Figgs Eye Clinic and Optical / Wilson Contact Lens
1410 Lakeside Court #103 Yakima, WA 98902
Phone: 453-2010 Fax: 225-6421

Patient Name: Last: _________________________ **First:** ___________________ **Middle Initial:**_________

Nickname: _________________________________ **Sex: M / F** **Date of Birth:** __________________

Mailing Address: ____ **Nursing Home:** ___________________

City: ______________________________________ **State:** ______________ **ZIP:** _______________

Home Phone: ______________________________ **Cell Phone:** ____________________________________

Contact Preference: Home or Cell **Email:** ____

SS#: ______________________ **Marital Status:** ____________**Spouses Name:** ______________________

Primary Language: _________________________ **Special Needs:** _______________________________

Employer: ______________________________________ **Phone Number:** ____________________________

Referring Doctor: ________________________________ **Phone Number:** ____________________________

Medical Doctor: _________________________________ **Phone Number:** ____________________________

Emergency Contact (Other than Home): ________________________ **Phone Number:** ________________

***Optional*: Birth State:** __________ **Race:** _______________ **Mother's Maiden Name:** _________________

PRIMARY INSURANCE – Plan Name: ____

Insured Party, if other than patient - Name: _______________________________________Birth Date: _____________

SS# and/or Policy#:____ Insured's Relationship to Patient:_____________

SECONDARY INSURANCE (IF APPLICABLE)– Plan Name: ____

Insured Party, if other than patient - Name: _______________________________________Birth Date: _____________

SS# and/or Policy#:____ Insured's Relationship to Patient:_____________

VISION INSURANCE (IF APPLICABLE) – Plan Name: ____

Insured Party, if other than patient - Name: _______________________________________ Birth Date: _____________

SS# and/or Policy#:____ Insured's Relationship to Patient:_____________

*****IF THIS IS A LABOR AND INDUSTRIES CLAIM, PLEASE COMPLETE THE FOLLOWING*****

Date of Injury: _______________________ Claim Number: ____

Employer at time of injury: ________________________________ Phone Number: _____________________

IF THE PATIENT IS A MINOR OR IS NOT RESPONSIBLE FOR THE BILL, PLEASE FILL OUT THE FOLLOWING:

Responsible Party: ____ SS#: __________________________

Phone Number: ___________________________Relationship: ___________________Birth Date: _____________________

Employer: ____ Employer Phone Number: _______________________

Figgs Eye Clinic is authorized to render service, medication and treatment as necessary. I also authorize any insurance benefits to be paid directly to the provider. I assume all responsibility for any unpaid balance, deductibles or denials.

Patient or (if a minor) Guardian Signature: ______________________________ **Date:** ___________

Name________________________________ Date: _____/_____/_____

Occupation ___________________________________ Last Medical Exam: _____/_____/_____

MEDICAL HISTORY: List all major injuries, surgeries and/or hospitalizations you've had:

____

____

Circle any of the following you've had: crossed eyes, lazy eye, drooping eyelid, glaucoma, retinal disease, cataracts, eye surgery, chronic eye infections or eye injury.

Are you pregnant or nursing? No ☐ Yes ☐

Do you wear glasses? No ☐ Yes ☐

If yes, how old is your current pair of lenses? _________________________

Do you wear contact lenses? No ☐ Yes ☐

If yes, how old is your current pair of lenses? _________________________

FAMILY HISTORY: *Please note any family history (parents, grandparents, siblings or children (living or deceased):*

			Relationship to You
Blindness	No ☐	Yes ☐	_________________________
Cataract	No ☐	Yes ☐	_________________________
Crossed Eyes	No ☐	Yes ☐	_________________________
Glaucoma	No ☐	Yes ☐	_________________________
Macular Degeneration	No ☐	Yes ☐	_________________________
Retinal Detachment	No ☐	Yes ☐	_________________________
Retinal Disease	No ☐	Yes ☐	_________________________
Arthritis	No ☐	Yes ☐	_________________________
Cancer	No ☐	Yes ☐	_________________________
Diabetes	No ☐	Yes ☐	_________________________
Heart Disease	No ☐	Yes ☐	_________________________
High Blood Pressure	No ☐	Yes ☐	_________________________
Kidney Disease	No ☐	Yes ☐	_________________________
Lupus	No ☐	Yes ☐	_________________________
Thyroid Disease	No ☐	Yes ☐	_________________________

SOCIAL HISTORY *(all information is kept strictly confidential.)*

Do you drive? No ☐ Yes ☐

Do you:

Drink alcohol? No ☐ Yes ☐ If yes, what frequency? ______________________

Use tobacco? No ☐ Yes ☐ If yes, what frequency/how long? _____________

Use illegal drugs? No ☐ Yes ☐ If yes, type/frequency/how long? ______________

Please check the appropriate box if you have been exposed to or infected with the following:

☐ Gonorrhea ☐ Hepatitis _____A _____B _____C ☐ HIV ☐Syphilis

****DO YOU HAVE OR HAVE YOU EVER BEEN DIAGNOSED WITH MRSA****

(methicillin-resistant Staphylococcus aureus)

YES ☐ NO ☐

OVER

REVIEW OF SYSTEMS: Do you currently, or have you ever had any problems with the following:

	YES	NO
Constitutional		
Fever, Weight loss/gain	☐	☐
Skin Disorders	☐	☐
Neurological		
Headaches	☐	☐
Migraines	☐	☐
Seizures	☐	☐
Eyes		
Loss of Vision	☐	☐
Blurred Vision	☐	☐
Distorted Vision/Halos	☐	☐
Loss of Side Vision	☐	☐
Double Vision	☐	☐
Dryness	☐	☐
Mucous Discharge	☐	☐
Redness	☐	☐
Sandy/Gritty Feeling	☐	☐
Itching	☐	☐
Burning	☐	☐
Foreign Body Sensation	☐	☐
Excess Tearing/Watering	☐	☐
Glare/Light Sensitivity	☐	☐
Eye Pain or Soreness	☐	☐
Chronic Infection Eye/Lid	☐	☐
Sties or Chalazion	☐	☐
Flashes in Vision	☐	☐
Floaters in Vision	☐	☐
Tired Eyes	☐	☐
Endocrine		
Thyroid/Other Glands	☐	☐

	YES	NO
Ears, Nose, Mouth, Throat		
Allergies/Hay fever	☐	☐
Sinus Congestion	☐	☐
Runny Nose	☐	☐
Postnasal Drip	☐	☐
Chronic Cough	☐	☐
Dry Throat/Mouth	☐	☐
Respiratory		
Asthma	☐	☐
Chronic Bronchitis	☐	☐
Emphysema	☐	☐
Vascular/Cardiovascular		
Diabetes	☐	☐
Heart Pain	☐	☐
High Blood Pressure	☐	☐
Vascular Disease	☐	☐
Gastrointestinal		
Diarrhea	☐	☐
Constipation	☐	☐
Genitals/Kidney/Bladder	☐	☐
Bones/Joints/Muscles		
Rheumatoid Arthritis	☐	☐
Muscle Pain	☐	☐
Joint Pain	☐	☐
Lymphatic/Hematologic		
Anemia	☐	☐
Bleeding Problems	☐	☐
Allergic/Immunologic	☐	☐
Psychiatric	☐	☐

If you answered **YES** to any of the above or **have a condition not listed**, please explain:

____

____

____

____

Name________________________________ Date: ______/______/______

Please list all medications, including aspirin, over-the-counter medications, vitamins and home remedies.

Medication/Strength/Dosage	**Reason for Taking**
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ **YES** ☐ **NO**

If yes, please list:

Medication	**Reaction**
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

If your medication or allergy list is too long to fit on the page, bring in a list for us to copy!

FIGGS EYE CLINIC, P.C.

LEO FIGGS, D.O. ANDREW CHEN, M.D. JEFF WILKINSON, O.D.

Specialist in Refractive Cataract and Laser Surgery

HIPAA Notice of Privacy Practices

We are required by law to maintain the privacy of, and provide individuals with, the notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the "HIPAA Notice of Privacy Practices", please ask to speak with our HIPAA Compliance Officer in person or by phone at 453-2010.

Please indicate the personal contacts (family and/or friends; not healthcare providers)with whom your personal health information may be shared:

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

"I acknowledge that I understand the 'HIPAA Notice of Privacy Practices."

Patient Name: ____

Signature: ________________________________Date: __________________

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REFRACTION NOTICE

PLEASE NOTE: At some time during your examination, a refraction may be performed.

Refraction is the process used to determine your glasses prescription.

If a refraction is done, you will be given your prescription card (which is good for two years) even if you are happy with your current prescription. You will be charged for this service.

Some insurance companies do not pay for this service, including Medicare.

*I understand that my insurance may not pay for a refraction. As a result, I accept the responsibility to pay the $60.00 refraction fee. If I pay for the refraction at the time of service and **DO NOT** have Figgs Eye Clinic bill my insurance, I will receive a 25% discount on the fee at a charge of $45.00 for my refraction.*

By signing this, it states that you are aware of the discount offered

Signature: ______________________________________ Date:_____________

Phone 509-453-2010 or 877-706-2010 Fax 509-225-6421 1410 Lakeside Court Suite 103 Yakima, WA 98902

Figgs Eye Clinic, P.C.
Specialist in Refractive Cataract and Laser Surgery
Leo D. Figgs, D.O.   Andrew Chen, M.D.   Jeff Wilkinson, O.D.
*1410 Lakeside Court, Suite 103 * Yakima, WA 98902 * 509-453-2010 * Fax 509-225-6421*

If Medicare or a Medicare Replacement Plan is your primary or secondary insurance, please fill out the:

Medicare Lifetime Authorization

Patient's Name and Address: ______________________________

____

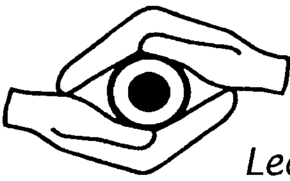
____

Patient's Medicare ID or
Medicare Replacement plan ID: ______________________________

Provider: Figgs Eye Clinic, PC
1410 Lakeside Court #103
Yakima, WA 98902

I request that payment under the medical insurance program be made either to me or to the provider named above on any bills for services furnished to me. I understand that this is a lifetime authorization and will remain effective until further notice in writing from the patient. I authorize the above named provider to release to the Social Security Administration or its intermediaries or carriers any information needed for this claim or any related Medicare claim. I further permit a copy of this authorization to be used in place of the original.

Date:_________________ Patient's Signature:__________________________



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PATIENT RESPONSIBILITY & FINANCIAL AGREEMENT

FINANCIAL RESPONSIBILITY: I assign any benefits to Figgs Eye Clinic, PC that I may have for reimbursement for my medical treatment received by Figgs Eye Clinic, PC which I may be entitled to from any insurance coverage, worker's compensation benefits, disability benefits, and all settlements, judgments and verdicts against any liable third party. I also understand and agree to pay a $30 fee incurred for any returned checks.

PROOF OF INSURANCE: All patients must provide valid and up-to-date proof of insurance coverage and a copy of their driver's license. If you provided incorrect or expired insurance information you will be responsible for the balance of the claim. Insurance denials for termination of coverage will be automatically billed to you.

ALL PAYMENTS ARE DUE AT THE TIME OF SERVICE: Figgs Eye Clinic, PC, as a courtesy to patients, will bill most insurance companies. If your insurance company fails to pay all or part of your bill, you are responsible for all charges. Knowing your insurance benefits-including eligibility, and covered benefits is your responsibility. Please contact customer service at your insurance company for questions you may have regarding your coverage. By signing this agreement, you agree to accept full responsibility of all Figgs Eye Clinic, PC charges.

If you do not have insurance we offer a 10% discount when the charges are paid in full at the time of your exam. If you are unable to pay in full you will be required to pay half of the charges on the day of the exam and then a monthly payment of at least 10% of the balance.

CO-PAYS: co-pays are due at the time of service. If you are unable to pay your co-pay, you will be charged a $10.00 billing fee.

I have read and understand the payment policies set forth. I understand my responsibility for payment of my account with Figgs Eye Clinic, PC and have provided to the best of my ability the information requested accurately and completely.

______________________________ Signature

______________________________ Date

______________________________ Printed Name

*1410 Lakeside Court, Suite 103 * Yakima, WA 98902*
*509-453-2010 * 877-706-1010 * Fax 509-225-6421*

Figgs Eye Clinic, PC
1410 Lakeside Ct Suite 103
Yakima, WA 98902
(509) 453-2010

Credit/Debit Card Recurring Payment Authorization Form

Schedule your payments to be automatically charged to your credit card. Just complete and sign this form to get started!

Recurring Payments Will Make Your Life Easier:

- It's convenient (saving you time and postage)
- Your payment is always on time (even if you're out of town)

Here's How Recurring Payments Work:
You authorize regularly scheduled charges to your Visa, MasterCard, American Express or Discover card. You will be charged the amount indicated below each billing period. Each charge will appear on your statement. You agree that no prior-notification will be provided unless the date or amount of the payment changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

Please complete the information below:

I ______________________________ authorize Figgs Eye Clinic, PC to charge my credit card
(full name)

indicated below for $________ on the ________ of each month for payment on my account with Figgs Eye Clinic, PC.

Billing Address ______________________________ Phone# ______________________

City, State, Zip ______________________________ Account #(s) ______________________

Account Type: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Cardholder Name ____

Account Number ____

Expiration Date ____________

SIGNATURE ______________________________________ DATE ____________________

I authorize the above named business to charge the credit/debit card indicated in this authorization form according to the terms outlined above. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit/debit card and that I will not dispute the payment with my credit card company; provided the transactions correspond to the terms indicated in this authorization form.