Patient Information Sheet

For your convenience, please print and complete the pre-registration forms before your visit.

Section 1:

Patients Legal Name: _____
First, Middle Name, Last *As it appears on Driver's License or Legal ID

Parent/Guardian: _____
(If Applicable) First, Middle Name, Last *As it appears on Driver's License or Legal ID

Address: _____
House Number, Street Name, Apt/Unit Number

_____
City, State, Zip Code

Home Phone: _____ Cell Phone: _____

Social Security Number: _____ Date of Birth: _____

Race: _____ Ethnicity: _____

Preferred Language: _____

How did you hear about us: ___ Referral ___ Friend/Family ___ Website ___ Facebook

___ Other: _____

Preferred Pharmacy: _____
Name, Address Zip Code, Phone Number

Section 2: Complete if Patient is under 18, a Full Time Student, or otherwise has a guardian.

Address: _____
*If different than above House Number, Street Name, Apt/Unit Number

_____
City, State, Zip Code

Home Phone: _____ Cell Phone: _____
*If different than above

Section 3: Emergency Contact Information

Contacts Full Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Horizon Eye Care P.A. ("Horizon")
Patient Agreement and Consent to Treatment

In order for Horizon to provide our patients with quality medical care, we must receive payment for our services. Ensuring that we are appropriately and promptly paid for the services rendered is our patient's responsibility. This document explains the obligations we require from our patients and how our patients meet these obligations. In exchange for services rendered, each patient agrees:

1. To authorize payment of surgical and medical benefits to Horizon, which would otherwise be payable to you. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment and titles V, XVIII and/or XIX of the Social Security Act is Correct.
2. To pay for all non-covered charges, copays, Co-insurance, deductibles, out of network charges, and refractions (the measurement of the eye in order to obtain a prescription for Contacts or glasses) at the time of service or when otherwise advised. If this is not possible, you agree to contact our patient accounts Department at (704) 365- 0555 BEFORE services are rendered.
3. To provide us with a copy of your most recent insurance card or other proof of insurance at the time of EACH visit. If you do not provide us with valid insurance information at the time of EACH visit and your insurance company subsequently denies our claim, you are personally responsible for any and all charges.
4. To obtain any authorization required by your insurance plan and/ or from your Primary Care Physician prior to each appointment. If you do not receive the required authorization, your insurance company may not pay us for our services. In these cases, you are personally responsible for any and all charges.
5. To monitor your insurance company's payment of your account and if unpaid following 30 days from the date of service to contact them regarding their non-payment. you also agree to cooperate with Horizon to resolve the unpaid status of your account.

As a courtesy to our self-pay patients seeking routine eye care, horizon will provide a reduced charge for payment at the time of service. The entire balance must be paid in full to receive the discount. Once you accept the discount, Horizon will not be responsible to file claims to any insurance company nor will Horizon accept payment on a discounted rate from the insurance company. In the event we received a payment from an insurance company under this circumstance, we will refund the money back to the insurance company. It is your responsibility to inform us at the point of service if you have insurance coverage for "routine" eye services.

The undersigned, whether as the patient or guarantor of a patient, agrees that in consideration all the services rendered by Horizon, that you are individually obligated to pay for such services in accordance with the regular rates, terms, and conditions of Horizon. In the event we must refer the patient's account to an attorney or collection agency for collection of an amount 90 days or older, the undersigned agreed to pay all actual attorney's fees and collection expenses, including any accrued interest and any bank fees incurred from a returned check.

I voluntarily consent to health care treatment from the physicians and staff at Horizon. I am aware that the practice of medicine is not an exact science. No guarantees have been made to me regarding the results of treatments or examinations by my caregivers. I consent to the use and disclosure of protected health information about me for treatment, payment, and operations.

I have read this form and have had the opportunity to ask questions and my questions have been answered. By my signature, I represent that I have voluntarily read, understood and agree to be bound by the above provisions.

_____ _____

Name (Patient or Guardian) Date

_____

Signature

Horizon Eye Care, P.A.
Medical History Questionnaire

Mr./Mrs./Miss/Ms./Dr. _____ Date of Birth:_____
(Circle One) First, Middle Name, Last

Referred By: _____ Primary Care Doctor: _____

Allergies (Please List): _____

Current Eye Medicine (Please List): _____

Current Medications (Please List): _____

Have you ever taken oral steroids (i.e., Prednisone, etc.) or used steroid eye drops or nasal steroids? YES / NO

Eye History:

Have you ever had any of the following eye problems? (Please check Yes or No for each)

	No	Yes		No	Yes
Cataracts			Diabetic Eye Disease		
Color Blindness			Dry Eyes		
Glaucoma			Eye Trauma		
Iritis			Macular Degeneration		
Lazy/Crossed Eyes			Retinal Detachment		
Retinitis Pigmentosa					

Medical History:

Have you ever had any of the following? (Please check Yes or No for each)

	No	Yes		No	Yes
Asthma			Arthritis		
Bleeding Disorders			Cancer		
Diabetes			Chronic Allergies		
Emphysema			Drug or Alcohol Abuse		
Heart Attack			Head Trauma		
Heart Failure			HIV Positive		
Hepatitis			Intestinal Disease		
High Blood Pressure			Lupus		
Irregular Heartbeat			Major Depression		
Kidney Disease/Stones			Migraines		
Liver Disease			Seizures		
Sickle Cell			Shock		
Sinus Problems			Stroke		
Thyroid Disease			Ulcers		

Other (Please Describe): _____

Please List ALL Surgeries: _____

HORIZON EYE CARE

Family History:

Has anyone in your family (Blood Relatives) had any of the following? (Please check Yes or No for each)

	No	Yes		No	Yes
Blood Disorders			Anesthesia Problems		
Cataracts			Asthma		
Corneal Disease			Blindness		
Crossed Eye			Cancer		
Diabetes			Macular Degeneration		
Glaucoma			Migraines		
Heart Disease			Retinal Detachment		
High Blood Pressure			Retinitis Pigmentosa		

Social History:

Marital Status (circle one): Single Married Divorced Widowed

Occupation: _____ Employer: _____

Hobbies: _____

Do you consume Alcohol? YES / NO How Much? _____

Do you smoke or consume Tobacco? YES / NO How Much? _____

Review of Systems:

Have you had any of the following problems recently? (Please check Yes or No for each)

	No	Yes		No	Yes
Asthma			Bruising/Easy Bleeding		
Balance Disturbance			Chest Pain/Irregular Heartbeat		
Blood in Urine			Diarrhea/Vomiting		
Cough and Wheezing			Environmental/Food Allergies		
Depressed Mood			Fatigue/Fever/Night Sweats		
Difficulty Walking			Headache		
Dizziness/Headache			Increased Thirst/Appetite		
Hearing Loss			Joint Pain/Weakness		
Skin Rash			Memory Difficulty		
Weight Loss					

Please Explain any "YES" responses: _____

_____

Please Sign and Date:

Patient (Parent/Guardian): _____ Date: _____

Doctor Review: _____ Date: _____

Horizon Eye Care, P.A.
Authorized To Release Protected Health Information (PHI)

1. With your permission, we may disclose your PHI to the individuals identified below. I authorized Horizon Eye Care, P.A. to release any personal information relating to my health care.

   To: _____ Relationship to Patient: _____

   To: _____ Relationship to Patient: _____

   To: _____ Relationship to Patient: _____

   To: _____ Relationship to Patient: _____

2. I understand that I have the right to restrict information that may be released, and that this restriction must be in writing.

   _____ No Restrictions

   _____ With Restrictions (List): _____

Printed Name: _____ Date: _____

Signature: _____

Horizon Eye Care, P.A.
Authorization for Treatment if Minor

I, being the parent and/or Guardian of _____, a minor (D.O.B: ____ _____) do hereby request and authorize the physicians and other health care providers of horizon eye care, P.A. (collectively the "Physician") to provide routine eye examinations and medical diagnosis services for my child, which are deemed suggested by the physician, whether or not I am present at the actual appointment.

Below is a list of individuals who have permission to bring my child in for treatment:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

It is understood that this authorization is given before any specific diagnosis or treatment in order to avoid delay in providing such treatment as deemed necessary by the Physician in the Physicians professional judgment. any treatment beyond the scope of this authorization requires express consent from the undersigned.

This authorization to treat will remain in effect until revoked by writing by the undersigned.

_____ _____
Signature of Parent or Guardian Date

_____ _____
Printed name of Parent or Guardian Date

_____ _____
Witness Date

Horizon Eye Care, P.A.
Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____

Address: _____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement receipt of the notice of privacy practices because:

_____ An emergency existed and a signature was not possible at the time.

_____ The individual refused to sign.

_____ A copy was mailed with a request for a signature by return mail.

_____ Unable to communicate with the patient for the following reason:

_____

_____ Other: _____

Prepared By: _____

Signature: _____

Date: _____

HORIZON EYE CARE

Routine vs Medical Eye Exams

Your reason for visiting the eye doctor and the results of your examination determine whether your insurance company will classify the exam as "routine" or "medical."

What is a routine eye exam? A routine eye exam is defined by insurance companies as an office visit for the purpose of checking **vision, screening for eye disease, and/or** updating **eyeglass prescriptions**. Routine eye exams produce a diagnosis like **nearsightedness, farsightedness, or astigmatism.**

Vision insurance plans provide coverage (or discounts) for routine exams, glasses and contact lenses. Most vision insurance plans do not cover **contact lens evaluations**. This fee is collected to evaluate the health of your eye for contact lens wear and to update your contact lens prescription.

In many cases, your medical insurance will not pay for a routine eye exam. By law, Medicare does not pay for routine vision exams.

Refraction fees: A refraction is the part of an office visit that determines your eyeglass prescription. It typically involves questions like, "which is clearer -one or two". Medical insurance will not cover the cost of refraction.

What is a medical eye exam? A medical eye exam produces a diagnosis like conjunctivitis, **dry eye, allergies, or cataracts**, to mention a few. A medical eye exam is also indicated if you have a medical condition that could affect the health of **your eyes.** Examinations to assess an eye complaint or a medical condition are billed to your medical insurance plan. These visits can be subject to **copays, coinsurance, and d**eductibles.

Your eye doctor is legally bound by your insurance carrier to follow certain healthcare guidelines regarding billing your insurance. A medical eye exam should be billed to your medical insurance, while a routine vision exam should be billed to either your vision insurance or to you if you are self-pay. *A* routine eye exam and a medical eye exam may not be combined or billed on the same date.

Because of this, our protocol is to take actionable steps to ensure you have the best experience possible with us. If your exam has the potential to be billed medically, our staff will take time to explain that to you. *W*e will do everything we can to help you understand any medical procedures performed or charges you receive.

Keep this in mind: Insurance coverage does not mean payment. Many medical plans have copayments and deductibles that must be met before your insurance will pay any amount towards your bill.