Family Eye Care Of Maryland Heights

Patient Registration Form
PLEASE PRINT

Please Fill Out All Information On Both Sides

How did you hear about us? [ ] Advertisement [ ] Doctor [ ] Existing Patient, (name_____)

Patient Information

Status: [ ] Existing Patient [ ] New Patient			**Today's Date:**
Salutation [ ] Mr. [ ] Mrs. [ ] Ms. [ ] Miss [ ] Dr.	Nickname		**Gender [ ] Male [ ] Female**
Patient's Full Name (First, Middle & Last)			
Home Address,	**City**	**State**	**Zip**
Home Phone	**Work Phone**	**Cell Phone**	**Email**
Date of Birth	**Social Security Number**	**Name of Parent or Guardian (if applicable)**	
Occupation / Student Grade Level			
Name of Person responsible for Payment (*if different from above*)		**Phone #**	
Address, City, State & Zip			
Emergency Contact	**City**	**State**	**Phone Number**
Name of Primary Care Physician	**City**	**State**	**Phone Number**

Vision Wear

Are You Interested In: [ ] Eyeglasses [ ] Contacts [ ] Other _____

Eyeglass: [ ] Never Worn [ ] Distance Only [ ] Near Only [ ] Lined Bi/Trifocal [ ] Progressive (No-Line)

Contact Lens: [ ] Never Worn [ ] Distance Only [ ] Near Only [ ] Lined Bi/Trifocal [ ] Progressive (No-Line)

Average Daily Wearing Time:	Average Replacement Period:	Continuous Wear Period:
Solution Used:	Drops Used:	

Additional Comments:

Eye Conditions

Have you ever been diagnosed with any of the following conditions?

[ ] Cataract [ ] Age-related Macular Degeneration [ ] Glaucoma [ ] Diabetes [ ] Diabetic Retinopathy [ ] Dry Eye

[ ] Eye infection, inflammation, or allergy [ ] Floaters and/or flashes of light [ ] Iritis or Uveitis [ ] Retina defects or degenerations

Are you having any of the following vision concerns?

[ ] Blurred vision [ ] Eyestrain [ ] Eye pain [ ] Severe sensitivity to lights [ ] Headache [ ] Poor night vision

[ ] Bothersome night glare [ ] Double vision [ ] Total loss of vision [ ] Other:_____

Medications

Medication/Allergie Name	Dosage	Reason	Approx. start date

Patient Registration Form

PLEASE PRINT, COMPLETE ALL INSURANCE INFORMATION, Sign & Date At The Bottom.

Insurance Information

Do You Have Insurance?

[ ] Yes, I have insurance **[ ] No, I do not have insurance coverage. Further, I understand that I am responsible for payment and services rendered to myself or my dependents at the time of service.**

Vision Insurance Company		Policy Holder Name
Policy Holder Relationship to Patient	Policy Holder DOB	Policy Holder SSN
Medical Insurance Company		Policy Holder Name
Policy Holder Relationship to Patient	Policy Holder DOB	Policy Holder SSN
Member ID #	Group Number	

Preferred Language
[ ] English [ ] Spanish [ ] Unknown

Ethnicity
[ ] Non-Hispanic or Latino [ ] Hispanic or Latino

Race
[ ] White [ ] Asian [ ] Black or African American [ ] Native Hawaiian or other Pacific Islander [ ] American Indian or Alaskan Native [ ] Other [ ] Unknown

Assignment of Benefits

Insurance Authorization and Assignment: I request that payment of authorized private insurance company benefits, Medicare and Medicaid services or other applicable benefits be paid on my behalf to Dr. Browning and or Family Eye Care of Maryland Heights for any furnished services. I authorize Family Eye Care of Maryland Heights to release any medical or other information about me to any private insurance company, Medicare and Medicaid or other company and it's agents, which might provide coverage to myself and or any dependents under the coverage listed above.

All Services are the Responsibility of the Patient: I understand that insurance benefits must be determined prior to my eye exam. If I become aware of insurance coverage after services have been rendered, I agree that I am personally responsible for submitting the claim to my insurance company for reimbursement. I understand that when my insurance company requires a referral from my primary-care physician, and I do not furnish the correct referral at the time of service, I will be responsible for payment if my insurance company refuses my claim. I also understand and acknowledge that I am financially responsible for non-covered services and any unpaid insurance balance over 30 days past due.

Payments: Co-pays and Deductible are Due at time of Service: I understand that not all services and materials may be covered by my insurance or may exceed benefits or coverage. I agree to pay all payments, co-pays and deductible at the time of services for all services and materials.

Contact Lenses: Annual contact lens exams are usually NOT covered by insurance plans. You will be required to pay the contact lens exam fee at time of service. With this fee, you are provided with the initial pair of contact lenses, any necessary training, initial contact sens cleaning supplies and 3 contact lens-related follow-up visits (if indicated) within the 3 month period after your examination date. There will be a charge for any subsequent follow-up contact lens check and/or refitting. When purchasing contacts, there will be no refunds or exchanges on Open boxes of contact lenses.

Returned Checks: I understand there is a $50.00 fee for any checks returned and or that needs to be processed a second (2nd.) time by the bank to collect on the amount of the check. This fee will be added to the unpaid balance and or account and both must be paid by cash or credit card within 15 days of notification.

Collections: I understand that if I fail to pay amounts owed, Family Eye Care of Maryland Heights has the right to secure an outside collection agency and/or attorney to collect the unpaid debt and to report the unpaid debt to a credit-reporting agency. I further understand that I will be responsible for any and all additional charges or fees necessitated by securing the collection agency or attorney, including any filing and court fees.

Prescription Rechecks: Only three (3) recheck will be honored for a period of 60 days from the date of dispensing. Costs associated with changes other than the prescription recheck will be the responsibility of the patient. Any recheck after three (3) times or 60 days, will be charged at a usual and customary fee of $45.00. Any other charges associated with the prescription, lens, frame or contact lens will be the patient's responsibility.

With my signature, I confirm all of the above 'Patient Registration Form' information is true and correct, and that I have read, understood and agree to the 'Assignment of Benefits' sections.

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please Present Your Vision & Medical Insurance Card When Returning This Form To The Front Counter

HIPAA Notice of Privacy Practices

Effective as of March/1/2011

Family Eye Care
Of Maryland Heights

2311 McKelvey Road
Maryland Heights, MO 63043
314-434-9450

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, **authorization** or opportunity to object unless required by law. **You may revoke the authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Print Name:_____ Signature: _____ Date: _____

Family Eye Care of Maryland Heights

Patient Health History

Name_____ Date_____

HEALTH

Do you take medications for, or have any of the following conditions?

Constitution
- ☐ **None**
- ☐ Cancer
- ☐ Chronic Fatigue
- ☐ Developmental Disorder
- ☐ Other:

Ear Nose and Throat
- ☐ **None**
- ☐ Dry mouth
- ☐ Hearing- Loss
- ☐ Laryngitis
- ☐ Sinusitis
- ☐ Other:

Neuro
- ☐ **None**
- ☐ Cerebral Palsy
- ☐ Epilepsy
- ☐ Migraine
- ☐ Multiple Sclerosis
- ☐ Stroke/CV
- ☐ Tumor
- ☐ Other:

Psychiatric
- ☐ **None**
- ☐ Anxiety Disorder
- ☐ Attention Deficit
- ☐ Bipolar
- ☐ Depression
- ☐ Other:

Cardiovascular
- ☐ **None**
- ☐ Congestive Heart Failure
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Vascular Disease
- ☐ Stroke/CVA
- ☐ Other:

Respiratory
- ☐ **None**
- ☐ Asthma
- ☐ Chronic Obstruction
- ☐ Sleep Apnea
- ☐ Emphysema
- ☐ Other:

Gastrointestinal
- ☐ **None**
- ☐ Acid Reflux
- ☐ Celiac disorder
- ☐ Colitis
- ☐ Crohn's Disease
- ☐ Ulcer
- ☐ Other:

Genitourinary
- ☐ **None**
- ☐ Herpes
- ☐ Kidney Disease
- ☐ Nursing
- ☐ Prostate ☐ Disease/Cancer?
- ☐ STD:
- ☐ Other:

Musculoskeletal
- ☐ **None**
- ☐ Ankylosing Spondylitis
- ☐ Arthritis
- ☐ Muscular dystrophy
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Other:

Integumentary (skin)
- ☐ **None**
- ☐ Eczema
- ☐ Herpes simplex/cold sores
- ☐ Herpes zoster/shingles
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Other:

Endocrine
- ☐ **None**
- ☐ Hormonal dysfunctions
- ☐ Thyroid Dysfunction
- ☐ Type I Diabetes
- ☐ Type II Diabetes
- ☐ Other:

Hem/Lymph
- ☐ **None**
- ☐ Ulcer
- ☐ Anemia
- ☐ High Cholesterol
- ☐ Other:

Allergy/immune
- ☐ **None**
- ☐ Lupus
- ☐ Sjogren's Syndrome
- ☐ Rheumatoid Arthritis
- ☐ Other:

Additional Comments

MEDICATIONS

Medication Name	Dosage	Prescribing Doctor	Reason	Start date
☐ **None**				

Continue other side

Allergies

Medication Allergies	Non-Medication Allergies (Animal, Plant, Food, Etc.)
☐ **No known**	☐ **No known**

Ocular & Social History

Do you currently have, or had, any of the following?

☐ **None** ☐ Amblyopia ☐ Cataract ☐ Dry eye ☐ Glaucoma ☐ LASIK / PRK	☐ **None** ☐ Glaucoma Suspect ☐ Inflammatory Disorder ☐ Injury ☐ Keratoconus	☐ **None** ☐ Macular Degeneration ☐ Nystagmus ☐ Patching ☐ Retinal Degeneration	☐ **None** ☐ Retinal Detachment ☐ Retinal Hole ☐ Strabismus ☐ Surgery ☐ Other:

Smoking Status

☐ Current <u>every day</u> smoker (Smoked at least 100 cigarettes during lifetime and still smokes everyday)
☐ Current <u>some day</u> smoker (Smoked at least 100 cigarettes during lifetime and still smokes periodically yet consistently)
☐ <u>Former</u> smoker (Smoked at least 100 cigarettes during lifetime but does not currently smoke)
☐ <u>Never</u> smoker (Not smoked 100 or more cigarettes during lifetime)

Family History

Has anyone in your family had one or more of the following conditions?

☐ **None** ☐ Cancer ☐ Diabetes ☐ Hypertension ☐ Thyroid ☐ Other:	☐ **None** ☐ Amblyopia (Lazy Eye) ☐ Cataract ☐ Dry Eye ☐ Glaucoma	☐ **None** ☐ Glaucoma Suspect ☐ Macular Degeneration ☐ Nystagmus ☐ Severe Hyperopia	☐ **None** ☐ Severe Myopia ☐ Strabismus (Eye Turn) ☐ Retinal Detachment ☐ Other:

Vision Wear

Eyeglass

☐ Never Worn ☐ Distance Only ☐ Near Only ☐ Lined Bi/Trifocal ☐ Progressive (No-Line)

Contact Lens

☐ Never Worn ☐ Soft Lenses ☐ Gas Permeable Lenses ☐ Hard Lenses

Eye	**Prescription (If known):**	**Brand:**
☐ Right		
☐ Left		
Average Daily Wearing Time:	Average Replacement Period:	Continuous Wear Period:
Solution Used:	Drops Used:	

Additional comments:

With my signature, I confirm all of the above '*Patient Health History*' information is true and correct to the best of my knowledge.

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

Signature of Patient, Parent, Guardian or Personal Representative

Date