

# Bellingham Bay Ophthalmology, LLC

## PATIENT INFORMATION \*\*\*\* (please complete both sides of the form)

Full (legal) name \_\_\_\_\_ Today's date: \_\_\_\_\_  
Nickname: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Sex: \_\_\_\_\_  
Street address: \_\_\_\_\_ PO Box: \_\_\_\_\_  
City: \_\_\_\_\_ State/ZIP: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
Home Phone ( ): \_\_\_\_\_ Cell Phone ( ): \_\_\_\_\_  
Employer: \_\_\_\_\_ Work Ph ( ): \_\_\_\_\_ SS#: \_\_\_\_\_  
Employer's address \_\_\_\_\_ Email: \_\_\_\_\_  
If student, school name: \_\_\_\_\_ Full/part time? \_\_\_\_\_  
Patient's family doctor: \_\_\_\_\_ Pharmacy: \_\_\_\_\_  
Friend or relative not living with you: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_  
**\*\* How did you hear about our Office/Doctors?** Phone book \_\_\_\_\_ Insurance website: \_\_\_\_\_ Internet search: \_\_\_\_\_  
Family or friend we can thank for referring you? \_\_\_\_\_  
Referred by Dr. : \_\_\_\_\_ Other reason: \_\_\_\_\_

## RESPONSIBLE PARTY INFORMATION

Who is responsible for this patient/account? Name: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Home PH: \_\_\_\_\_  
Street address: \_\_\_\_\_ PO Box: \_\_\_\_\_  
City: \_\_\_\_\_ State/ZIP: \_\_\_\_\_  
Cell PH ( ) \_\_\_\_\_ Work Phone ( ): \_\_\_\_\_  
Employer: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Employer's address: \_\_\_\_\_

## MEDICAL INSURANCE INFORMATION (complete above section if patient is not the subscriber)

Primary Medical Insurance: \_\_\_\_\_ Co-pay, if any: \$ \_\_\_\_\_  
Subscriber: \_\_\_\_\_ ID#: \_\_\_\_\_ Group#: \_\_\_\_\_  
Secondary Medical Insurance: \_\_\_\_\_  
Subscriber: \_\_\_\_\_ ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

## VISION INSURANCE INFORMATION

Vision Insurance: \_\_\_\_\_  
Subscriber: \_\_\_\_\_ ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

# Bellingham Bay Ophthalmology, LLC

## Eye Physicians and Surgeons

James M. Kim, M.D., John H. Hodge, M.D., Teresa A. Thornberg, M.D.

### **FINANCIAL POLICY**

We hope that by providing you with this information regarding our financial policy we can prevent misunderstandings, and that you will be comfortable discussing financial and insurance matters with us. Please read it carefully and be assured that you may speak with our Accounts Manager at (360) 676-1929 if you have any questions or concerns.

**Please note:** Please provide us with all current medical and vision insurance cards. We will also ask that you provide photo ID at your first appointment or parent's photo ID if the patient is a minor. You must also have your referral from your primary care doctor if your insurance requires one. If you are having surgery we will arrange for any pre-authorization or referrals for you. **We may need to reschedule your appointment if you arrive without the proper referral and/or current insurance cards.**

**As a courtesy we will bill most insurance policies.** We are preferred providers for most medical insurance companies. Please note, however, **we are not providers for many vision insurance companies** (Blue Vision, Eye Med, Superior Vision, Vision Service Plan and Northwest Benefit Network are examples). It is the *patient's responsibility* to check with the insurance company before the appointment, regarding coverage, deductible and eligibility questions and to determine whether or not our doctors are participating or non-participating providers for the insurance company. Once we have billed your insurance company it is your responsibility to follow up with them on outstanding claims. You are ultimately responsible for payment for services provided to you.

**Payment Policy:** For patients with no insurance, we request payment in full at the time of service. We are pleased to be able to offer a 10% discount if you pay in full at the time of service (private pay patients only). If you are unable to pay in full we will ask that you make payment arrangements with our Accounts Manager at the time you schedule your appointment, which will require setting up automated payments – this can be done from your checking account or Visa, Mastercard, American Express, Discover and/or debit cards.

Co-pays are due at the time of service. We're very pleased to offer new technology that allows us to keep your payment information on file so that you don't have to stop at bookkeeping at each visit to pay. We can also now accept automated payments, as your budget allows, from any of your checking, savings or credit card accounts. This will allow us to work within your budget, interest-free and stress-free. If you have a deductible or have a balance after insurance pays, we do request a monthly payment on all accounts that have a balance. Our Accounts Manager can also assist you with financing through Chase Health Advance if applicable. NSF checks will be assessed a \$25.00 fee. Delinquent accounts will be referred to Physicians and Dentists Credit Bureau and may result in termination of care at our office.

**ATTENTION: MEDICARE PATIENTS - the refractive portion (the test to determine your glasses prescription) of an eye exam is never covered by Medicare.** You will be asked to pay for that portion of the exam if your supplement or Medicare Advantage Plan does not cover the refraction. This also applies to medications dispensed from our office.

**Dismissal Policy:** Please note that Bellingham Bay Ophthalmology, LLC reserves the right to dismiss a patient from our practice for any reason, including repeated missed appointments, failure to pay on an account, or disruptive or inappropriate behavior. Once a patient has been dismissed from our office that dismissal will stand.

**The age of maturity in this state is 18 years old.** According to Revised Washington State Law 26.16.205: "The expenses of the family and education of the children under 18 years of age are chargeable upon the property of both husband and wife, or either of them...." Hence, both father and mother are liable for the expenses of their minor child. This applies whether the parents are married or divorced.

I have read the above Financial Policy and understand and agree to its terms. I hereby authorize my insurance benefits to be paid directly to Bellingham Bay Ophthalmology, LLC. I am financially responsible for any balance due because of co-pay, deductible, referral or authorization not obtained prior to visit, or incorrect or lapsed insurance information. I authorize the release of my medical information as required by the insurance company (ies) to process claims.

Signature (or Guardian's signature): \_\_\_\_\_ Date: \_\_\_\_\_

Print patient's full name: \_\_\_\_\_ (3/11)

# Bellingham Bay Ophthalmology

## New Patient History Form

Patient name: \_\_\_\_\_

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

Do you **currently** have any problems in the following areas? If "Yes, please explain.

	Yes	No	Explanation of Problem
Blurred vision or sudden vision loss			
Double vision, poor side vision			
Poor depth perception			
Flashing lights, floaters, halos			
Glare or light sensitivity			
Irritation, pain in/around eyes			
Dryness, itching, redness, discharge			
Excessive tearing/watering			
Styes/chalazions, swelling of eyelid			
Drooping eyelid			
Eyes turn in/out			
Arthritis			
Fever or weight loss			
Eczema, rosacea or nail changes			
Ear, nose or throat problems			
Recent heart attack or angina			
Irregular heartbeat or pacemaker			
High blood pressure			
Diabetes – if so, how long?			
Blood clots in your legs			
Asthma			
Emphysema			
Pneumonia			
Tuberculosis			
Liver disease, jaundice or hepatitis			
Ulcers or acid reflux disease			
Urination or kidney problems			
Stroke, fainting or seizures			
Migraine headaches			
Thyroid disease			
Anemia			
Depression, bipolar disorder			
AIDS or HIV positive			
Cancer or tumors			
Other - please describe			

List any medications you take: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any allergies to medications: \_\_\_\_\_

List any medical conditions you have been treated for: \_\_\_\_\_  
\_\_\_\_\_

List any surgeries you have had (including dates): \_\_\_\_\_  
\_\_\_\_\_

Date of your last eye exam \_\_\_\_\_

Have you ever had an eye injury?  Yes  No. If so, please describe: \_\_\_\_\_  
\_\_\_\_\_

Do you smoke?  Yes  No If so, how much? \_\_\_\_\_

Do you drink alcohol?  Yes  No If so, how much? \_\_\_\_\_

Do you wear glasses?  Yes  No Do you wear contact lenses?  Yes  No

**History of your blood relatives:** Please note if there is a history of any of the following:

	Yes	No	Relationship to Patient
Glaucoma			
Cataracts			
Macular degeneration			
Retinal detachment or retinal disease			
Color or night blindness			
Crossed or lazy eyes			
Unexplained vision loss			
Diabetes			
Heart disease			
High blood pressure			
Problems with anesthetic			

Physician signature \_\_\_\_\_ Date \_\_\_\_\_