DR. BLACK'S EYE ASSOCIATES (MINOR PATIENTS)

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

RESPONSIBLE PARTY/GUARDIAN ADDRESS

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

CHILD MEDICAL HISTORY

Patient Name:_____ Date:_____

Pediatrician/Primary Care Physician_____ Pharmacy:_____

Date of Birth:_____ Date of Last Eye Exam:_____

Ethnicity: Hisp____ Non Hisp____ Preferred Language: English / Other_____ Race:_____

Eye Symptoms

	YES	NO		YES	NO		YES	NO		YES	NO
Eye Crossing			Burning			Redness			Floaters or Spots		
Eye Squinting			Tearing			Discharge			Blurred Vision		
Eye Drifting			Itching			Pain			Loss of Vision		

Other: _____

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

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

Please List medications the patient is currently taking (including eye medications)

Medication Name	Dosage	Medication Name	Dosage

Is the patient allergic to any medications? YES ____ NO ____ If YES _____

Ocular History

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

Eye Surgery or Other Procedure _____

Medical History

	YES	NO		YES	NO		YES	NO		YES	NO
Diabetic ____ yrs.			ENT/ Sinus			Cancer			Heart Disease/Stroke		
High Blood Pressure			Migraines			Thyroid			Lung Problems		
Kidney Disease			Skin Disorders			Arthritis			Immune Disorders		
Autism											

Surgery/Other Procedures: _____

Family History

Cataracts		Strabismus (Lazy Eye)		Near Sightedness		Retinal Detachment	
Diabetes		Amblyopia (Poor vision)		Far Sightedness		Glaucoma	

Other _____

Social History

Does anyone smoke in the child's home? YES _____ NO _____ Does the child smoke? YES _____ NO _____

Grade Level (If applicable) _____ Is the patient meeting developmental milestones? YES _____ NO _____

Hobbies: _____

Dr. Black's eye associates

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 the patient's 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 **$ 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 Name (please print): _____

Responsible Party Signature:_____ Date:_____

Relationship to patient (if not self)_____

Dr Black's Eye Associates

POLICY: CONSENT TO MEDICAL TREATMENT OF UNATTENDED MINORS

As a general rule, we require the consent of a parent or legal guardian in order to provide health care services to a minor child (someone under the age of 18). With so many parents working outside the home or with other commitments, we realize that you may not be able to accompany your child on every visit to the clinic. If your minor child presents to the clinic unaccompanied, we will not be able to see the unaccompanied minor. If the minor presents in the company of an adult other than a parent or legal guardian, they must have documentation from the parent or legal guardian giving consent for treatment. If they do not have a consent for treatment the appointment will be rescheduled.

In an effort to provide the care needed and avoid having to reschedule your child's appointment, we have developed a consent form that, once completed by a parent or legal guardian, will be placed in your child's medical record for use as necessary. This form will allow us to provide routine and medical treatment (including eye dilation) for your minor child when deemed necessary by qualified medical personnel. Adults, other than the parent or legal guardian who accompany a minor child to an appointment and are authorized by the Consent to Treat a Minor on record, will be asked to present photo ID upon checking the patient in for the appointment. This consent form will remain in effect until revoked in writing.

Patient name: **DOB:**

I, the undersigned, parent(s) or legal guardian of the above named patient, a minor, do hereby authorize the physicians at Dr Black's Eye Associates to act as agent(s) for the undersigned to consent to ocular examination, **dilation**, medical diagnosis and treatment or other medical care which is deemed advisable by, and is this is to be rendered under the general or special supervision of, the treating physician who is licensed to practice in the state of Indiana or Kentucky, whether such diagnosis or treatment is rendered at the office of said physician**. I further acknowledge that I am responsible for any portion of charges that are not covered by the child's insurance.**

Consent to treat a minor child accompanied by an adult other than the child's parent or legal guardian I, the parent or legal guardian of the patient named above, do hereby authorize the physician at Dr Black's Eye Associates to perform medical treatment as per the statements above when accompanied by either of the following names adult persons over the age of 18:

Adults name:_____PRINT NAME

Relationship to the child_____
(Grandparent, Aunt, Uncle, Sister, Brother, Family Friend)

Adults name:_____ PRINT NAME

Relationship to the child_____
(Grandparent, Aunt, Uncle, Sister, Brother, Family Friend)

This authorization is valid:

- For any and all routine or medical procedures (including installation of eye drops for eye pressure and dilation (Typically covered by insurance)
- Contact Lens evaluation, fitting and prescription (typically not covered in full by insurance)
- For Date of Service only: ____/____/_____

This authorization is valid until REVOKED IN WRITING (unless noted above)

Parent or Legal Guardian:_____Date:____/____/_____
signature

Parent or Legal Guardian:_____Date:____/____/_____
print name

Photo ID Verified _____ (Name/Initials of employee)