DR. BLACK'S EYE ASSOCIATES

MRN FOR OFFICE USE ONLY

PATIENT INFORMATION

NAME		DOB	GENDER
PATIENT SSN	OPTIONAL: PREFERRED NAME	OPTIONAL: PREFERRED PRONOUN(S)	
ADDRESS	CITY, STATE, ZIP CODE		
HOME/CELL PHONE	OTHER PHONE		
EMAIL	EMERGENCY CONTACT NAME & PHONE NUMBER		
PHARMACY NAME & LOCATION	PRIMARY CARE PHYSICIAN		

FINANCIAL RESPONSIBILITY

RESPONSIBLE PARENT / GUARDIAN NAME	RELATIONSHIP TO PATIENT	
DOB	SSN	PHONE NUMBER

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME		POLICY HOLDER NAME	
POLICY #	GROUP #	INSURANCE COMPANY ADDRESS	CITY, STATE, ZIP CODE
SECONDARY INSURANCE COMPANY NAME		POLICY HOLDER NAME	
POLICY #	GROUP #	INSURANCE COMPANY ADDRESS	CITY, STATE, ZIP CODE

Please review the below information and initial and sign where indicated. Failure to do so may result in delay or denial of services.

INSURANCE CLAIM FILING:

All services rendered will be filed with applicable Insurance carrier(s), including Medicare & State Medicaid, as a courtesy to me. My financial responsibility may include, but may not be limited to: deductible, copayment, or non-covered service(s). By initialing below I authorize payment of authorized benefits on my behalf to Eye Associates for any services rendered. I also authorize any holder of my medical information to release to The Health Care Finance Administration (HCFA), and its agents, any information needed to determine these benefits payable for services.

Initial: _____

PHARMACY AUTHORIZATION

I grant permission for Eye Associates to access and apply my pharmaceutical benefits data electronically via RxHub. This permission permits Eye Associates to obtain insurance coverage information, obtain formulary information, display therapeutic alternatives, and obtain information regarding other prescriptions prescribed by other providers via RxHub.

Initial: _____

PATIENT COMMUNICATION

I permit Eye Associates, and any affiliates which may include collection and billing organizations, to contact me by telephone, email or text message via any information provided, including any other contact information associated with my account. I further agree that Eye Associates may use any method to contact me, including but not limited to Automated Telephone Dialing System (ATDS) or prerecorded message. I also agree that I will notify Eye Associates if I am no longer authorized to receive calls at any number or email address provided.

Initial: _____

I authorize treatment of the above named person and have reviewed the above information regarding Insurance Claim Filing, Prescription / Pharmacy Authorization, Electronic Health Records and Patient / Policy Holder Communication. I agree to all terms and conditions as listed above.

Print Name Signature Today's Date

Dr. Black's eye associates

(888) EYE-CARE
www.Have2020.com

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 Symptoms - 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:_____

Females: Are you currently pregnant or nursing? ❑ Yes ❑ No

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____

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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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eye associates

(888) EYE-CARE
www.Have2020.com

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 $ 40.00

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:_____