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PATIENT INFORMATION SHEET

VisionFirst

TODAY'S DATE: _____

1. HOW DID YOU HEAR ABOUT US?

- Billboard
- Community Event
- Doctor referral
- Friends and Family
- Info received in the mail
- Radio _____
- Website
- Yellow Pages
- Other _____

2. PATIENT NAME (First) _____ (Middle) _____ (Last) _____

Mailing Address _____

Physical Address (if different) _____

City _____ State _____ Zip _____ Email _____

Home Phone _____ Alternate (cell/work) Phone _____

Birthdate ____/____/____ Sex _____ Employed Unemployed Retired Student Disabled

Occupation _____ Employer/School Name _____

Pharmacy Name _____ Pharmacy Location (city) _____

Primary Care Phys _____ Referring Phys _____

3. SPOUSE NAME (First) _____ (Middle) _____ (Last) _____

Spouse Birthdate ____/____/____ Occupation _____ Employer _____

Work Phone _____ Alternate (cell/other) Phone _____

4. BILLING INFORMATION – To whom should bills be sent?

- SAME AS PATIENT (skip to #5)
- SAME AS SPOUSE (skip to #5)
- OTHER (Complete info below)

GUARANTOR NAME (if different from patient or spouse) _____

Mailing Address _____

Physical Address (if different) _____

City _____ State _____ Zip _____ Birthdate ____/____/____ Sex _____

Home Phone _____ Alternate (cell/work) Phone _____

5. EMERGENCY CONTACT INFORMATION

- SAME AS PATIENT (skip to #6)
- SAME AS SPOUSE (skip to #6)
- OTHER (Complete info below)

Name _____ Home Phone _____

Relationship to Patient _____ Alt Phone _____

6. INSURANCE INFORMATION – Please allow us to make copies of your insurance cards

PRIMARY MEDICAL INSURANCE _____ Copy Amt \$ _____

Contract number _____ Group Number _____

Policy Holder Information: SAME AS PATIENT SAME AS SPOUSE SAME AS GUARANTOR

SECONDARY MEDICAL INSURANCE _____ Copy Amt \$ _____

Contract number _____ Group Number _____

Policy Holder Information: SAME AS PATIENT SAME AS SPOUSE SAME AS GUARANTOR

VISION PLAN CARRIER _____ Copy Amt \$ _____

Contract number or SSN _____ Group Number _____

Policy Holder Information: SAME AS PATIENT SAME AS SPOUSE SAME AS GUARANTOR

PLEASE COMPLETE THE BACK OF THIS PAGE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA):

PLEASE CHECK (✓) ALL OPTIONS THAT APPLY: I acknowledge that I have received a copy of VisionFirst Eye Center's Notice of Privacy Practices. I authorize VisionFirst to release my medical information as follows (except for the necessary release to referring physicians and my insurance company as addressed in RELEASE OF INFORMATION below):

CHOOSE ONE FROM THIS COLUMN

- DO NOT** leave messages on my answering machine regarding appointment times, insurance information, etc.
- OK** to leave messages on my answering machine regarding appointment times, insurance information, etc.

CHOOSE ONE FROM THIS COLUMN

- DO NOT** release my health information to anyone other than myself
- OK** to release my health information to **ANY FAMILY MEMBER**
- OK** to release my health information **ONLY** to the following: _____

RELEASE OF INFORMATION:

I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable. I allow fax transmittal of my medical records if necessary.

AUTHORIZATION FOR TREATMENT:

By virtue of my signature I authorize VisionFirst Eye Center, Inc. and any of its employees or other authorized personnel or agents to provide general healthcare service to me.

MEDICARE / INSURANCE PAYMENT AGREEMENT:

I request that payment of authorized Medicare / Insurance benefits be made to either me or on my behalf to VisionFirst Eye Center, Inc. for any services furnished to me by its physicians or suppliers. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services or other insurer and its agents any information needed to determine these benefits payable to 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 coverage is indicated in item 9 of the HCFA 1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare-assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and **the patient is responsible only for the deductible, coinsurance, and non-covered services.** Coinsurance and deductible are based upon the charge determination of the Medicare or other insurance carrier. I understand that **I am responsible for all charges not covered by my insurance company.** I understand that in order to cover my services, a **referral** from my primary care physician **may be necessary** (this is normally required by Health Maintenance Organizations). I also understand that if VisionFirst Eye Center, Inc. does not receive a written authorization or referral from my primary care physician, I will be held financially responsible for any and all charges incurred.

NOTICE OF EXCLUSIONS FROM MEDICARE / HEALTH INSURANCE BENEFITS

Medicare and other insurance plans do not pay for all of your health care costs. Medicare and other health plans only pay for covered benefits. Some items and services are not Medicare or other health plan benefits and Medicare or other health plans will not pay for them. When you receive an item or service that is not a Medicare or other health plan benefit, you are responsible to pay for it personally or through any other insurance that you may have. The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself. Before you make a decision, you should read this entire notice carefully. Ask us to explain, if you don't understand why your insurance won't pay.

Medicare will not pay for a refraction because **routine eye care, eyeglasses and examinations are considered an exclusion from Medicare benefits.** Many health insurance plans will not pay for routine eye care, eyeglasses and examinations. The estimated cost for a refraction (if paid on date of service) is **\$30.00.** **Refractions paid after date of service include a billing fee of \$40.00, for a total of \$70.00**

I have read and fully understand the above information.

COLLECTIONS AGREEMENT - I agree, in the event that my account should be delinquent after 60 days, if this office forwards my account to a collection agency and/or collection law firm, for resolution, that all costs incurred by this office and any collection agency and/or collection law firm are my responsibility and will be paid as part of the resolution of my account balance. **PATIENT INITIALS** _____

Patient or authorized signature _____ **Date** _____

Signer's relationship to patient Self Parent Of Minor Child Power Of Attorney Other _____



VisionFirst
LakeShore Laser

Medical History

Name: _____

Today's Date: _____ Date of Birth: _____

Primary Care Physician: _____

1. Have you been diagnosed with any type of eye disease? Please circle all that apply:

Glaucoma Cataracts Blindness Crossed Eye Macular Degeneration Retinal Disease Diabetic Retinopathy

2. Have you ever had surgery?

Type of Surgery

Approximate Date(s)

3. Are you currently being treated for any medical conditions? Please circle all that apply:

Diabetes Thyroid	High Cholesterol Atherosclerosis	High Blood Pressure Heart Attack (date) _____ Bypass Surg. (date) _____	Palsy Parkinsons	Asthma Emphysema
Arthritis Osteoporosis	Stroke TIA	Congestive Heart Failure Mitral Valve Prolapse	Seizures Migraines Fibromyalgia	COPD Stomach Intestine Colon
Hepatitis B Hepatitis C HIV	Depression Memory Loss Anxiety	Anemia Bleeding Disorders Cancer: _____	Kidney Other	

4. Do you have a family history of medical problems? Please circle and list family relationship:

Glaucoma _____ Diabetes _____ Cancer _____ High Blood Pressure _____ Heart Problems _____
Blindness _____ Crossed Eyes _____ Macular Degeneration _____ Retinal Disease _____

5. Are you allergic to any medications? Please list: _____

6. Please list all medications (including EYE drops) that you are currently taking.

Medication

Dosage

Medication

Dosage

7. Do you smoke? YES (___packs per day) No

Do you drink alcohol? YES (___drinks per day) No

12. Do you have problems, even **with glasses or contact lenses**, with the following activities?

- Reading small print (like labels on medicine bottles, telephone books, food labels?) YES NO
- Reading a newspaper or book? YES NO
- Reading a large-print book, or large-print newspaper, or large numbers on a telephone? YES NO
- Seeing steps, stairs, or curbs? YES NO
- Reading traffic signs, street signs, or store signs? YES NO
- Doing fine handwork like sewing, knitting, crocheting, or carpentry? YES NO
- Writing checks or filing out forms? YES NO
- Playing games such as bingo, dominoes, or card games? YES NO
- Working on a computer? YES NO
- Taking part in sports like bowling, handball, tennis, or golf? YES NO
- Cooking? YES NO
- Watching television? YES NO

13. Have you been bothered by:

- Poor night vision? YES NO
- Seeing rings or halos around lights? YES NO
- Glare caused by headlights or bright sunlight? YES NO
- Hazy and/or blurry vision? YES NO
- Seeing well in poor or dim light? YES NO

Poor color vision?

- YES NO
- Double vision? YES NO

14. Please answer the following questions about driving:

- Do you currently drive a car? YES (continue) No

When did you stop driving?

- Less than 6 months ago.
- 6 to 12 months ago.
- More than 1 year ago.
- I have never driven **(STOP)**

- How much difficulty do you have **driving during the day** because of your vision?

- No difficulty.
- A little difficulty.
- A moderate amount of difficulty.
- A great deal of difficulty.

- How much difficulty do you have **driving at night** because of your vision?

- No difficulty.
- A little difficulty.
- A moderate amount of difficulty.
- A great deal of difficulty.

<i>For office use only:</i>		
<u>Date Updated</u>	<input type="checkbox"/> if Chgs	<u>Initials</u>



VisionFirst

WHY DO I HAVE TO PAY FOR A REFRACTION: QUESTIONS AND ANSWERS

Q: What is a refraction?

A: A refraction is the process of determining the eye's refractive error. In other words, this is a test that helps the doctor decide if eyeglasses or contact lenses will help to correct your vision.

Q: Why is it necessary?

A: A refraction is sometimes necessary depending on the patient's complaints on the day of the eye exam. For example, if you were experiencing blurred vision, and couldn't read the eye chart, we need to figure out whether you simply need corrective lenses (eyeglasses) to see the chart, or if we need to run additional tests to figure out why you can't see. A refraction is an essential part of your eye exam. Unfortunately, many insurance carriers WILL NOT cover the refraction, and expect the patient to pay out-of-pocket for the service.

Q: Will I be told in advance if I need a refraction?

A: Yes, but only a technician or doctor is qualified to tell you if it is necessary. Business office staff members cannot tell you if you need this service when you register for your visit. However, if a technician or doctor decides that you need this service, they will let you know BEFORE it is done. You will be given the option to accept or decline the service.

Q: What happens if I decide not to have a refraction, even if it is recommended?

A: If we are not allowed to do a refraction, we may not be able to determine the cause for your decrease in vision. Without a refraction, we will not be able to give you a current prescription for contact lenses or eyeglasses.

Q: How much does a refraction cost?

A: If you pay on the day of the service, we charge **\$30** for a refraction (*this amount includes a discount for paying on the day of the refraction*). This amount is in addition to the visit co-pay and/or deductible. We will bill your insurance for the refraction, and if your insurance pays the fee, we will gladly refund your refraction fee. **PLEASE NOTE:** If you do not pay on the day of service, and your insurance does not pay for the refraction, the fee for paying AFTER the date of service is \$70.

Q: What if I have a refraction, but I don't need a new eyeglass prescription because my prescription has not changed?

A: This fee is due and payable whether or not your prescription has changed, and whether or not you get a new prescription from the doctor. You will always be offered a current prescription if we charge the refraction fee, but if you tell the doctor you don't need a prescription, we still need to charge the fee. The fee covers the technician and/or doctor's time and effort in providing the service.

ACKNOWLEDGEMENT

I have read the above information and understand the refraction is a non-covered service. The co-pay and deductible are separate from and not included in the refraction fee.

- I want to receive this service so that I can have a new eyeglass prescription, if needed, and I accept full financial responsibility for the cost.
- I do not want to receive this service, and understand that I will not receive a new eyeglass prescription.

Patient Signature (Parent may sign for minor)

Date



VisionFirst

Contact Lens Consent Form

Providing our patients with a contact lens prescription requires our office to;

- ◆ perform a complete eye examination to assess the health of the eye and determine the patient's prescription; and
- ◆ measure the curvature and size of the cornea to determine proper fit of the contact lens.

The eye examination and the contact lens evaluation are separate procedures and are charged separately.

The refraction (test) that is needed to write a prescription for a pair of eyeglasses is also charged separately.

Patients that request a prescription for contact lenses will be responsible for payment of both the examination fee and the evaluation fee. Patients who want a prescription for a pair of eyeglasses will also be responsible for the refraction fee.

Contact lens evaluation fees, based on the patient's prior experience with contact lenses, are generally as follows:

If our office HAS NEVER prescribed contact lenses for you before, your evaluation will include:

- ◆ *Testing* to determine the curvature of your cornea and tear film; AND
- ◆ *Education* on how to insert and remove the lenses, and how to care for them on a daily basis; AND
- ◆ *Trial lenses* that you can take home and wear for several days or weeks to determine how well you can see and how comfortable you are wearing the lenses (except for rigid or hard lenses);
- ◆ *Follow-up visits* to make sure the lenses are not damaging your cornea; AND
- ◆ *A prescription* for your *contact lenses* that can be filled at any location that sells contact lenses.

Pricing for this type of evaluation is as follows:

- Soft (spherical) contact lenses \$ 70.00
- Soft toric or rigid gas permeable lens, or monovision fitting \$ 90.00
- Multi-focal (bifocal) lenses \$110.00
- Medical lenses for keratoconus patients \$200.00

If our office HAS prescribed contact lenses for you in the past, you will receive all of the services listed above, as required for your situation.

Pricing for this type of evaluation is as follows:

- Soft (spherical) contact lenses \$ 35.00
- All other type lenses and monovision fitting \$ 55.00

PLEASE INITIAL EACH POINT BELOW:

- _____ MEDICAID does not pay for the contact lens evaluation or for contact lenses.
- _____ Contact lenses cannot be returned once the box is opened. If the lenses appear damaged upon opening the box, please keep the lens and all packing materials (box and vials), and return to the vendor. Refunds for damaged material cannot be given without these items.
- _____ Lenses purchased from other sources or suppliers will not be warranted for defects. It is the patient's responsibility to ensure that all lenses purchased from another supplier meet the exact specifications (prescription and/or lens powers and brand of lens) as prescribed by our office.
- _____ HARD, GAS PERMEABLE or CUSTOM contact lenses require a deposit of 100% of the cost of the lens upon dispensing.
- _____ Patients must pay a \$10.00 dispensing fee per lens for trial lenses dispensed after the evaluation period.
- _____ By state law, contact lens prescriptions are valid for up to ONE year. Replacement lenses will be sold only to those patients whose prescription remains valid and have not surpassed the expiration date. A written copy of the contact lens prescription may be released to the patient in accordance with Federal requirements and patient compliance guidelines.

Patient Signature _____ Date _____

Parent or Legal Guardian _____ Date _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are maintained properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may disclose your health information.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

We may use or disclose your health information only for the following reasons: **treatment, payment and health care operations**. Examples of how we use or disclose information for treatment purposes are: scheduling an appointment for you; communicating results of a physical examination to a referred specialist; prescribing medications, glasses, or contact lenses and faxing them to be filled; or obtaining copies of your health information from another physician that has treated you. Examples of how we use or disclose information for payment purposes are: asking you about your health or vision insurance plans or other sources of payment; preparing or sending bills or claims; and collecting unpaid amounts by ourselves or through a collection agency or attorney. "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; defense of legal matters; business planning; participation in managed care plans; and outside storage of our medical records.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

Any other uses and disclosures of your health information will be made only with your written authorization, unless otherwise permitted or required by law. Disclosures of health information without your written authorization permitted or required by law include:

Public Health Authority - Examples include: We may disclose medical information about you for the purpose of controlling diseases, injury, or disability; to report births and deaths; to report child abuse or neglect; to report reactions to medications or problems with products; to notify people of recalls of products they may be using; and to notify the appropriate government authority if we believe a patient has been a victim of abuse, neglect or domestic violence.

Health Oversight Agency - Examples include: We may release medical information about you for government authorized audits, investigations, and inspections;

Legal Proceedings - Examples include: If you are involved in a lawsuit, we may disclose medical information about you in response to a court order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful purpose by someone else involved in the dispute.

Law Enforcement - Examples include: We may release medical information to a law enforcement official in response to a court order, subpoena, warrant, or summons; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime; about a death that may be the result of criminal conduct; about criminal conduct at the practice, and in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description, or location of the person who committed the crime.

Coroners, Funeral Directors, and Organ Donation as authorized by law - Examples include: a. We may release medical information to a coroner or medical examiner. For example, to identify a deceased person or determine the cause of death. b. We may also release medical information about patients to funeral directors as necessary to carry out their duties. c. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation, or to an organ donation bank.

Research approved by an institutional review board - Examples include comparing the health and recovery of all patients who received on medication to those who received another, for the same condition and research for incurable disease.

Military Activity and National Security - Examples include: a. If you are a member of the armed forces, we may release medical information about you as required by military command authorities. b. We may release medical information about you to authorize federal officials for intelligence, counterintelligence, and other national security activities by law.

Workers' Compensation - Examples include: We may release medical information about you for workers' compensation programs, which provide benefits for work-related injuries and illnesses.

Inmates - Examples include: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

You may revoke the authorization, at any time, in writing, except to the extent that we have already taken actions relying on your authorization. Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments, services, or products available at our office that might help you.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights with respect to your health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on uses and disclosures of health information for purposes of treatment, payment, or health care operations. We do not have to do this, but if we agree, we must honor the restrictions that you have requested.
- The right to reasonable requests to receive confidential communications of health information from us by alternative means or alternative locations.
- The right to inspect and copy your health information.
- The right to amend your protected information.
- The right to receive an accounting of disclosures of health information.
- The right to obtain a paper copy of this notice upon request.

OUR NOTICE OF PRIVACY PRACTICES

This notice is effective as of April 10, 2003. By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think we have not properly respected the privacy of your health information, you are free to complain to us by reporting to our Privacy Officer or the U.S. Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint, "Attention: Privacy Officer" at the address at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

For further information about the complaint process, you may contact our Privacy Officer at VisionFirst Eye Center.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257 Toll Free: 1-877-696-6775