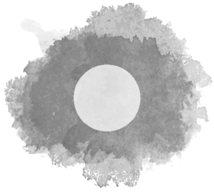

Dr. Black's eye associates

Kristopher Pugh, MD
Edwin Apenbrinck, MD
Thomas Harper, MD
Steven Howell, MD
Curtis Jordan, MD
Victor Neamtu, MD
David Strickland, MD

Jacob Yunker, MD
Dana Conway, OD
Michael Dankovich, OD
Mindy Gunn, OD
Carolyn Hall, OD
Natalie Katt, OD

Jennifer Kellems, OD
Karoline Munson, OD
Jessica Pugh, OD
Ada Sanchez, OD
Rob Steller, OD
Christopher Stroud, OD

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For Office Use Only:
Date:____________________
Location:____________________
Doctor:____________________

PATIENT REGISTRATION

Patient Name:____________________

Street Address:____________________

City:__________ State:____ Zip:____ Home Phone:__________

Race:________ Ethnicity:________ Language:________

Employer's Name:________________ Work Phone:__________

Social Security Number:________________ Sex: Male / Female

Date of Birth:________________ Marital Status: M / S / W / D

Name of Spouse:________________ Spouse's Date of Birth:________

Spouse's Employer:________________ Spouse Soc. Sec. #:__________

Referral Dr.:________________ Family Dr.:________________

Email Address:____________________

Emergency Contact: Please list a friend or relative with a phone number that lives outside of your home:

________________	________________	________________
Name	Patient's relationship to emergency contact	Contact phone number

<u>Insurance Information</u>

Primary Insurance Company:____________________

Supplemental Insurance Company:____________________

Additional Supplement Insurance Company:____________________

* Please give your insurance cards to us so we may make a copy for our records.
* Please make sure to sign and date the indicated areas on the reverse of this form.

I authorize treatment of the person named on the front of this form. I have read the following "insurance claim filing" information and agree to pay all fees for such treatment if denied by my insurance carrier.

INSURANCE CLAIM FILING

MEDICARE: We will file all services to your Medicare. You will be responsible for any deductible, copayment, or non-covered services. We are a Medicare Provider. STATE MEDICAID: We will file all services to your State Medicaid. You will be responsible for any balance as determined by your Medicaid policy. We are a Medicaid Provider. ALL OTHER INSURANCE: We will file all services not covered by your carrier(s) as a courtesy to you. You will be responsible for any services not covered by your carrier that would not otherwise be adjusted due to any contract we may hold with your insurance carrier. Your responsibility may include, but will not be limited to copay, deductible, or charge derived due to an exclusion in your policy, such as routine eye exam coverage, or lack of a referral number if your policy requires one. I request that payment of authorized benefits be paid on my behalf to Eye Associates for any services furnished. I authorize any holder of medical information about me to release to the HCFA and its agents any information needed to determine these benefits payable for services.

Signature:____ Date:____________________________

By signing below I give permission for Eye Associates, to access my pharmacy benefits data electronically through RxHub.

This consent will enable Eye Associates to:

- Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RxHub.

Signature:____ Date:____________________________

Our practice, Eye Associates of Southern Indiana, participates with Nextgen Healthcare Information Systems, LLC and the Nextgen Patient Portal. To better communicate and allow you to manage your medical records we will create a login and password for you for your Patient Portal account. To do so, we accept the Terms and Conditions of the Nextgen Patient Portal website for you. When logging in for your first time, go to Have2020.com and select Patient Portal. The link provides you with the Terms and Conditions in its entirety. By signing this document, I agree to the Terms and Conditions of the Nextgen Patient Portal. By signing below, I ask Eye Associates to complete my enrollment and accept the Terms and Conditions on my behalf. I agree that I was offered a copy of the Terms and Conditions and that I may cancel this account at any time.

Signature:____ Date:____________________________

I acknowledge and agree that Eye Associates and any affiliates, including collection and billing companies, may contact me by telephone, email or text message to any telephone number I provided to you, and any other telephone number associated with my account, including wireless or mobile telephone numbers. I further agree that you may use any method of contact to these numbers, such as Automated Telephone Dialing System (ATDS) or prerecorded message. I also agree that I will notify Eye Associates if I have given up ownership or control of any such telephone number.

Signature:____ Date:____________________________

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MEDICAL HISTORY

Patient Name:____ Date:____________

Email Address:_______________________________Emergency Contact:_______________________

Pharmacy:____________________________ Primary Care Physician_____________________________

Date of Birth:__________________________ Date of Last Eye Exam:_____________________________

Ethnicity: Hisp____ Non Hisp____ Preferred Language: English / Other____________ Race:____________

Do you wear contacts? ❑ Yes ❑ No Do you wear glasses? ❑ Yes ❑ No

Eye Symptoms

	YES	NO		YES	NO		YES	NO		YES	NO
Blurred Vision			Burning			Discharge			Flashes of Light		
Loss of Vision			Tearing			Pain			Floaters or Spots		
Redness			Itching			Dry Eyes			Glare or Halos		

Other ____

Review of Systems - Please answer YES or NO for each question

	YES	NO		YES	NO		YES	NO		YES	NO
Fatigue			Shortness of Breath			Heat Intolerance			Joint Pain		
Fever			Chest Pain			Increased Thirst			Joint Swelling		
Hearing Loss			Irregular Heartbeat			Increased Urination			Muscle Weakness		
Congestion			Abdominal Pain			Dizziness			Bleeding/Bruising		
Sore Throat			Nausea			Depression			Food Allergies		
Cough			Cold Intolerance			Rash			Seasonal Allergies		

Please List medications you are currently taking (including eye medications)

Medication Name	Dosage	Medication Name	Dosage
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________

Are you allergic to any medications? YES____ NO_____ If YES:_________________________________

Ocular History - Please answer YES or NO for each question

	YES	NO		YES	NO		YES	NO		YES	NO
Cataracts			Macular Degeneration			Injury			Crossed/ Lazy Eye		
Glaucoma			Retinal Detachment			Surgery			Laser Treatments		

Eye Surgery or Other Procedure:____

Medical History - Please answer YES or NO for each question

	YES	NO		YES	NO		YES	NO		YES	NO
ENT/Sinus			Diabetic ____yrs.			Kidney Disease			Cancer		
Migranes			High Blood Pressure			Lung Problems			Thyroid		
Arthritis			Skin Disorders			Heart Disease/Stroke			Immune Disorders		

Surgery/Other Procedures:____

Family History - Please answer what applies directly to First Generation Relatives (Mother, Father, Sister, Brother)

Cataracts: YES____ Relation___________Glaucoma: YES____ Relation___________ Diabetes: YES____ Relation___________

Macular Degeneration: YES____ Relation____________ Retinal Detatchment: YES____ Relation____________

Social History - Please answer YES or NO and fill out any other information

Do you smoke? YES____ NO____ Packs a Day/Years:__________ Former Smoker? YES____ NO____

Are you at risk for falls? YES___ NO ____ How many falls in the last year? ___ Did the fall result in injury? YES___NO___

HIPAA COMPLIANCE PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our Notice of Privacy Practices before signing this consent.

The terms of the Notice of Privacy Practices may change. If this happens, you will be notified and asked at your next visit to review the changes and complete an updated HIPAA Compliance Consent Form.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or health care operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment or health care operations.

By signing this form, you consent to our use and disclosure of your protected health care information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation shall not be retroactive.

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosure will cease upon receipt of the revocation.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send you a text to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your voicemail? YES NO

May we discuss your medical condition(s) with a family member or authorized person? YES NO

• If YES, please list below the name(s) and relationship(s) of any persons that we may discuss your medical condition(s) with:

____

____

Patients name:____________________________ Date of birth:__________
(print name please)

Signature:____________________________ Date:__________

Relationship to patient (if not self)____________________________

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Notice of Certain Non-Covered and/or Excluded Services, Supplies or Equipment And Patient Agreement to Pay

EYE ASSOCIATES OF SOUTHERN INDIANA
(812) 284-0660 / (888) EYE-CARE

Patient Name: ________________________________ Patient Date of Birth: __________________

Date of Notice: _________________

Dear Patient,

You are being provided with this Notice and Waiver for Certain Non-Covered and/or Excluded Services because Provider had determined that services, supplies and/or equipment you have requested from Provider, may be excluded or not covered by your health benefit plan with your insurance company.
Please be advised that your insurance will only pay for services, supplies or equipment that it determines to be medically necessary and/or not experimental or investigational under the applicable insurances policies. If your insurance determines that a particular services is "not reasonable or necessary," "experimental" "investigational", or "not medically necessary" under the applicable insurance health benefit plan and/or policies, or other applicable standards, your insurance will deny payment of that service. If your insurance determines that a particular piece of equipment is a deluxe model and your health benefit plan only covers the standard, your insurance may only make a partial payment up to the amount of the standard benefit. This means that you will be personally responsible for paying Provider for all or a portion of that service, supply or equipment.

The following is a description of the service, supply, or equipment which may be excluded or otherwise not covered under your health benefit plan, as well as the approximate cost you will be responsible for paying the provider as a result of the denial:

REFRACTION $30.00

If you have additional questions about why the above item may not be covered (in whole or in part), please contact your insurances Customer Service at the number located on the back of your insurance card.

PATIENT AGREEMENT TO PAY:

I have been notified by my physician/medical facility/medical equipment supplier that my insurance may deny payment, in whole or part, for the services, supplies and equipment identified above. I understand that I have the right to decide whether or not to receive the services, supplies and equipment identified above. I HAVE DECIDED TO RECEIVE THE SERVICE/SUPPLY. If my insurance denied payment for a service or supply that is not covered under my health benefit plan, I agree to be personally and fully responsible for payment to provider. If your insurance makes a payment in the amount of a "standard" service or supply and I desire to receive a "deluxe" equipment/services. I understand and agree that I am obligated to pay this amount regardless of whatever amount appears as "member responsibility" on any Explanation of Benefits from that I may receive from your insurance.

Patient's Signature:____

Date of Signature:______________________________