Devin Harrison, M.D.
Andrew Chen, M.D.
Sumit Manhas, O.D.
475 Bradley Blvd, Richland, WA 99352
Phone 509-943-2240 Fax 509-943-1575

COLUMBIA RIVER
EYE CENTER

PATIENT INFORMATION

Acct. #: _____

Last Name	First Name Middle Initial
Address	City State Zip
Sex ☐ Male ☐ Female Date of Birth Social Security#	Primary Care Physician
Marital Status ☐ S ☐ M ☐ D ☐ W Spouse's Name and Date of Birth	Preferred Pharmacy
Home Phone Work Phone Cell Phone	E-mail address *
Local Emergency Contact	Phone # Relationship to Patient

Best way to contact you? ☐ **Text** ☐ **Email** ☐ **Call** ☐ **ALL**

FINANCIAL RESPONSIBILITY FOR THIS ACCOUNT IF OTHER THAN SELF

Name and Date of Birth (Subscriber of Insurance Policy)_____

Who is the responsible party? ☐ Mother ☐ Father ☐ Both ☐ Other _____

Resp party's full name _____

Address _____

Date of Birth _____

Social Security # _____

Work Phone _____

Insurance name _____

Billing address: _____

Policy # _____

Group # _____

_____

Referred by: ☐ Relative ☐ Friend ☐ Yellow Pages ☐ Optometrist ☐ Doctor

Name of referring doctor or person:

INSURANCE AUTHORIZATION AND INFORMATION

I hereby authorize The Columbia River Eye Center to furnish information to insurance carriers concerning any illness and treatment, and fully assign payment directly to the doctor for services rendered. All the above information is true to the best of my knowledge. I understand I am liable for any and all charges insurance does not pay. I also agree to pay any collection and/or attorney fees that should arise from nonpayment.

Signature: (patient or guardian)_____ Date: _____

Medical History Questionnaire

Name: _____ Date: _____

Date of birth: _____ Date of last eye exam: _____

List all **MEDICATIONS** you currently take:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

List any medication **ALLERGIES** you have:

_____ _____ _____

_____ _____ _____

List all **MAJOR ILLNESSES** (diabetes, high blood pressure, etc.) or injuries (concussion, etc.):

_____ _____ _____

_____ _____ _____

_____ _____ _____

Circle any problems you are ***currently*** experiencing with your **EYES**

VISION

Glare
Blurred
Double
Distorted
Fluctuating
Loss of vision

DISCOMFORT

Dry
Itching
Sandy / Gritty
Watery
Redness
Discharge

OTHER

Glaucoma
Macular Degeneration
Cataracts
Eye Lid Abnormalities

SOCIAL HISTORY

Current occupation: _____

Do you drive? ☐ YES ☐ NO

Do you have visual difficulty when driving? ☐ YES ☐ NO

Do you have problems with night vision? ☐ YES ☐ NO

Do you currently wear contact lenses? ☐ YES ☐ NO

Do you currently wear glasses? ☐ YES ☐ NO

Do you drink alcohol? ☐ YES ☐ NO if YES: occasional 1/day 2-3/day 4+/day

Do you Smoke? ☐ YES ☐ NO if YES: occasional ½ pack/day 1 pack/day 1+ pack/day

Former Smoker? ☐ YES ☐ NO if YES: how long since you quit? _____

Have you ever had a blood transfusion? ☐ YES ☐ NO

Check any conditions which apply to you.

GENERAL HEALTH
- ☐ Fever
- ☐ Weight loss _____lbs.
- ☐ Weight gain _____lbs.

Other _____

EARS / NOSE / THROAT
- ☐ Sinus infection
- ☐ Ear infection
- ☐ Chronic cough
- ☐ Dry mouth

Other _____

CARDIOVASCULAR
Disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart attacks

Other _____

Surgery
- ☐ Angioplasty
- ☐ Bypass
- ☐ Valve replacement
- ☐ Carotid Artery

Other _____

RESPIRATORY
- ☐ COPD
- ☐ Asthma
- ☐ Emphysema
- ☐ TB

Other _____

GASTROINTESTINAL
- ☐ Ulcer
- ☐ Reflux
- ☐ Irritable Bowel
- ☐ Ulcerative Colitis / Crohn's

Other _____

CANCER
- ☐ Breast
- ☐ Prostate
- ☐ Lung
- ☐ Colon

Other _____

URINARY TRACT
- ☐ Kidney problems

Other _____

BLOOD / LYMPH
- ☐ Anemia
- ☐ Hepatitis
- ☐ HIV

Other _____

SKIN
- ☐ Acne
- ☐ Psoriasis
- ☐ Skin cancer
- ☐ Rosacea

Other _____

NEUROLOGICAL
- ☐ Stroke
- ☐ Multiple Sclerosis
- ☐ Parkinson's

Other _____

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia

Other _____

ENDOCRINE
- ☐ Diabetes
- ☐ Thyroid

Other _____

MUSCLES / BONES / JOINTS
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Osteoporosis

Other _____

ALLERGIC / IMMUNOLOGIC
- ☐ Hay fever
- ☐ Lupus
- ☐ Sjogrens

Other _____

FAMILY HISTORY M = Mother F = Father S = Sibling GP = Grandparent

DISEASE	YES	NO	Relationship to Patient
Blindness			
Glaucoma			
Macular degeneration			
Retinal detachment			
Strabismus / Amblyopia / Lazy eye			
Migraines			
Diabetes			
Heart disease or high blood pressure			
Stroke			
Cancer			
Other			

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DISEASES AND SURGERY OF THE EYE

Thank you for choosing The Columbia River Eye Center for your eye care needs. Our goal is to provide you with the highest quality medical experience. Please read our office policies carefully and sign below. We will be happy to answer any questions you may have.

- **Patients are financially responsible for the services they receive. We are happy to bill your primary and secondary insurances, however we require that you provide your most current insurance information on a yearly basis or as needed by the front office staff.**
- **For any insurance that requires prior authorization, it is the patient's responsibility to make sure that they are in place prior to the day of the appointment. If these authorizations are not active before the appointment, we will need to reschedule to a later date.**
- **If you arrive 15 or more minutes late for your appointment, we will need to reschedule the appointment to a later date. We do require 24 hours' notice if you are unable to keep your scheduled appointment.**
- **Copays must be paid at the time of service.**
- **The refraction fee is not a covered benefit of Medicare, Medicare Advantage, and some commercial insurance plans. There is a $60.00 charge associated with this and it is due at the time of service.**
- **We do appreciate if you kept your account current with our office. If you are unable to make a payment, you must contact our Billing Department to set up payment arrangements. All accounts over 90 days past due will be turned over to our collection agency.**
- **There is a $40.00 service fee for any returned checks.**
- **We ask that you turn off your cell phone when you enter the examination room to have quality time with your health care provider.**

Thank you for your cooperation in these matters.

Signature of responsible party_____ Date _____

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NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

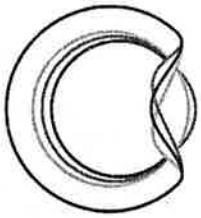
We keep a record of the health care services we provide you. You may ask to see a copy of that record. You may also ask us to correct that record. We will not disclose your record to others unless you direct us to do so or if the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our office manager.
By my signature below I acknowledge receipt of the Notice of Policy Practice. This form will be retained in your medical record.

_____ _____
Signature of patient or responsible party Date

I hereby specifically authorize disclosure of my protected health information to the persons indicated below:

Name:_____ Relation:_____

Name:_____ Relation:_____



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MEDICARE LIFETIME AUTHORIZATION

TO: Medicare Part B
P.O. Box 6700
Fargo, ND 58108-6700

AUTHORIZE FROM: _____ **TO: UNTIL REVOKED**
(Today's Date)

PROVIDER: The Columbia River Eye Center
475 Bradley Blvd
Richland, WA 99352

I request that payment under this medical insurance program be made to the provider named above on any bills for services furnished to me during the effective period of the release to the social security administration or its intermediaries or carriers for any information needed for this claim or any related Medicare claim. I further permit a copy of the authorization to be used in place of the original.

I also appoint the provider or his/her representative as my authorized representative for the purpose of appealing denied claims or refunding inappropriately paid claims.

_____
Patient signature

Patient name _____

Insured name _____

Subscriber's number _____