PLEASE PRESENT ALL VISION AND MAJOR MEDICAL INFORMATION TO RECEPTIONIST

Please Print

Date: _____

Patient's Legal Name:

_____

DOB: _____/_____/_____ SSN#: _____/_____/_____

Address: _____

City/State: _____ Zip: _____

Race: White African American Asian

Other Decline to Answer

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email: _____

Note: It is now required that we obtain an email address so we can upload your visit to the patient portal.

Responsible Party Information: (If Different From Above)

Name:_____

DOB:_____/_____/_____ SSN:_____/_____/_____

Address:_____

City/State:_____ Zip:_____

Home Phone:_____

Cell Phone:_____

Work Phone_____

Employer: _____

Occupation: _____

Last PCP Visit: _____/_____/_____

PCP Dr.: _____

Last Eye Exam: _____/_____/_____

Prev. Eye Dr.: _____

MISCELLANEOUS

Do you wear glasses?	Yes	No
Do you wear contact lenses?	Yes	No
Are you interested in contact lenses?	Yes	No
Are you pregnant?	Yes	No
Are you breastfeeding?	Yes	No

Insured's Name: (If Different From Above)

Name:_____

DOB:_____/_____/_____ SSN: _____/_____/_____

Address:_____

City/State:_____ Zip: _____

REVIEW OF SYSTEMS: Do you **currently** have any of the following problems or conditions?

Constitutional
- Fever, weight loss/gain, cancer ☐Yes ☐No
- HIV+/ AIDS ☐Yes ☐No

Cardiovascular
- Heart Disease ☐Yes ☐No
- High Blood Pressure ☐Yes ☐No
- High Cholesterol ☐Yes ☐No
- Stroke ☐Yes ☐No
- Vascular Disease ☐Yes ☐No

Ear/Nose/Mouth/Throat
- Sinusitis ☐Yes ☐No
- Chronic Cough ☐Yes ☐No
- Dry mouth ☐Yes ☐No

Respiratory
- Asthma ☐Yes ☐No
- Chronic Bronchitis ☐Yes ☐No
- Emphysema ☐Yes ☐No
- Sleep Apnea ☐Yes ☐No

Gastrointestinal
- Crohn's Disease ☐Yes ☐No
- Hepatitis A, B, C ☐Yes ☐No
- Colitis ☐Yes ☐No
- Ulcer/Reflux ☐Yes ☐No

Genito-Urinary
- Bladder/Genital/Kidney Disease ☐Yes ☐No
- Herpes Simplex ☐Yes ☐No
- Prostate ☐Yes ☐No

Musculoskeletal
- Fibromyalgia ☐Yes ☐No
- Osteoarthritis ☐Yes ☐No
- Rheumatoid Arthritis ☐Yes ☐No
- Gout ☐Yes ☐No

Integumentary (skin)
- Skin Cancer ☐Yes ☐No
- Skin Disease ☐Yes ☐No
- Shingles ☐Yes ☐No

Neurological
- Headaches ☐Yes ☐No
- Migraines ☐Yes ☐No
- Multiple Sclerosis ☐Yes ☐No
- Seizures ☐Yes ☐No

Psychiatric
- Anxiety ☐Yes ☐No
- Bipolar ☐Yes ☐No
- ADHD ☐Yes ☐No

Endocrine
- Type I Diabetes ☐Yes ☐No
- Type II Diabetes ☐Yes ☐No
- Thyroid/Other Gland ☐Yes ☐No

Lymphatic/Hematologic
- High Cholesterol ☐Yes ☐No
- Anemia ☐Yes ☐No
- Bleeding Problems ☐Yes ☐No

Allergic/Immunologic
- Eczema ☐Yes ☐No
- Hives ☐Yes ☐No
- Lupus ☐Yes ☐No
- Organ Transplant ☐Yes ☐No

Personal Ocular History

(Mark yes or no to each question)

- Age-related macular degeneration ☐Yes ☐No
- Amblyopia (Lazy eye) ☐Yes ☐No
- Blindness (One Eye) ☐Yes ☐No
- Blindness (Both Eyes) ☐Yes ☐No
- Cataracts ☐Yes ☐No
- Glaucoma ☐Yes ☐No
- Injury to eye region ☐Yes ☐No
- Keratoconus ☐Yes ☐No
- Retinopathy ☐Yes ☐No
- Strabismus (Crossed Eyes) ☐Yes ☐No
- Tear film insufficiency (Dry Eyes) ☐Yes ☐No
- History of refractive surgery (Lasik, PRK, RK) ☐Yes ☐No

Other:

_____

_____

Family History (Mark yes or no to each entry. If yes, list which family member.)

Amblyopia (Lazy Eye) ☐Yes ☐No _____
Blindness or vision impairment ☐Yes ☐No _____
Cataract ☐Yes ☐No _____
Macular Degeneration ☐Yes ☐No _____
Glaucoma ☐Yes ☐No _____
Retinal Disorder ☐Yes ☐No _____

Strabismus (cross eyes) ☐Yes ☐No _____
Cancer ☐Yes ☐No _____ (type) _____
Diabetes Mellitus ☐Yes ☐No _____
Stroke ☐Yes ☐No _____
Arthritis ☐Yes ☐No _____
Hypertension ☐Yes ☐No

_____

Social History (Check one for each question)

Are you a drug user? ☐Yes ☐No
Are you a: ☐ Non-drinker ☐ Social drinker

Tobacco Use (mark which one applies)

☐ Heavy tobacco smoker ☐ Light tobacco smoker
☐ Never a smoker ☐ Former smoker

Medications ☐**No Medications**

List all CURRENT prescriptions, over-the counter prescriptions, eye drops and dosages, vitamins.

_____

_____

Medication Allergies ☐No medication allergies

List any allergies you may have:

_____

_____

Tech Initials _____ **Date**_____ **Dr. Signature** _____

Tech Initials _____ Review Date _____ Dr. Initials _____

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM FOR HELTON EYE CARE

You may refuse to sign this acknowledgment & authorization. In refusing, we may not be allowed to process your insurance claims.

Date:_____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

(This includes your spouse, children, step parents, grandparents, and any caretakers who can have access to this patient's records):

Name:_____Relationship:_____Phone number:_____

Name:_____Relationship:_____Phone number:_____

Name:_____Relationship:_____Phone number:_____

Name:_____Relationship:_____Phone number:_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA?

▪ First Name Only ▪ Proper Surname ▪ Other _____

PLEASE CIRCLE YOUR PREFERRED METHOD OF COMMUNICATION:

Home phone Cell phone text message Email

Can we leave automated appointment reminders on your home or cell phone? Yes or No

Can we leave messages letting you know your glasses and contacts are ready? Yes or No

The undersigned acknowledge receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS A PROTECTED HEALTH INFORMATION DOCUMENT RELEASE SHOULD I REQUEST MY MEDICAL RECORDS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE. Your Signature also lets us release information to your PCP, or any other Specialist that you see. Examples Endocrinologist, Neurologist, Rheumatologist, est.

_____ _____

Please PRINT patient's name **Please SIGN patient's name**

_____ _____

Legal Guardian **Date**

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

Helton Eye Care
(812) 689-4721

Patient Name: _____
DOB: _____

Patient Number: _____
Date of Notice: _____

Dear Patient,

You are being provided with this Notice and Waiver for Certain Non-Covered and/or Excluded Services because your provider has determined that services, supplies, and/or equipment you have requested from the 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 insurance policies. If your insurance determines that a particular service 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 your 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 (glasses prescription check) $30.00

If you have additional questions about why the above item may not be covered (in whole or in part), please contact your insurance's 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 THE SERVICE/SUPPLY. If my insurance denies 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 the provider. If your insurance makes a payment in the amount of a “standard” service or supply and I desire to receive a “deluxe” service or supply, I agree that I am responsible for paying the difference between the provider’s billed charges for the “deluxe” equipment/services. I understand and agree that I am obligated to pay this amount regardless of whatever amount appears as “members responsibility” on any Explanation of Benefits form that I may receive from your insurance.

Patient’s Signature:
_____

Date of Signature: _____

PATIENT FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS FORM

1. **FINANCIAL RESPONSIBILITY:** I agree to pay Helton Eye Care and it assigns, for any and all services rendered or expenses incurred as the responsible person on this account. I understand that bills are payable in full upon the rendering of treatment. However, HEC will bill any applicable insurance as a courtesy. I assign HEC all benefits due me for services rendered and expenses incurred under any applicable policy of insurance. I understand I am financially responsible to HEC for all charges and services not covered by this assignment and promise to pay any remaining balance.
2. **COLLECTION POLICY:** An account is considered delinquent when insurance has not paid within 30-45 days after HEC billing or if payment in full has not been received within 30 day of the final insurance payment. Delinquent accounts can be assessed penalties and interest at the annual rate of 12% and may be turned over to a collection agency. I further agree that in the event legal action is required in order to enforce payment on this account, I will pay all court costs, expenses, attorney's fees and other costs incurred and/ or expended as a result of such proceeding.
3. **CONTINUING SERVICES:** I understand that HEC may create a separate account for each time which services or expenses are incurred on this account. I understand that all professional services are not refundable but can receive refunds on the merchandise. I acknowledge and agree that the terms and conditions in this Financial Responsibility and Assignment of Benefits as outlined above shall be effective for continuing and additional services incurred after execution of this form.

ABOUT YOUR INSURANCE

There are two types of health insurance that may help pay for your eye care services and materials. You may have both and our practice accepts both: 1) Medical Insurance (such as Blue Cross/Blue Shield and Medicare) and, 2) Vision Insurance (such as VSP and EyeMed).

- Vision insurance only covers ROUTINE VISION EXAMS along with eyeglasses and contact lenses.
- Medical insurance MUST BE USED if you have any eye health problem that has ocular complications. Your doctor will determine if these conditions apply to you but some are determined by your case history.
- Most medical insurance plans do have routine vision screening benefits but these are very different than an actual vision examination. Vision screenings are basic screenings for eye disease. **They do not cover diagnosis, management or treatment of eye diseases nor do they allow for a prescription to be written for eyeglasses or contact lenses.**
- If you have both types of insurance plans, it may be necessary for us to bill some services to one plan and other services to the other plan. We will use coordination of benefits to do this properly and to minimize your out-of-pocket expenses.
- We will bill your insurance plan for services if we are a participating provider for that plan. We will try to obtain advanced authorization of your insurance benefits in an attempt to let you know what is covered. Any co-pays, deductibles or non-covered services will be your responsibility.

I have read and understand the above policies.

PATIENT NAME:

_____ _____

Patient or Legal Guardian Signature Date

NO SHOW POLICY

Due to an increase in no shows and last minute rescheduled appointments, it is now the policy of Helton Eye Care to monitor and manage these no shows more strictly. This is necessary to ensure that we are able to provide timely access for all patients. A high number of unutilized appointments delays necessary eye care for patients.

Scheduled appointments must be cancelled or rescheduled at least 24 hours prior to the scheduled appointment time. Any patients who fails to arrive for a scheduled appointment without cancelling the appointment at least 24 hours prior will be considered a no show and will be charged a $35 no-show fee. Unpaid "no show balances" must be paid prior to the scheduling of future appointments.

After three no shows a patient may be denied a future appointment to Helton Eye Care and may need to seek eye care elsewhere.

We understand that special circumstances may arise beyond your control that prevents you from notifying the office within 24 hours. Please sign below acknowledging you are aware of this new policy

Signature_____ Date: _____

Helton Eye Care
Contact Lens Fitting, Evaluation, and Management Policy

We want to thank you for considering a contact lens evaluation with the doctors of Helton Eye Care. We would like you to understand what is involved with a contact lens evaluation and if you have any questions the doctor will determine if you are a candidate for contact lens training, where you will be taught how to properly insert and remove the contact lefises for one to two weeks and return for a follow-up examination. If you are a previous wearer, the doctor will evaluate if any changes are needed and if no changes have been made to the fit, you will be free to purchase your prescribed contact lense the day of examination. Below are the categories of Contact Lens Fitting fees. Your fees will be determined by the doctor, and are due at the time of fitting and are non-refundable. Fees do not include the price of the contact lenses.

- Basic Contact Lens Fitting: $70
- Advanced Contact Lens Fit-Multifocal Contacts, Monovision: $90
- Complex Contact Lens Fitting - Gas Perms, Myopia Control Multifocal Contact Lens Fitting: $120
- Specialty Contact Lens Fitting: $250- Specialty Lenses for Keratoconus, Post-Surgical, and Other Irregular Corneal Conditions
- Renewal of Contact Lens Fit and Power: $30-No Change in Current Fit and Allows You to Refill Contact Lenses for One Full Year

Notice: Based on State law, your contact lenses must be evaluated with a doctor examination on a yearly basis in order to refill your prescription.
Your evaluation/fitting fee covers your trial lenses and up to two months of follow-up care related to the fit of the lenses. Follow-up care is vital to determine the fit of the lens and to protect the health of the eye. If you elect to forego the follow-up care and return beyond the initial two month period, you will be charged our fitting fee of $30. We do urge you to protect your vision and return for follow-up care. Trial lenses are not for permanent use. You must have follow-up care to be able to buy contact lenses. The prices of contact lenses will vary depending on the type of contacts that your doctor recommends and your prescription.
Fairness to Contact Lenses Consumers Act: This act went into effect February 4, 2004. As stated by this act, you will be given a copy of your contact lens prescription once the prescription is finalized with the examining doctor. Receiving a trial lens IS NOT a finalized prescription. A finalized prescription is determined at the follow-up appointment after you have been wearing the trial lenses. The doctor will approve the fit and vision with the contacts. At this point, you may receive a copy of your prescription.
I have read and understand the above information and agree to the terms set forth in the contract and have had all my questions answered.

Signature:

_____

Date: