Mt. Carmel VETERANS SERVICE CENTER

WELLNESS • TRANSITION • RESOURCES
VETERANS • MILITARY • FAMILY

Date: _____

How did you hear about Mt. Carmel VSC?

□ Friend/Family □ Television □ Mt. Carmel Website
□ Military Installation □ Radio □ Mt. Carmel Partner
□ Word of Mouth □ Social Media □ Other:_____

Client Information:

Last Name:	**First Name:**	MI:	Nickname/Alias:
Address:	**City:**	**State:**	**Zip Code:**
Circle One: Own/rent Residing w/family or friend Staying at a shelter Living in hotel Living in car Staying outside/in a tent			
Phone: Cell Home Work	**Alternate Phone:** Cell Home Work		
Email:			
Date of Birth:	**Gender:** ☐Male ☐Female ☐Other:_____ ☐Prefer not to say		
Race: ☐American Indian/Alaskan Native ☐Asian ☐Black/African American ☐White/Caucasian ☐Hawaiian/ Pacific Islander ☐Multi-Racial ☐Other: _____ ☐Refuse/Prefer not to answer		**Ethnicity:** ☐Hispanic/Latinx ☐Non-Hispanic/Non-Latinx	
Primary Language:			
Marital Status: ☐Single ☐Married ☐Common-Law ☐Separated ☐Divorced ☐Widow			
Number of Children in the household (under 18, in the household part or full time):			
Number of adults in the household (18 and older):			
Highest Level of Education: ☐GED ☐High School Diploma ☐Did not finish school ☐Associates ☐Bachelors ☐Masters ☐Doctorate ☐Some College			
Degree Field:	**Household Annual Gross Income: $**		

Military Information: (if you are a dependent please complete this section with sponsors details)

Current Military Status: ☐Active Duty ☐Veteran ☐Guard ☐Reserves				
Branch:				
Date of Enlistment:	**Date of Discharge:**			
Rank/Grade:	**MOS/AFSC/Rate:**			
Deployment History:				
Type of Discharge: ☐Honorable ☐General Under Honorable ☐Other Than Honorable ☐Bad Conduct ☐Dishonorable ☐Officer Discharge ☐Entry Level Separation				
Separation Type: ☐Active ☐ETS (completed term/contract) ☐Medical ☐Retirement ☐Administrative				
Do you have a copy of your DD 214? ☐No ☐Yes				
Do you have a Service Connected Disability? ☐No ☐Yes, _____%				
Are you registered with Veteran Affairs? ☐No ☐Yes				

Additional Information:

Do you have health insurance? ☐No ☐Yes, company/type:
Do you receive any Federal/Public Assistance (SNAP, WIC, TANF, Medicaid, etc.)? ☐No ☐Yes
Do you have access to the internet? ☐No ☐Yes
Are you enrolling in services today directly as a response to the COVID-19 Pandemic? ☐No ☐Yes
Over the past month, have you wished you were dead or wished you could go to sleep and not wake up? ☐No ☐Yes

Comprehensive History Form

General History Date _____/_____/_____

Name: _____ Name you prefer to be called: _____

Date of Birth: _____/_____/_____ Age: _____ Gender: M / F / O Ethnicity: _____ Race: _____

Occupation: _____ Hobbies: _____

Previous Eye Clinic: _____ Date of Last Eye Exam: _____/ _____/ _____

MAIN REASON FOR YOUR VISIT TODAY? _____

Ocular History Do you currently, or have you ever had any of the following problems:

Blurred Vision	Burning/Tearing	Floaters	Crossed/Turned Eye
Dry Eyes	Sensitivity to Sunlight	Flashes of Light	Cataracts
Itchy Eyes	Glare from Lights at Night	Double Vision	Glaucoma
Red Eyes	Painful Eyes	Lazy Eye	Macular Degeneration

Previous Eye Surgery: Y / N If Yes, explain: _____

Do you wear Contacts: Y / N If Yes, what brand: _____ Hours worn per day: _____

Social History Do you currently use, or have you ever used:

Tobacco Products: Y / N If yes, how much? _____ Drink Alcohol: Y / N If yes, how much? _____

Medical History Do you currently, or have you ever had any problems in the following areas:

Name of Physician/Clinic: _____ Date of Last Exam: _____/ _____/ _____

Medication Allergies: Y / N If yes, which ones: _____

Neurological

Seizures	Y / N
Epilepsy	Y / N
Headaches/Migraines	Y / N

How often: _____
Location: _____
Duration: _____
Onset/Time of day: _____
Severity: _____
Treatment: _____

Psychiatric

Anxiety	Y / N
Depression	Y / N
Attention Deficit	Y / N

Ear, Nose, Mouth

Sinus Congestion	Y / N
Dry Mouth/Throat	Y / N
Chronic Cough	Y / N
Hearing Loss	Y / N

Allergic/Immunologic

Allergies/Hay Fever	Y / N
Arthritis	Y / N
Sjogren's Syndrome	Y / N
Lupus	Y / N
MS	Y / N
HIV	Y / N

Respiratory

Asthma	Y / N
COPD	Y / N
Sleep Apnea	Y / N

Musculoskeletal

Ankylosing Spondylitis	Y / N
Fibromyalgia	Y / N

Vascular/Cardiovascular

High Blood Pressure	Y / N
Heart Disease	Y / N
Stroke	Y / N

Cancer Y / N

Endocrine

Thyroid Disease	Y / N
Diabetes Type 1	Y / N
Diabetes Type 2	Y / N

A1c_____ When: _____
BS _____ When: _____

Genitourinary

Pregnant/Nursing	Y / N
Kidney Disease	Y / N

Hematologic/Lymphatic

High Cholesterol	Y / N
Anemia	Y / N

Integumentary

Rosacea	Y / N
Eczema	Y / N
Psoriasis	Y / N

Gastrointestinal

Crohn's Disease	Y / N
Celiac Disease	Y / N

Conditions not listed and Medications:

Family History Check if present in mother, father, grandparents, or siblings. Specify who, maternal (M), paternal (P):

Cataracts	Blindness	High Blood Pressure	Arthritis
Retinal Problems	Macular Degeneration	Diabetes	Thyroid
Glaucoma	Lazy Eye	Heart Disease	Neurological Disorder

Dilation is a recommended procedure for most patients to help rule out certain eye diseases with the potential for partial or total loss of vision and without dilation they may go undetected. Most people experience an increased sensitivity to light and blurred vision. Being advised, I choose to have my eyes dilated: Y / N

I have read, agree, and answered the above correctly and truthfully to the best of my knowledge

Patient Signature: _____ Date: _____/ _____/ _____

Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: ____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records;

examination rendered to me and claims information. This information may be released

to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (day)_____ between (time)_____

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____

Eye Love Care, Inc

(719) 596-2020 Fax – (719)465-2625

Name: *First:* _____ *Middle Initial:* ____ *Last:* _____

Address: _____

City: _____ ***State:*** _____ ***Zip:*** _____

Social Security #: _____-_____-_____ ***Birthdate:*** _____/_____/_____

Gender: _____ ***Marital Status: M S D W***

Home Phone: (____)-_____-_____ ***Work:*** (____)-_____-_____

Cell: (____)-_____-_____ ***Other:*** (____)-_____-_____

Email: _____

Messages may be left on: Home phone____ Cell phone____ Work phone____ Email____

Occupation/Employer: _____

EMERGENCY CONTACT: *Name:* _____

*Relationship:*_____ *Address:*_____ *Phone:*_____

PRIMARY INSURANCE : _____ ***Effective Date:*** _____

INSURED ID #: _____ *GROUP/POLICY #:* _____

POLICY HOLDER'S NAME: _____

PATIENT'S RELATIONSHIP TO POLICY HOLDER: _____

POLICY HOLDER'S DOB _____/_____/_____ ***SS#***_____-_____-_____

SECONDARY INSURANCE: _____ ***Effective Date:*** _____

INSURED ID #: _____ *GROUP/POLICY #:* _____

I authorize Eye Love Care, Inc to release information from my medical records as may be necessary or requested by my insurance company to process claims and to my primary care and/or referral providers for continuity of care. I authorize payment directly to Eye Love Care,Inc of the benefits otherwise payable directly to me under the terms of my insurance. I understand I am financially responsible for charges not covered as detailed in the Practice Policies. If collection action is necessary, I understand that I am responsible for payment of all expenses of collecting my unpaid balance, including attorney fees, and that I specifically relinquish privilege of confidentiality necessary to process my account. This signature also is my consent for treatment.

Patient Signature: _____ Date: _____
(Parent if minor)

Eye Love Care, Inc

Office and Financial Policies

Welcome to our office! We are pleased that you have chosen us to provide your care and services. We would like to inform you of our policies. We accept cash, personal checks and credit cards for payment.

No Insurance/Non-Contracted Insurance: We are a preferred provider for all major insurance companies, however there may be some plan exceptions. Please contact your carrier for verification. We will bill your insurance for you, but all co-pays and past due amounts are due prior to the time of service.

Medicare: Eye Love Care, Inc is participating provider for the Medicare program. We will submit your claim/ services to Medicare. If you have a secondary or supplemental, we will submit after payment from Medicare, however, we must have a copy of your card and the appropriate information.

Contracted Insurance (HMO, PPO, EPO, POS): If you have insurance we are contracted with, we submit your insurance claims for you, if you supply us with the necessary information. This includes a copy of your card, the address to submit clams to and a telephone number to allow us to verify coverage. You are still responsible for payment of your co-payment at the time of service and any amounts not covered by your insurance, including deductible. If your coverage is denied for any reason, you are responsible for payment of the entire balance due, based on our normal fee schedule.

Co-payments: Co-payments or co-insurance is due at the time of service prior to the appointment.

Returned Check Fees: Checks returned for insufficient funds or closure of account will have an additional fee of $50.00 plus the amount that was due. You are responsible for any bank fees charged to you by your bank. Your account will be put on a cash pay only basis thereafter.

Assignment of Benefits and Authorization to Release Information: I hereby assign my Medicare and/or any other insurance benefits to which I am entitled. I authorize and direct my insurance carriers(s) including private insurance, and other health /medical plan to issue payment by check(s) directly to Eye Love Care, Inc for services rendered to me or my dependents regardless of my insurance benefits, if any.

I authorize Eye Love Care, Inc to furnish and/or release any information necessary to insurance carriers concerning my illness or treatment to process my insurance claims and a photocopy of my signature can be used to process my insurance claim for the period of a lifetime. This order will remain in effect until revoked in writing.

I have requested medical services from Eye Love Care, Inc on behalf of my dependents or myself and I understand that by making this request, I become fully responsible for any and all charges incurred in the course of treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all charges incurred immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original. ***Insurance coverage is a matter between my insurance company and myself; I am ultimately responsible for the payment of my account.***

"I agree that in the event that my account is turned over to a collection agency or attorney due to non-payment, that I will pay up to an additional 50 % of the balance as reasonable collection fees (to be added to the balance at the time the account is placed for collection) plus any court costs and attorney's fees incurred in connection with the collection of my account."

I have had the opportunity to read and understand the payment policies set forth and have been given the opportunity to ask questions about these policies. I understand my responsibility for payment to Eye Love Care, Inc.

Printed Name (Responsible Party over 18 years old)

Signature **Date**