PATIENT FORM

GENERAL INFORMATION

First, Last, MI, Preferred Name

Street Address

City, State, Zip

Phone, Type

Phone 2, Type

Email

Preferred Contact Method *cell phone* | *email* | *text* | *other (please explain)*

Patient Social Security Number

Date of Birth

Male/Female

Occupation/Employer *full-time* | *part-time*

Marital Status *married* | *single* | *divorced* | *legally separated* | *widowed*

Language, Race, Ethnicity

Emergency Contact Person and Phone

INSURANCE INFORMATION

Vision Insurance

Vision Insurance Member Name

Vision Insurance Member ID#

Vision Insurance Member Date of Birth

Primary Medical Insurance

Primary Member Name

Insurance ID#

Insurance Policy#/Group ID#

Primary Member Date of Birth

Primary Member Social Security Number

Primary Member Employer

Your Relationship to Primary Member *spouse* | *child* | *other (please explain)*

Secondary Medical Insurance

Secondary Medical Insurance Member Name

Secondary Medical Insurance ID#

Secondary Medical Insurance Policy #/Group ID#

Secondary Medical Insurance Member Date of Birth

Secondary Medical Insurance Member Social Security Number

Your Relationship to Secondary Medical Insurance Member

PATIENT FORM

EYE HISTORY

Date of Last Eye Exam

Currently Wear Glasses?

Currently Wear Contacts?

Reason for Today's Visit

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

Cataracts	*yes*	*no*	*family*
Crossed Eye	*yes*	*no*	*family*
Glaucoma	*yes*	*no*	*family*
LASIK or RK	*yes*	*no*	*family*
Lazy Eye	*yes*	*no*	*family*
Macular Degeneration	*yes*	*no*	*family*
Retinal Detachment	*yes*	*no*	*family*

Are you currently experiencing, or have experienced, any of the following? Check all that apply.

- ☐ Blurry Vision *near or distance*
- ☐ Burning
- ☐ Discharge
- ☐ Double Vision
- ☐ Dryness
- ☐ Excess Tearing/Watering
- ☐ Eye Infection
- ☐ Eye Pain or Soreness
- ☐ Floaters or Spots
- ☐ Halos
- ☐ Headaches
- ☐ Itching
- ☐ Light Flashes
- ☐ Light Sensitivity
- ☐ Redness
- ☐ Sandy or Gritty Feeling

MEDICAL HISTORY

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

AIDS/HIV	*yes*	*no*	*family*
Allergies	*yes*	*no*	*family*
Arthritis	*yes*	*no*	*family*
Asthma	*yes*	*no*	*family*
Blood/Lymph Disorder	*yes*	*no*	*family*
Cancer	*yes*	*no*	*family*
Diabetes	*yes*	*no*	*family*
Ears, Nose, Throat Conditions	*yes*	*no*	*family*
Gastrointestinal Conditions	*yes*	*no*	*family*
Heart Disease	*yes*	*no*	*family*
High Blood Pressure	*yes*	*no*	*family*
High Cholesterol	*yes*	*no*	*family*
Kidney Disease	*yes*	*no*	*family*
Lupus	*yes*	*no*	*family*
Neurological Conditions	*yes*	*no*	*family*
Psychiatric Disorder	*yes*	*no*	*family*
Seizures	*yes*	*no*	*family*
Skin Conditions	*yes*	*no*	*family*
Stroke	*yes*	*no*	*family*
Thyroid Dysfunction	*yes*	*no*	*family*

Current Medications (prescription and over-the-counter and dosage)

Medication Drug Allergies

Height **Weight**

Are you pregnant or nursing?

Do you smoke?

Have you ever smoked?

: HENRY VISION CENTER

Name: C. Identification Number:

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare/Medicaid/Commercial Insurance doesn't pay for **D. SERVICES/MATERIALS** below, you may have to pay. Medicare/Medicaid/Commercial Insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare/Medicaid/Commercial Insurance may not pay for the **D. SERVICES/MATERIALS** below.

D. SERVICES/MATERIALS	E. REASONS MEDICAR/MEDICAID/COMMERCIAL INSURANCE MAY NOT PAY	F. Estimated Cost
EXAM AND REFRACTION. CONTACT LENS FITTING AND CONTACT LENS MATERIALS. EYEGLASS FRAMES, LENSES, AND COATINGS. OCULAR PHOTOS OR SCANS NEEDED TO SEE THE INSIDE AND BACK OF THE EYE, AND ANY VISUAL FIELD TESTING.	SERVICES PROVIDED MAY NOT BE COVERED BY INSURANCE. INSURANCE DEDUCTIBLES MAY NOT BE MET. INSURANCE MAY REQUIRE COPAY/COINSURANCE AMOUNT.	MEDICARE 20% COINS. REFRACTION $55 OTHER SERVICES/MATERIALS ESTIMATED COST WILL VARY BASED ON INSURANCE.

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D. SERVICES/MATERIAL** listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare/Medicaid/Commercial Insurance cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare/Medicaid/Commercial Insurance billed for an official decision on payment, which is sent to me on a Medicare/Medicaid/Commercial Insurance Summary Notice (MSN). I understand that if Medicare/Medicaid/Commercial Insurance doesn't pay, I am responsible for payment, but I can appeal to Medicare/Medicaid/Commercial Insurance by following the directions on the MSN. If Medicare/Medicaid/Commercial Insurance does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare/Medicaid/Commercial Insurance. You may ask to be paid now as I am responsible for payment. I cannot appeal if is not billed.

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare/Medicaid/Commercial Insurance would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare/Medicaid/Commercial Insurance decision. If you have other questions on this notice or Medicare/Medicaid/Commercial Insurance billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048) or your insurance provider number on the back of your card.
Signing below means that you have received and understand this notice. You may ask to receive a copy.

I. Signature:	J. Date:

HENRY VISION CENTER - VISION SOURCE

WELCOME TO OUR OFFICE!

PATIENT NAME:	DATE OF BIRTH: / /
ADDRESS:	HOME PHONE:
SS#:	CELL PHONE:

We are now making greater use of email to communicate with our patients. To sign up for on-line services such as scheduling an exam, appointment reminders and appointment confirmations, or to give us feedback once services are provided, please print your current e-mail address below:

NEW PATIENTS: If you are new to our office, how did you hear about our practice? Please circle one:

- Google
- Yahoo
- Twitter
- Yellow Pages
- Facebook
- Yelp
- Other:_____
- Friend/Family:_____

Please let us know if you were referred to our practice by a friend or family member. We have a great **referral incentive** in place and would like to recognize our most loyal patients!

EXISTING PATIENTS: If you are an existing patient, please circle which form of communication prompted you to make your appointment:

- Monthly Newsletter
- Email Reminder
- Phone Call Reminder
- Other:_____

CONTACT LENS POLICY
(APPLICABLE ONLY IF YOU ARE INTERESTED IN CONTACT LENSES)

Our doctor performs a comprehensive eye exam to check the overall health of your eyes, as well as additional testing that determines the strength and type of contact lens that best suits your eyes. This also includes a pair of trial contact lenses and a 1-week progress visit to check the fit of your contacts and the health of your eyes.

Fees that are paid for examinations, contact lens evaluation/fitting, and progress checks for contacts lenses are non-refundable. A period of 30 days is allowed for all contact lens follow-up visits. There will be a **separate charge for any additional visits past the 30-day time frame**. Your prescription is finalized once you have worn the contacts and expressed to us that you would like to proceed with the order. Once the order is placed, the contact lens companies do not take back the contacts so we are unable to provide a refund for these boxes.

Patient's Initials _____

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS.

In the course of providing services to you we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for services and to conduct healthcare operations involving our office. We have comprehensive notice practices that describe these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this consent document. As described in our Notice of Privacy Practices the use and disclosure of your health information is necessary for you to receive follow up care from this office or another health professional. Our Notice of Privacy Practices will be updated when our privacy practices changes. Whenever our practices change you can get an updated copy here at our office or from www.henryvision.net website.

When you sign this consent you signify you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform healthcare operations. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed healthcare operations in reliance upon our ability to use or disclose your health information in accordance with this consent. We can decline to serve you if you elect not to sign this consent form. You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our Notices of Privacy Practices, we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our Notices of Privacy Practices describes how to ask for a restriction.

I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATION.

Date_____ Signature of Patient_____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form.

_____ _____

Relationship to Patient Print Name

INSURANCE CONSENT

I, _____, give consent to this practice to release my medical records (self, patient, or guardian) above specified to _____.
(Insurance Company Name)

I understand that my medical records are confidential. I understand that by signing this consent form, I am allowing my medical information to be released upon my insurance company's request for the purpose of healthcare operations (including but not limited to, provider review function, claims payments and quality assessment). I also understand that I may revoke this consent by written request at any time with this doctor. If revoked it is understood by all parties that all information released prior to being notified of such revocation was made with my consent.

Signature: _____ Date: _____

NO SHOW/CANCELLATION POLICY

It is important to be present for your appointment. Not making your appointment inconveniences other patients. Please call us at least 24 hours in advance if you need to move your appointment time or date in order to avoid a $45 cancellation fee. We understand that emergencies do happen therefore we allow patients the following before we decide to no longer provide services: If a patient does not show up for their appointment for 3 consecutive visits or cancel the same day of the appointment up to 3 times.

FINANCIAL POLICY

Thank you for choosing our practice! Our office staff is very committed to successfully treating and caring for your medical needs. However, it is very important to us that you understand payment of your bill is part of this treatment and care. We ask that you carefully read and initial all of the following numbered items.

1. _____. If we participate with your managed care plan or you have a commercial insurance plan under which you are covered, we will bill the carrier for all services rendered. You will be responsible at the time of service for the payment of:

    - **The annual deductible**
    - **Co-payments**
    - **Charges for non-covered services**

Before services are rendered, our office will call your insurance company to verify eligibility and benefits. However, verification of benefits is **NOT** a guarantee of payment. You will be billed if:

- **We obtain a denial from your insurance company**
- **We have not received payment from the insurance company within 60 days of our filing your claim.**

We will make every effort to contact your insurance to verify benefits, but in the event we are unable to reach them, you will be responsible for your co-payment as well as payment for any procedures performed. Such procedures include but are not limited to, punctual closures, glaucoma scans, visual fields or other medically necessary testing.

2. _____. If you purchase glasses, contact lenses, or other supplies from our offices, **please understand that the products/supplies are non-refundable. All materials are to be paid in full prior to ordering**. If there is a balance due for any other service or material purchase from a previous date, it **must be paid** prior to ordering new product. We will be happy to adjust your glasses, replace nose pads, and screws at no charge. A shipping charge and service fee of $35-55 is required when ordering product including warranty replacements. Some exclusion may apply.

3. _____. If you have no health insurance, payment is expected in full at the time of service

4. _____. There will be a $45 service fee charged to your account if your check is returned by your bank for any reason. Upon notification from our office of your returned check, payment of the entire balance is due immediately. We will accept payment in the form of Credit card, cash or money order. Should you fail to reply within 7 days, our office will forward the balance to Telecheck for collections. There may be additional fees from Telecheck as well.

5. _____. We are Medicare participating providers; therefore, we will bill Medicare directly. However, as with any insurance carrier, you will be responsible at the time of services for payment of:

    - **The annual deductibles**
    - **Co-payments**
    - **Charges for non-covered services**

You will also be asked to sign an Advanced Beneficiary Notice (ABN) form in the event a service is provided, which we know is not covered by Medicare.
For your convenience we accept cash, pre-printed NON temporary checks, Visa, MasterCard, American Express, Care Credit and Discover. If you have any questions please do not hesitate to ask us. We are here to assist you in any way possible.
Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office.

_____ _____

Signature (If minor, parent must sign) Date

HENRY
vision center

CONSENT TO TREAT MINOR CHILDREN

I, _____, the undersigned parent/legal guardian of _____, whose date of birth is ___/___/_____, do hereby give my consent to Dr. Henry and the staff of Henry Vision Center to examine and administer treatments, as they do deem necessary, to the above named individual. I understand that I am responsible for the charges for the goods and services provided. I am aware that I am able to revoke this authorization at any time by written correspondence to Henry Vision Center.

X _____

Signature of Parent/Legal Guardian

Date: ____/____/_____

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for **Henry Vision Center, LLC** to use and disclose protected health information about me to carry out treatment, payment and healthcare operations.

Henry Vision Center, LLC's Notice of Privacy Practice provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Henry Vision Center, LLC** reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Henry Vision Center, LLC's** privacy officer at 3656 Hwy 138 SE Stockbridge, GA 30281.

With this consent, **Henry Vision Center, LLC** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, **Henry Vision Center, LLC** may mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this constant, **Henry Vision Center, LLC** may e-mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment remainder cards and patient statements. I have the right to request that **Henry Vision Center, LLC** restrict how it uses or discloses my protected health information to carry out treatment, payment and healthcare operations. However, the practice is not required to agree to my requested restriction, but if it does, it is bound by this agreement.

By signing this form, I am consenting to **Henry Vision Center, LLC's** use and disclosure of my protected health information to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Henry Vision Center, LLC** may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian