LEHMAN BIXLER
PROFESSIONAL EYE CARE

About you

Your given name:_____

Your preferred name:_____

Date of birth:_____

Address:_____

_____

Phone: home_____, daytime_____

Employer or school:_____

Occupation or grade level:_____

About your insurance

If your visit is covered by insurance through a spouse or parent, we need the following information.

Insured person's name:_____

Insured's date of birth:_____

About your eyes

Today's visit is due to:

- sudden change in vision:_____
- gradual change in vision:_____
- injury or something in eye:_____
- eye infection or discomfort:_____
- follow-up of past problems:_____

In the past, have you ever had:

- eye injury:_____
- eye surgery:_____

Last eye exam:

- when:_____where:_____

Drug allergies:

Please list any allergies to medicines:

_____

About your general health

Please describe briefly if you or a close relative has had diseases of these types:

Eye disease (such as macular degeneration, glaucoma, RP): _____

_____

Ear, nose, throat or mouth:_____

_____

Diabetes or other endocrine disorders:_____

_____

_____

Cardiovascular (high blood pressure, heart problems, etc):_____

_____

Respiratory:_____

_____

Gastrointestinal:_____

_____

Genitourinary:_____

_____

Musculoskeletal:_____

_____

Skin or breast:_____

_____

Neurological:_____

_____

Psychiatric:_____

_____

Blood or lymph:_____

_____

Allergies or immune system:_____

_____

Constitutional symptoms (fever, weight loss, decreased vision):_____

_____

Your general physician:_____

Today's date:_____

Signature on File (Medicare)

I authorize Dr. Scott Lehman and/or Dr. Scott Bixler to release to Medicare or other insurers any medical or other information about me needed to determine benefits for services obtained in Dr. Lehman's and Dr. Bixler's office.

I permit a copy of this authorization to be used in place of the original.

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Scott E. Lehman or Dr. Scott D. Bixler, for services furnished me.

I understand that Medicare pays for eye health visits to an optometrist only when eye health symptoms or conditions are present.

I understand that if the reasons for the exam and the results of the exam do not justify an eye health care visit, that Medicare will not be billed and will not pay for any part of the exam and that I am personally and completely responsible for the entire exam fee.

I understand that Dr. Lehman's and Dr. Bixler's regular examination fee ($133.00) includes a portion ($21.00) which is for a refraction (determination of spectacle lens prescription) and that this is not an eye health procedure and is not a Medicare covered service. I also understand that I will be responsible for the refraction fee ($21.00) even though Dr. Lehman and Dr. Bixler are Medicare participating providers, unless I ask not to have a refraction performed.

I understand that Medicare does not cover glasses or contact lenses unless they are the first pair following cataract surgery.

Signed_____ Date_____

Signature on File (Non-Medicare)

I authorize Lehman and Bixler Optometrists, P.C. to release any medical or other information necessary to process any insurance claims. I authorize payment of medical benefits to Dr. Scott Lehman/Dr. Scott Bixler.

Signed_____ Date_____

Acknowledgement of Receipt

I acknowledge that a copy of **Notice of Privacy Practices** for Lehman and Bixler Optometrists, P.C. has been offered to me, and I have either accepted it or declined to receive it.

Signed_____ Date_____