contact lens prescription an ***Annual Contact Lens Evaluation*** will need to be done in order to renew your contact lens prescription.

All contact lens services are to be paid for at the time of service. Contact lens services are billed through our clinic and contact lens "hardware" is billed through **The Spectacle Shop**. Please call your insurance carrier directly if you have detailed questions about coverage for contact lenses. If you have questions regarding charges for contact lens please call **Eugene Eye Clinic at (541) 683-3744**, Monday through Friday 8 a.m. - 5 p.m.

Thank you for continuing to trust us with your vision needs.

Sincerely,

Drs. Gross & Reynolds

PATIENT REGISTRATION FORM

Eugene Eye Clinic, LLC
2460 Willamette Street
Eugene, OR 97405

Jason P. Gross, M.D.
Kent D. Reynolds, O.D.

PATIENT INFORMATION

Today's Date: ____________________

Name: ____ Preferred Name: ____________________
(Last) (First) (MI)

Mailing Address: ________________________________ City: ____________________ St.: ______ Zip: ________________

Email Address: ____ Social Security No.: ________________________

Date of Birth: ______________________ Preferred Method of Contact: Phone Call / Text / Email

Home phone no.: ________________________ Cell phone no.: ______________________ Work phone no.: ______________________

Sex: M / F Marital Status: S / M / D / W / DP Patient Employer: ____

Emergency Contact Person: ______________________________________ Relationship: ____________________________________

Home#: ______________________________ Cell#: ________________________________ Work#: ________________________________

Who can we thank for referring you / How did you hear about us? ____

Who is your Primary Care Physician? ____

INSURANCE INFORMATION

If anyone else other than yourself is the subscriber of one or more of your insurance policies, please fill in the information below to assist with timely and accurate billing.

Primary Insurance Co: _________________ Subscriber name: ____________________ Subscriber's DOB: __________

Secondary Insurance Co: _________________ Subscriber name: ____________________ Subscriber's DOB: ________

Legal Guardian or Power of Attorney Information

(This is to be completed when patient is a minor or a Power of Attorney is on file)

Name: ____
Address (if different than patient): ____
Relationship to patient: ________________ Date of Birth: __________________
Phone #: _____________________________

Signature: ____

MEDICAL HISTORY QUESTIONNAIRE

Name: ______________________ Birth Date: ___ /___/___ Today's Date: ______________

Primary Care Physician: ______________ Please list all medication allergies: ______________

List any medications you take (including prescriptions & over-the-counter medications): ______________

List all major injuries, surgeries and/or hospitalizations you have had: ______________

REVIEW OF SYSTEMS

Do you currently, or have you ever had any of the following:

Pregnant? Y / N Nursing? Y / N

System	Yes	No
CARDIOVASCULAR		
High Blood Pressure	❑	❑
Heart Disease	❑	❑
Other: ________	❑	❑
RESPIRATORY		
Asthma	❑	❑
Emphysema/COPD	❑	❑
Other: ________	❑	❑
GENITOURINARY		
Prostate / Treatment	❑	❑
List Medication: ________		
ENDOCRINE		
Diabetes	❑	❑
Thyroid Disease	❑	❑
Other: ________	❑	❑
NEUROLOGICAL		
Numbness/Headache/Seizure	❑	❑
Alzheimers/Dementia	❑	❑
Parkinson's	❑	❑
Stroke/ TIA	❑	❑
Other: ________	❑	❑

System	Yes	No
MUSCULAR		
Arthritis	❑	❑
Joint Pain/ Stiffness/Cramps	❑	❑
Back/ Neck Problems	❑	❑
Chronic Pain	❑	❑
Other: ________	❑	❑
GASTROINTESTINAL		
Hep B/ C / Unknown	❑	❑
Gastric Reflux/Ulcers/Diarrhea	❑	❑
Upset Stomach	❑	❑
Other: ________	❑	❑
Skin		
Rash	❑	❑
Pimples	❑	❑
Shingles	❑	❑
MRSA/ MDRO	❑	❑
Cysts/Growths	❑	❑
Other: ________	❑	❑
EARS/ NOSE/ THROAT		
Hard of Hearing	❑	❑
Stuffy Nose / Earache	❑	❑
Other: ________	❑	❑

System	Yes	No
IMMUNOLOGIC / HEMATOLOGY		
Lupus	❑	❑
HIV / Persistent Infections	❑	❑
Prolonged Steroid Use	❑	❑
Other: ________	❑	❑
PSYCHIATRIC / GENERAL		
Night Sweats	❑	❑
Anxiety / Depression	❑	❑
Panic Attack/Claustrophobia	❑	❑
Other: ________	❑	❑
EYES		
Poor/Low Vision	❑	❑
Decreased Vision	❑	❑
Redness	❑	❑
Pain	❑	❑
Other: ________		
FAMILY HISTORY		
Cataracts	❑	❑
Glaucoma	❑	❑
Macular Degeneration	❑	❑
Diabetes	❑	❑
Other Eye Diseases:	❑	❑
CONSTITUTIONAL		
Weight Loss / Gain	❑	❑

SOCIAL HISTORY: Drink Alcohol? Y / N Tobacco? Y/N Rec. Drugs? Y / N

Recent Eye Exam: ____ /____ (Month / Year) Previous/Referring Eye Physician: ______________

Previous eye surgery? Y / N ______________

Refractive eye surgery ? Y / N

Do you wear glasses? Yes ❑ No ❑

If yes, how old is your present pair of glasses? ______________

How many pairs of glasses do you currently use? ______________

Do you wear contact lenses? Yes ❑ No ❑

Type of contact lenses: ❑ Rigid ❑ Soft ❑ Extended Wear ❑ Other

How old is your present pair of contacts? ______________

Are they comfortable? Yes ❑ No ❑

Mark any you would like to learn more about:

- Transitions Sun Lenses ❑
- Impact Resistant Lenses ❑
- High Index Lenses ❑
- Progressive vs. Bifocal Lenses ❑
- Intermediate/Computer Lenses ❑
- Safety Glasses ❑
- Blue Light Blocking Lenses ❑
- Polarized vs. Sun Tints ❑
- Anti-Reflective/Glare Coating ❑
- Indoor Tint ❑
- UV Blocking Lenses ❑
- Sport Goggles ❑

Glaucoma	❑	Flashes / Floaters	❑
Cataracts	❑	Burning / Itching	❑
Glare Sensitivity	❑	Redness	❑
Dry or Watery Eyes	❑	Eye Pain	❑
Double/ Distorted Vision	❑	Drainage	❑
Loss of Vision	❑	Foreign Body Sensation	❑
Reading Difficulty	❑		

- Do you perform fine or close-up work? ❑
- Are you outdoors often? ❑
- Is safety protection a concern? ❑
- Do you have trouble reading signs? ❑
- Do you have trouble seeing at night? ❑
- Are you bothered by glare and/or lights? ❑
- Extended/regular use of computer screens? ❑
- Sensitive to bright sunlight? ❑

I have reviewed this history: ______________________________

Jason P. Gross, M.D. / Kent D. Reynolds, O.D. Date

Eugene Eye Clinic, LLC
Jason P. Gross, M.D.
Kent D. Reynolds, O.D.
2460 Willamette Street
Eugene OR, 97405

FINANCIAL AGREEMENT

Welcome to Eugene Eye Clinic, LLC. We would like to inform you about our office's financial and privacy policies.

FOR ALL PATIENTS:
By signing below, I acknowledge that I have provided my current insurance information and I authorize the release of any medical information necessary to process claims. I authorize payment of medical benefits directly to Eugene Eye Clinic, LLC for services performed by Drs. Jason Gross & Kent Reynolds. I acknowledge that Eugene Eye Clinic, LLC will bill my insurance as a courtesy. Any services not covered by my insurance will be my responsibility, including services denied due to lack of referral from my primary care provider. Any balances due are to be paid within 90 days of the statement date. After 90 days any balance due will be turned over to an outside collection agency. While payment in full is preferred, you may discuss payment arrangements with the billing staff. I also request payment of government benefits on my behalf to Eugene Eye Clinic, LLC.

Date: ___________________ Signature: ____

FOR MEDICARE PATIENTS:

I request that payment of authorized Medicare benefits be made on my behalf to Eugene Eye Clinic, LLC for services furnished me by Drs. Jason Gross & Kent Reynolds. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the CMS 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Eugene Eye Clinic, LLC accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

Date: ___________________ Signature: ____

HIPAA Privacy Acknowledgment

We are required by law to protect the privacy of your medical information and to provide you with our written Notice of Privacy Practices. Our Notice of Privacy Practices is available for you to review at your convenience in our waiting areas and front desk. Please take a copy for your records. By signing below, you acknowledge that you have received a copy of our Notice of Privacy Practices. Your patience and cooperation is greatly appreciated.

Date: ___________________ Signature: ____

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Kent D. Reynolds, OD
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Eugene, Oregon 97405
541-683-3744

Authorization to Discuss Health Information with **Friends, Family or Caregivers**

Patient name____Patient DOB___________________

________I authorize Eugene Eye Clinic, LLC to leave a personal voice message or recorded message on the primary phone number I have provided.

Please initial:

________I do not authorize Eugene Eye Clinic, LLC to discuss my information with anyone other than myself.

OR

I authorize Eugene Eye Clinic, LLC to discuss the areas I have identified below with the individuals listed.

_______ Unlimited access to all information listed below

________Insurance and Billing information

________Discuss treatment and diagnosis

Please print:

____________________________	_______________	____________________
Name of authorized person	Relationship	Phone Number
____________________________	_______________	____________________
Name of authorized person	Relationship	Phone Number
____________________________	_______________	____________________
Name of authorized person	Relationship	Phone Number

__________________________________ __________________
Patient Signature **Date**

This authorization will remain in effect until revoked or updated by the patient.

EUGENE EYE CLINIC, LLC
JASON P. GROSS, MD
KENT D. REYNOLDS, OD

MEDICAL VS. VISION BENEFITS WAIVER

WHY DO I NEED TO CHOOSE BETWEEN A MEDICAL EYE EXAM AND A VISION EYE EXAM?

There is significant confusion regarding insurance coverage for eye exams. Some vision plans only cover "Routine" vision exams while others will cover your exam only if you have a medical eye condition or disease. Our staff will ask whether you are here for a medical eye exam or a "Routine" vision exam. We can do our best to educate you on your benefits, but we do not want to choose your exam for you. Also, we cannot re-file your claim with a different benefit once the initial claim has been filed.

VISION EXAM

A "Routine" Vision exam is for people who do not have medical eye disease(s) or symptoms of disease. Your eyes will be examined for any needed correction (glasses or contacts) or any potential indicators of eye disease. A Routine vision exam allows you to update your glasses and/or contact lens prescription and screen the health of your eyes. For this type of visit, vision insurance is billed. If our doctors find anything medical during your vision exam, the discussion and possible further testing may be needed at an additional visit to address the medical findings. In that case, your medical insurance would be billed for that next visit. If you are concerned about medical conditions, you should choose to bill your medical insurance.

MEDICAL EXAM

A comprehensive "Medical" eye exam is for the diagnosis and treatment of disease(s) and/or condition(s) of the eye performed by a physician. This exam evaluates the reason for the symptoms and assesses any treatment needed. Some conditions evaluated with a medical exam include dry eyes, allergies, red eyes, cataracts, glaucoma, diabetic retinopathy, macular degeneration and other sight-threatening diseases. In most cases your eyes will be dilated so the doctor can get a good view of the inside and back of your eye. For this type of visit, medical insurance is billed and may apply to annual deductible, coinsurance, or other forms of out-of-pocket expenses assessed by your insurance carrier.

WHAT IF I HAVE BOTH MEDICAL AND VISION INSURANCE?

Some insurance plans allow us to bill both types of insurance to utilize your benefits in the way that best suits your situation. If you have medical problems related to your eyes, you should use your medical benefits. However, if you need your prescription, then the refraction portion of your exam may be billed to your vision benefit by checking both Medical & Vision options listed below.

> Most patients will have a refraction done during either type of exam. A refraction is a diagnostic test used to determine your best corrected vision. For some medical conditions, a refraction is needed even when eyeglasses aren't prescribed. The majority of insurance company's do not cover this procedure. If your insurance doesn't cover your refraction you will be asked to pay the fee of $60.

Please Bill Today's Visit to My _____**Medical Insurance** ______**Vision Insurance**

Patient Signature: ____ Date: ________________________