☐Mr. ☐Mrs. ☐Ms. ☐Miss ☐Dr. **Name:** ***First:*** ***M.I.:*** ***Last:***

Street: City: State: Zip:

Home Phone: Work Phone:

Cell Phone: E-mail:

Date of Birth: Sex ☐ M ☐ F SSN (last 4):

Marital Status ☐ Single (Never Married) ☐ Married ☐ Divorced ☐ Widowed Pronoun ☐ He ☐ She ☐ They

Race: **Language:**

Ethnicity ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Insured Subscriber's Name: Date of Birth:

☐ Self ☐ Spouse ☐Parent ☐Other

Street: City: State: Zip:

Phone Number: Gender ☐ M ☐ F SSN (last 4):

Medications and Supplements you are taking ☐none

List:

Allergies to Medications ☐none

List:

Personal Ocular History

☐ Laser Vision Correction
☐ Glaucoma
☐ Cataract
☐ Macular Degeneration
☐ Retinal Hole/Tear/Detachment
☐ Amblyopia (Lazy Eye)/Strabismus (Eye Turn)
☐ Diabetic Retinopathy
☐Other:_____

Family Ocular History

☐ Glaucoma Relation: _____
☐Cataract Relation: _____
☐ Macular Degeneration Relation: _____
☐ Retinal Hole/Tear/Detachment Relation: _____
☐ Amblyopia (Lazy Eye) /Strabismus (Eye Turn) _____
☐Other: _____

Personal Medical History

☐Arthritis
☐Cancer
☐Diabetes
☐Headaches
☐Heart Disease
☐High Blood Pressure
☐High cholesterol
☐Stroke
☐Thyroid Disorder
☐Other: _____

Family Medical History

☐Arthritis Relation: _____
☐Cancer Relation: _____
☐Diabetes Relation: _____
☐Headaches Relation: _____
☐Heart Disease Relation: _____
☐High Blood Pressure Relation: _____
☐High cholesterol Relation: _____
☐Stroke Relation: _____
☐Thyroid Disorder Relation: _____
☐Other: _____

Social History

Tobacco Use	☐Current	☐Former	☐Never
Alcohol Use	☐Current	☐Former	☐Never
Marijuana Use	☐Current	☐Former	☐Never
Recreational Drug Use	☐Current	☐Former	☐Never

How did you hear about us? ☐ Other patient(s): _____ ☐ Insurance ☐ Previous Dr. Glassner patient

☐ Doctor/Clinic: _____ ☐ Newsletter/Ad: _____ ☐ Social Media ☐ Web search

CONSENT FOR DILATION

Dilating drops are used to dilate or enlarge the pupils of the eye to allow Dr. Seidman and Dr. Goettge to get a better view of the inside of your eye. Dilating drops frequently blur vision for a length of time, which varies from person to person and may make bright lights bothersome, reading difficult and computer usage limited until the dilation drops wear off. The average dilation drops wear off in approximately 2 – 4 hours in adults and up to 24 hours for children.

Dr. Seidman and Dr. Goettge recommends to dilate patients' eyes every year, including children's eyes. **Patients with diabetes must be dilated every year.** We realize that sometimes the day and or time may be inconvenient. If you chose to not have your eyes dilated, please be aware that without the dilation the eye examination is not as thorough.

☐ I hereby **authorize** Dr. Seidman or Dr. Goettge or her technicians to administer dilating eye drops today. The eye drops are necessary to diagnose and manage many eye conditions. (No additional charge)

☐ I hereby **decline** Dr. Seidman or Dr. Goettge or her technicians to administer dilating eye drops today.

Signature _____ Date _____

Consent for Retinal Photography

Retinal photography is used to get an instant view of your optic nerve, macula and blood vessels. Comparing photos between eyes and over various years is a great tool in early detection of many ocular diseases including glaucoma and macular degeneration as well as systemic diseases like high blood pressure and diabetes. This diagnostic test is ordered for all patients 12 years and older on an annual basis. The test is an additional $50 before insurance benefits. The photographs are a great tool diagnosing and manage many eye and systemic conditions.

☐ I hereby **authorize** Dr. Seidman or Dr. Goettge or her technicians to administer the prescribed retinal photographs today. ($50 charge)

☐ I hereby **decline** Dr. Seidman or Dr. Goettge or her technicians to administer the prescribed retinal photographs.

Signature _____ Date _____

Contact Lens Evaluation Fee Agreement

A contact lens is a medical device that rests on the front surface of your eye. It is important that they fit well and be worn properly to decrease risk to your eye health and vision. A contact lens prescription can only be determined by your eye doctor. This ensures you have lasting comfort, the right type of lens and good vision. Contact lens prescriptions are not valid until all follow-up care in finalized. A valid prescription is needed to purchase contact lenses.

Full payment is due at the time contact lenses are ordered and is non-refundable. We will replace defective lenses with an annual supply purchase.

The contact lens fitting fee ranges from $119-$249 due to complexity of your individual case and cannot be determined without refraction. Some insurance plans have a copay towards the contact lens evaluation. The fee is in addition to your eye exam fee. This includes the training on the insertion, removal, and care of your lenses. It also covers all follow up visits related to the contacts within a 60-day period. Visits after 60 days will be charged as a refit fee.

The standard contact lens prescription will be good for 12 months. You will need to have a new comprehensive exam and contact evaluation to renew and purchase more contacts.

I understand that contact lens fitting and evaluation fees may not be covered by my insurance. All related fees are my responsibility and will be paid at the time of service.

_____Date_____

Signature of patient or parent if patient is under 18 years old

With an annual contact lens supply purchase the patient will receive a one time contact lens follow up at 6 months to check for prescription changes.

If you experience a prescription change we will also exchange unopened and unmarked boxes of contact lenses as part of the prescription guarantee. The membership is valid for 12 months from your initial contact lens evaluation.

FINANCIAL POLICY

All insurance coverage is a matter between the subscriber/patient and their insurance company. The patient is ultimately responsible for payment. It is your responsibility to know your insurance coverage and policy.

Payments are due at time of service.

DOCTOR REFERRAL The patient is responsible to obtain a valid referral and/or pre-certification prior to any procedure or office appointment, if the patient's policy requires one. If non-rendered, the balance is patient responsibility.

REFRACTION FEE Please note that most medical insurance companies, including Medicare, **DO NOT COVER** refractions. This procedure may be required at all visits. Our office charge is $50.00 for this component of the eye examination. Payment will be required at time of service.

MEDICARE The billing department will file your claim with Medicare; however your supplemental insurance is only billed as a courtesy. If no payment is received within 60 days, the balance becomes patient responsibility.

OPTICAL and CONTACT LENS POLICY Payment for eyeglasses, contact lenses and fittings are the responsibility of each patient. Payment in full is expected at the time of ordering of material and/or fittings. **All Sales Are Final.**

APPOINTMENT POLICY If you are unable to keep a scheduled appointment with our office, 24-hour notice is required or a $30.00 fee will be assessed.

PRIMARY INSURANCE: It is your responsibility to provide our office with the correct insurance carrier at the time of service. If you fail to provide Eyecare Center of Ken Caryl the proper insurance information at the time of service, payment of claim will be your responsibility.

SECONDARY INSURANCE: As a courtesy, we will forward secondary insurance to the carrier. After 60 days, if we have not received payment from the secondary insurance we will hold the patient responsible for payment.

Collections Only after exhausting our own internal attempts, it may become necessary to send an account to our collections agency. The patient will be responsible for all costs incurred in collecting the account, including court costs and attorney fees. A rebilling fee of $45 will be assessed to the patient's account prior to sending to the collections agency, not including the outstanding balance amount due.

Returned Checks: Any check payment returned for any reason including but not limited to insufficient funds will result in an additional processing fee of $25. A hold time of 48-72 hours will be enforced on all material orders paid by check, before processing. Our office reserves the right to refuse check payments in the future.

Signature _____ Date _____

☐ **Please check the box if you have ROUTINE Eye Coverage, i.e. Vision Service Plan(VSP) or Eye Med**. Authorizations from these insurance groups are required before the examination begins. It is the responsibility of the patient to inform the front desk of his/her routine coverage information at the time of check in.

ASSIGNMENT OF BENEFITS: I AUTHORIZE PAYMENTS OF VISION AND MEDICAL BENEFITS TO THE PROVIDER FOR PROFESSIONAL SERVICES RENDERED.

Signature _____ Date _____

RELEASE OF INFORMATION: I authorize the release of any medical information required in the course of my examination or treatment if necessary to determine benefits.

Signature _____ Date _____

EYECARE CENTER OF KEN CARYL

SUMMARY NOTICE OF PRIVACY PRACTICES

THIS IS A SUMMARY OF OUR NOTICE OF PRIVACY PRACTICES, WHICH DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains Patient rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. You may obtain a copy by asking the front desk or Beth Seidman who is the Privacy Officer for Eyecare Center of Ken Caryl . She can be reached by phone at 303-973-6333. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

Our pledge to protect your privacy:

Eyecare Center of Ken Caryl is committed to protecting the privacy of your medical information. Your care and treatment is recorded in a medical record. So that we can best meet your medical needs, we share your medical record with the providers involved in your care. We share your information only to the extent necessary to collect payment for the services we provide, to conduct our business operations, and to comply with the laws that govern health care. We will not use or disclose your information for any other purpose without your permission.

Patient Rights - You have the following rights regarding your medical information:

- to request to inspect and obtain a copy of your medical records, subject to certain limited exceptions;
- to request to add an addendum to or correct your medical record;
- to request an accounting of Eyecare Center of Ken Caryl disclosures of your medical information;
- to request restrictions on certain uses or disclosures of your medical information; to request that we communicate with you in a certain way or at a certain location; and to receive a copy of the full version of our Notice of Privacy Practices.

We may use and disclose medical information about you for the following purposes:

- to provide you with medical treatment and services;
- to bill and receive payment for the treatment and services you receive;
- for functions necessary to run Eyecare Center of Ken Caryl and assure that our Patients receive quality care;
- to provide basic contact information (no medical information is provided) to our development office for purposes of fundraising for Eyecare Center of Ken Caryl ; to support our standing as a federally qualified health center; and as required or permitted by law.

EYECARE CENTER OF KEN CARYL

ACKNOWLEDGEMENT OF RECEIPT OF SUMMARY NOTICE OF PRIVACY PRACTICES

Effective March 4, 2019

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke the Consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. Eyecare Center of Ken Caryl provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Name of Patient (print)	Signature of Patient	Date

Signature of Patient Representative (Required if Patient is a minor or an adult who is unable to sign this form)	Relationship to Patient	Date

I understand that my health care and the payment for my health care will not be affected if I do not sign this_____(initial)

COMMUNICATION PREFERENCES:

From time to time Eyecare Center of Ken Caryl may wish to use or disclose your protected health information to individuals involved in your care for notification purposes after we have obtained your verbal or written permission.

Eyecare Center of Ken Caryl is authorized to: (Please check all that apply.)

- ☐ Notify or speak with my spouse or my family members, i.e., children, siblings, mother, father regarding treatment or proposed treatment
  Family Member & Name:_____Phone#
- ☐ Notify or speak to my caregiver regarding treatment or proposed treatment
  Caregiver Name:_____Phone#
- ☐ Notify or speak to my friend regarding treatment or proposed treatment
  Friend Name_____Phone#
- ☐ Notify my transportation service regarding my delivery or pick-up to or upon completion of my treatment
  Transport Service_____Phone#
- ☐ Other (please specify)_____

How may we contact you with reference to your appointment, proposed treatment, follow-up appointments, lab testing, radiology and other situations regarding your protected health information?

If I am not available Eyecare Center of Ken Caryl may: (please check all that apply)

- ☐ Leave a message with my spouse or those members listed above
- ☐ Leave a message on my answering machine, voice mail or cell phone
- ☐ Leave a message with my interpreter (for foreign speaking patients)
- ☐ Other_____