

Welcome to Parker Vision Specialists, P.C.

Appointment Date: _____, 20____ :____ m

<u>title</u> <u>first name</u> <u>middle name or initial</u> <u>last name</u>		<u>preferred name</u>	<u>if patient is a child, parent's name</u>
<u>mailing address</u> (street, city, state, zipcode)		<input type="checkbox"/> male <input type="checkbox"/> female	<u>parent's address, if different from at left</u>
		<u>date of birth</u> (mm/dd/yy) / /	
I prefer you contact me <input type="checkbox"/> by postal mail at the address shown above <input type="checkbox"/> by day phone: () - <input type="checkbox"/> by home phone: () - <input type="checkbox"/> by my email: @ <input type="checkbox"/> by other means:		<u>if patient is a student, circle which grade</u> Preschool K 1 2 3 4 5 6 7 8 9 10 11 12 school: teacher:	
<u>social security #</u>	<u>significant other</u>		How Did You Choose Us? <input type="checkbox"/> Our Web Site <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Insurance Booklet <input type="checkbox"/> Family Has Been In <input type="checkbox"/> Primary Care Doctor <input type="checkbox"/> Eye Specialist Doctor <input type="checkbox"/> In Building, Stopped By <input type="checkbox"/> Lecture/Health Fair <input type="checkbox"/> Referred by Patient <input type="checkbox"/> Other
<u>employer & work address</u>	<u>emergency contact name, phone, email</u>		
<u>vision insurance name & address</u>	<u>insured name</u>		
<u>group #</u>	<u>ID #</u>		
<u>medical insurance name & address</u>	<u>insured name</u>		
<u>group #</u>	<u>ID #</u>		
<u>financially responsible party</u>	I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of government benefits to myself or the party who accepts assignment above. signed: _____ print name: _____	I authorize payment of medical benefits to the above listed physician or supplier for services rendered. signed: _____ print name: _____	
<u>payment preference</u> <input type="checkbox"/> Insurance <input type="checkbox"/> Check <input type="checkbox"/> Charge Card <input type="checkbox"/> Cash Payment is expected at the time services are rendered, including non-covered portions of insurance.			
<u>family physician name & address</u>	Internal Use Only Acct. #: _____ FD Initials: _____ Waivers Signed (ABN, Finance, HIPPA)? Y N Time: _____ Photograph Taken? Y N Copies of Insurance? Y N Address/Phone Number/email Verified? Y N		

Parker Vision Specialists, P.C. patient info form: Medical History of _____ page 2 of 4

Date of last eye exam: _____ Previous Eye Doctor: _____

Current occupation: _____ Hours per day using a computer: _____

Hobbies/Sports: _____

Are you interested in Laser Refractive Surgery? Y / N

Are you interested in Corneal Refractive Therapy or contact lenses? Y / N

Have you ever worn contacts? Y / N Reasons for stopping? _____

Do you currently wear contacts? Y / N How many hours per day? _____ How many days per week? _____

Do you currently wear glasses? Y / N _____ Full time _____ Distance only _____ Near only _____ Bifocal _____ Computer

How old are your current prescriptions for contacts? _____ Glasses? _____ Do you wear sunglasses? Y / N

Please mark any of the following symptoms you experience:

___ Decreased distance vision ___ Headaches ___ Redness ___ Dry Eyes

___ Decreased near vision ___ Glare while driving ___ Itchy eyes ___ Irritation/Burning

___ Decreased night vision ___ Eyestrain ___ Watery eyes ___ Hay fever

___ Decreased side vision ___ Floaters ___ Double vision ___ Flashes of light

___ Light sensitivity Other symptoms: _____

Current medications, vitamins and/or herbal supplements: _____

Allergies to medications: _____

Eye History:

	Self	Blood relative and Whom?
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Amblyopia (Lazy Eye)..... Y / N..... Y / N _____

Macular degeneration..... Y / N..... Y / N _____

Retinal detachment..... Y / N..... Y / N _____

Strabismus..... Y / N..... Y / N _____

Glaucoma..... Y / N..... Y / N _____

Blindness..... Y / N..... Y / N _____

Cataracts..... Y / N..... Y / N _____

Color Blindness..... Y / N..... Y / N _____

Have you had vision therapy? Y / N When? _____ If yes, what for? _____

Have you had an eye injury or surgery? Y / N If yes, for what? _____

Medical History:

	Self	Blood relative and Whom?
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Psychiatric (example: depression)..... Y / N..... Y / N _____

Allergies/Immunologic (hayfever, lupus)..... Y / N..... Y / N _____

Cardiovascular (high blood pressure, cholesterol)..... Y / N..... Y / N _____

Respiratory (asthma, COPD)..... Y / N..... Y / N _____

Neurological (stroke, M.S., migraines)..... Y / N..... Y / N _____

Musculoskeletal (arthritis, fibromyalgia)..... Y / N..... Y / N _____

Integumentary (acne or skin disorders)..... Y / N..... Y / N _____

Endocrine (diabetes, thyroid)..... Y / N..... Y / N _____

Gastrointestinal (Crohn's, IBS, acid reflux)..... Y / N..... Y / N _____

How is you general health? (Please circle) Good Fair Poor

Other (for example: cancer, kidney, liver, HIV, TB): _____

Do you use tobacco? Y / N Have you in the past smoked? Y / N When? _____

Do you use recreational drugs? Y / N

Do you use alcohol? Y / N For doctor only: Dr. Sig _____

Are you or could you be pregnant? Y / N How many weeks? _____ For office only: Tech ID _____

Financial Policy

The following is a statement of our financial policy. ***Please carefully read*** and sign at the bottom.

Routine Exams: We will bill your insurance provided you have routine coverage and are eligible at the time of service. We must have a copy of your card to bill your insurance (except VSP, VBA, VCPA). If you cannot provide your card, you must pay for your visit in full at the time of service. If prior authorization or unique claim forms are required, it is your responsibility to obtain this prior to your visit. All co-pays are due at the time of service. *It is your responsibility to know the benefits and coverage requirements of your insurance policy.*

Medical Exams: We must have a copy of your card to bill your insurance. If you cannot provide your card, you must pay for your visit in full at the time of service. If your insurance requires a referral, it is your responsibility to obtain this prior to your visit. If you do not obtain the referral, you will be responsible for all charges. If you require assistance in this, our office may be able to help you. *It is your responsibility to know the benefits and coverage requirements of your insurance policy.*

Optical Orders: We will bill your insurance provided you have optical benefits and are eligible at the time of service. We must have a copy of your card to bill your insurance (except VSP, VBA, VCPA). If you cannot provide your card, you must pay for your order in full at the time of service. If prior authorization or unique claim forms are required, it is your responsibility to obtain this prior to your visit. Our policy is to collect at least one half of the balance due for optical orders. The remainder is due upon receipt of your order; an order cannot be released until it is paid in full.

Contact Lenses: Please note that additional services are required that would not be necessary for a normal vision exam. A contact lens exam fee is charged in addition to the normal vision exam fee. *Most insurance companies will not cover this fee.* This fee includes nine months of follow up care with our doctors and is due at the time of service. When possible this fee will be charged to your insurance, but must be charged with a contact lens order.

All co-pays and other balances are due at time of service. After your insurance company has processed our claim, if there is any balance due from you, such as deductible or coinsurance, we will send a statement to you. Balance is due upon receipt of this statement. If payment cannot be made in full within 30 days, please contact our office for a possible payment arrangement. If payment arrangements are not made, you may be sent to a collection agency. Our collection agency will assess finance charges on the balance due. Once the account has been sent to collection, we no longer have control of the account and can no longer discuss details of your account with you.

We will do our best to verify your insurance eligibility and benefits at the time of service. However, a quotation of eligibility and benefits from your insurance company does not guarantee payment. *Please understand that financial responsibility for your account is yours, not your insurance company's.*

An NSF fee of \$20 will be assessed for any check returned by the bank.

For your convenience, we accept cash, check, Visa, MasterCard, American Express, Discover and Flex Spending cards. If you are uninsured, full payment is due at the time of service.

I have read, understand and agree to this financial policy.

Signature of Patient/Guardian Printed Patient Name Date

Parker Vision Specialists, P.C.

Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At our office, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as a billing service. We may have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us your written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for copies.

You have the right to request amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have a right to receive a copy of this notice. If you would like a copy, please ask the receptionist.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint.

However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer (See attached list for contact information).

This notice goes into effect as of April 14, 2003.

Acknowledgement: I have received a copy of this office's Notice of Privacy Practices.

Signed _____

Date _____

Print Name _____

If signing as a parent or guardian, please note the name of the patient _____