MUELLER VISION
LASIK & CATARACT EYE SURGERY

Patient Name: ____________________________________ Date Completed: _______________

PATIENT INFORMATION:

Prefix ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐Other _____________ **Gender** ☐ Male ☐ Female ☐Other _____________

Last Name____ First Name ____ MI _____

Preferred Name _________________________ Date of Birth _________________ Social Security # ________________________

Address ____ Apt # _____________

City ______________________________ State ______ Zip _____________

Race ☐ Black/African American ☐ Asian ☐ White ☐ Hispanic or Latino ☐ Decline

Home # ____________________________ Cell #______________________________ Work # _____________________________

Email Address ____

Preferred Contact: ☐Text ☐Email ☐Call ☐Ok to leave message ☐Don't leave message

Patient Marital Status: ☐Single ☐Married ☐Divorced ☐Other ___________________________________

How did you hear about us? ☐ Primary Care Provider ☐Ophthalmologist ☐Optometrist ☐Friend ______________
☐Google ☐Facebook ☐Online Search ________________ ☐Other _______________

Referred by ____ **Your Optometrist**______________________________________

Were you referred by your Optometrist ☐ Yes ☐ No ☐N/A

EMERGENCY CONTACT:

Name ____ Relationship __________________ Phone _________________________

Patient Employment Status: ☐Full-Time ☐Part-Time ☐ Retired ☐Unemployed ☐Active Military ☐Student

INSURANCE INFORMATION:

Primary Insurance Carrier ____Type of Plan PPO / HMO / Other

ID #: ____ Group #: ____

Policy Holder's Last Name _______________________________ First Name ________________________________ MI _____

Policy Holder's DOB ___________________________________ Social # __________________________ M or F (circle one)

Employer Name _______________________________________ Phone # ____

Patient's relationship to Insured (circle one) Self Spouse Child

Secondary Insurance Carrier ____ Type of Plan PPO / HMO / Other

Policy Holder's Last Name __________________________________First Name ______________________________ MI ____

Policy Holder's DOB ____ Social # _________________________ M or F (circle one)

Patient's relationship to Insured (circle one) Self Spouse Child

MUELLER VISION
LASIK & CATARACT EYE SURGERY

Patient Name: ___________________________________ Date Completed: _______________

Signature on File, Assignments of Benefits, Financial Agreement:

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to MUELLER VISION LASIK & CATARACT EYE SURGERY for services furnished me by MUELLER VISION. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) and its agents any information needed to determine these benefits or the 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 HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. MUELLER VISION 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.

2. **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to MUELLER VISION, if possible or otherwise to me.

3. **RELEASE OF INFORMATION:** MUELLER VISION may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to MUELLER VISION for reimbursement for services rendered, and (2) any health care provider for continued patient care. MUELLER VISION may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute, or regulation. A copy of this authorization may be used in place of the original.

4. **OTHER INSURANCE:** I understand that MUELLER VISION maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. And that MUELLER VISION has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by MUELLER VISION if I belong to a plan that does not appear on the above-mentioned list.

____ ____________________ ___________________
Signature of Patient/Legally Authorized Person Date Time

Mueller Vision No Show policy:

We schedule our appointments so that each patient receives the right amount of time to be seen by our physicians and staff. That is why it is very important that you keep your scheduled appointment with us and arrive on time. As a courtesy, and to help patients remember their scheduled appointments, Mueller Vision sends text message and email reminders 3 days, 2 days, and 2 hours in advance of the appointment time. If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you, and accommodate those patients who are waiting for an appointment. As a courtesy to our office as well as to those patients who are waiting to schedule with the physician, please give us at least 24 hours' notice. If you do not cancel or reschedule your appointment with at least 24 hours' notice, we may assess a $35.00 "no-show" service charge to your account. This "no-show charge" is not reimbursable by your insurance company. You will be billed directly for it. After three consecutive no-shows to your appointment, our practice may decide to terminate its relationship with you. I understand the "no-show" policy of Mueller Vision and agree to provide a credit card number, which may be charged $35.00 for any no-show of a scheduled appointment. I understand that I must cancel or reschedule any appointment at least 24 hours in advance to avoid a potential no-show charge to the credit card provided.

Patient Signature: ____ Date: _______________________

Patient Name: ____________________________________ Date Completed: _______________

Mueller Vision Patient Financial Policy:

Thank you for choosing us as your primary ophthalmology provider. We are committed to providing you with quality eye care. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please take note of the following points:

1. **Insurance Participation**:
   - We participate in most insurance plans, including Medicare. If you are insured by a plan, we do business with, payment in full is expected at each visit.
   - If you are not insured by a plan, we do business with, payment in full is expected at each visit.
   - If you have an up-to-date insurance card, we can verify your coverage. Otherwise, payment in full is required.
   - It is your responsibility to know your insurance benefits. Feel free to contact your insurance company for any coverage-related queries.
2. **Co-payments and Deductibles**:
   - All co-payments and deductibles must be paid at the time of service.
   - This arrangement is part of your contract with your insurance company.
   - Failure to collect co-payments and deductibles can be considered fraud.
3. **Payment Methods**:
   - We accept Visa, MasterCard, American Express, money order, cash, and checks.
   - A returned check incurs a $35 charge, payable by cash or money order.
4. **Proof of Insurance**:
   - Complete our patient information form before seeing the doctor.
   - Provide a copy of your driver's license and current valid insurance for proof of insurance.
   - Incorrect insurance information may result in responsibility for the claim balance.
5. **Claims Submission**:
   - We will submit your claims and assist you in getting them paid.
   - Your insurance company may require direct information from you.
   - The balance of your claim remains your responsibility, regardless of insurance payment.
6. **Coverage Changes**:
   - Notify us if your insurance changes before your next visit.
   - We'll make appropriate adjustments to help you receive maximum benefits.
7. **Refund Policy:**
   - Accounts are reconciled at the end of each quarter. If a refund is due, it will be refunded ONLY to the card used at the time of service or a check can be issued.
8. **Non-Covered Services**:
   - Some services may not be covered by Medicare or other insurers.
   - You must pay for these services in full at the time of the visit.

Remember, your insurance benefit is a contract between you and your insurance company, and we are not party to that contract. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you[1].

Patient Signature: ____ Date: _____________________

MUELLER VISION
LASIK & CATARACT EYE SURGERY

Patient Name: ___________________________________ Date Completed: _______________

Authorization to Disclose Private Healthcare Information:

I, _________________________________, do authorize Mueller Vision to release information including the diagnosis, records; examination rendered to me, and claims information. Information may be released to:

- ☐ My spouse, ____
- ☐ On my voicemail, ____
- ☐ In a text message to my cell phone, ____
- ☐ My email, ____
- ☐ My child, ____
- ☐ My friend, ____
- ☐ Other, ____

____ ________________________

Patient Signature Date of Birth

Acknowledgement of Notice of Privacy Practices:

By signing this form, you acknowledge that you may request a copy of the *Notice of Privacy Practices* of Mueller Vision. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

I acknowledge notice of the *Notice of Privacy Practices* of Mueller Vision.

____ ________________________

Patient Signature Date

MUELLER VISION
LASIK & CATARACT EYE SURGERY

Patient Name: ___________________________________ Date Completed: _______________

Mueller Vision Credit Card on File Policy:

As healthcare continues to evolve, we recognize the importance of ensuring timely payments for services rendered. With high-deductible health plans becoming more common, patients are increasingly responsible for their balances. To streamline this process, we have implemented a **Credit Card on File Policy**.

How It Works:

- **At the time of registration**, we will request your credit card information.
- Your credit card numbers will be **encrypted and securely stored off-site**; no card details will be kept at our practice.
- After receiving your Explanation of Benefits (EOB) from your insurance company, we allow **30 days** for you to pay any outstanding balance.
- If the balance remains unpaid, your credit card will be charged for the amount due.

Benefits for You:

- **Convenience**: Pay balances and co-pays conveniently.
- **Automatic Payments**: Use your preferred credit card for automatic payments.
- **No Checks**: Avoid writing checks or mailing payments.
- **Email Notifications**: Receive receipts and notifications via email.

Please note that this policy **does not affect your rights** regarding credit card usage. You can still dispute charges or question insurance determinations.

Your credit card on file may be used for:

- Visit payments not collected initially.
- No-show or late cancellation charges.
- Insurance discrepancies.
- Outstanding balances overdue by more than 31 days.

Credit Card Type (circle one): **Visa / Master Card / Discover / Amex**

Credit Card Information:

- Card Number:
- Security Code:
- Expiration Date:
- Name appears on the card:
- Billing Address:

Patient Authorization: I authorize **Mueller Vision** to charge the credit card above as per the terms of this policy. This authorization remains in effect until revoked in writing. The credit card number will be redacted before scanning this form into the Electronic Medical Record. Feel free to reach out to our office if you have any questions about this payment method.

_______ Decline

Patient Signature: ____ Date: ______________________

MUELLER VISION
LASIK & CATARACT EYE SURGERY

Patient Name: ___________________________________ Date Completed: _______________

Educational & Media Release Form:

_______ I grant permission to MUELLER VISION and its agents or employees to observe and use photographs and/or video taken of me on the date listed below for use in promotional and educational training, materials such as brochures, newsletters, advertisements, and magazines, and to use such photographs/video in electronic versions of the same publications or on MUELLER VISION websites or other electronic forms of media, and to offer them for use or distribution in other publications, electronic or otherwise, without notifying me. Furthermore, I authorize the use of my name, likeness, and voice for all program promotion, institutional promotion, and any other purposes in connection with the program deemed appropriate and necessary by MUELLER VISION.

________ I hereby waive any right to inspect or approve the finished photographs/video or printed or electronic matter that may be used in conjunction with them now or in the future, whether that use is known to me or unknown, and I waive any right to royalties or other compensation arising from or related to the use of the photographs/video/website.

________ I hereby agree to release, defend, and hold harmless MUELLER VISION and its agents or employees, including any firm publishing and/or distributing the finished product in whole or in part, whether on paper, via electronic media, or on websites, from and against any claims, damages, or liability arising from or related to the use of the photographs/video, including but not limited to any misuse, distortion, blurring, alteration, optical illusion, or use in composite form, either intentionally or otherwise, that may occur or be produced in taking, processing, reduction, or production of the finished product, its publication, or distribution.

________ The statements attributed to me in any testimonial I make available reflect my actual experience with the Licensed Parties and my candid opinions about the Licensed Parties and/or their products and services. I understand that I have the right to rescind this Consent and Release by delivering written notice to the Office Administrator of MUELLER VISION; provided however that this will not enforce any requirement upon the Licensed Parties to recall or destroy any materials already used, published, or disclosed.

________ I am 18 years of age or older and I am competent to contract in my own name. I have read this release before signing below, and I fully understand the contents, meaning, and impact of this release. I understand that I am free to address any specific questions regarding this release by submitting those questions in writing prior to signing, and I agree that my failure to do so will be interpreted as a free and knowledgeable acceptance of the terms of this release.

By signing below, I understand and agree with the above initial statements.

________ Decline

____ _____________________

Signature Date

MUELLER VISION
LASIK & CATARACT EYE SURGERY

Consent to Treatment Form

Patient Name: ____Date of Birth: ______________________

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1. Purpose of Consent
I voluntarily consent to receive medical and/or surgical care, diagnostic tests, and treatments provided by the physicians, optometrists, technicians, and staff at Mueller Vision. This includes routine eye examinations, diagnostic imaging, dilation, refraction, and minor office-based procedures as deemed necessary for my care.

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2. Risks and Benefits
I understand that:

- No treatment or procedure is without risk.
- Risks may include, but are not limited to: temporary discomfort, changes in vision, dilation side effects (such as light sensitivity or blurred near vision), allergic reactions to medications, and—in the case of procedures or surgeries—rare but serious complications.
- The risks, benefits, and alternatives to any procedure will be explained to me before it is performed.

Patient Initials: ________

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3. Medications and Dilation
I understand that certain eye examinations may require dilation of my pupils and/or the use of diagnostic medications. These may temporarily impair my ability to drive, work, or read. I will take appropriate precautions as advised by my provider.
Patient Initials: ________

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4. Laboratory, Diagnostic, and Referrals
I authorize the release of necessary health information to other healthcare providers, laboratories, or insurance companies for the purpose of my diagnosis, treatment, and/or payment.
Patient Initials: ________

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5. Consent to Photography/Imaging
I consent to diagnostic imaging and photography of my eyes and related structures for the purpose of diagnosis, treatment, and documentation of my medical record. These images will not be shared for educational or promotional use without my separate written authorization.
Patient Initials: ________

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6. Financial Responsibility
I understand that I am responsible for payment of services rendered, including any amounts not covered by insurance.
Patient Initials: ________

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7. Right to Refuse or Withdraw Consent
I understand that I have the right to refuse treatment or withdraw my consent at any time, recognizing that this may affect my care.
Patient Initials: ________

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8. Acknowledgment
I acknowledge that I had the opportunity to ask questions and that all questions were answered to my satisfaction.

Patient / Legal Representative Name (Print): ____
Relationship (if not patient): ____
Signature: ____ Date: __________________
Provider/Witness: ____ Date: __________________

MUELLER VISION
LASIK & CATARACT EYE SURGERY

Patient Name: ___________________________________ Date Completed: _______________

What is the reason for your visit today? ____

____

History of eye surgery? (Circle One) Yes No

	Eye	Date		Eye	Date
☐ Cataract Surgery			☐ Macular Degeneration		
☐ Injury / Trauma			☐ Glaucoma		
☐ Glaucoma Surgery			☐ Cataracts		
☐ RK/PRK/LASIK Surgery			☐ Dry Eyes		
☐ Retinal Surgery			☐ Strabismus Surgery		

☐ Other ____

List current eye drops being used ____

Do you wear glasses? ☐ Yes ☐ No If yes, Single vision / Bifocal / Trifocal / Progressive / Readers

Do you wear contact lenses? ☐Yes ☐No If yes, are they soft or hard lenses: ___________________________________

When was the last time you wore them? ________________________________ Single Vision / Monovision / Multifocal / NA

Family history of eye disease? Yes No If yes, explain ____

History of major health problems? ☐Diabetes ☐ High Blood Pressure ☐ High Cholesterol ☐ Heart Disease
☐ Stroke ☐ Kidney Disease ☐ Dementia ☐ Cancer ____________

Other: ____

List Current Medications ____

____

____

Drug Allergies ____ ☐ None

Past Surgical History: ☐ Neck ☐ Back ☐ Head

Other surgeries in last 10 year____

Primary Care Provider ____ Phone # _________________________________

Cardiologist ____ Phone # _________________________________

Other Specialist____ Phone # _________________________________

Preferred Pharmacy ____________________________________ Street or Intersection________________________________

City ____ Phone # ____

MUELLER VISION
LASIK & CATARACT EYE SURGERY

Patient Name: ______________________________________ Date Completed: _______________

Review of Systems

X *Please **X** if applicable*

Cardiovascular	Constitutional	Gastrointestinal	Genitourinary
☐ chest pain	☐ fatigue	☐ abdominal pain	☐ genital discharge
☐ irregular heartbeat	☐ fever	☐ constipation	☐ genital lesions
☐ shortness of breath	☐ night sweats	☐ heartburn	☐ painful urination
	☐ weakness	☐ nausea	☐ urgency
	☐ weight loss	☐ vomiting	
☐ *Negative*	☐ *Negative*	☐ *Negative*	☐ *Negative*

HEENT	Hematologic	Metabolic	Musculoskeletal
☐ dizziness	☐ bleeding	☐ cold intolerance	☐ back pain
☐ hearing loss	☐ bruising	☐ excess hunger	☐ joint pain
☐ hoarseness	☐ tender nodes	☐ excessive thirst	☐ muscle aches
☐ ringing in ears		☐ frequent urination	☐ stiffness
☐ sore throat		☐ heat intolerance	☐ swelling
☐ *Negative*	☐ *Negative*	☐ *Negative*	☐ *Negative*

Neurological	Psychiatric	Respiratory	Skin
☐ balance problems	☐ anxiety	☐ cough	☐ hair loss
☐ headache	☐ depression	☐ trouble breathing	☐ rash
☐ numbness	☐ insomnia	☐ wheezing	☐ skin lesions
☐ tingling	☐ irritability		
	☐ nervousness		
☐ *Negative*	☐ *Negative*	☐ *Negative*	☐ *Negative*

Social History

X *Please **X** if applicable*

Smoking	Alcohol	Recreation Drugs	Occupation	Hobbies
Frequency	*Frequency*	*Frequency*	☐ Business	
☐ 1 – Current Everyday Smoker	☐ Never	☐ Never	☐ Manual labor	☐ Computers
☐ 2 – Current Some Day Smoker	☐ Rarely	☐ Rarely	☐ Office work	☐ Music
☐ 3 – Former Smoker	☐ Occasional	☐ Occasional	☐ Retired	☐ Sewing
☐ 4 – Never Smoked	☐ Daily	☐ Daily	☐ Student	☐ Sports
☐ 5 – Smoker, Status Unknown	☐ Frequently	☐ Frequently	☐ Teacher	☐ Travel
☐ 9 – Unknown if Ever Smoked	☐ Heavy	☐ Heavy	☐ Other	☐ Other
Type of Tobacco	*Type of Alcohol*	*Type of Drug*		
☐ Cigarettes	☐ Beer	☐ Amphetamines		
☐ Cigar	☐ Liquor	☐ Cocaine		
☐ Pipe	☐ Wine	☐ Intravenous drugs		
☐ Electronic Cigarettes		☐ Marijuana		