Family Vision

missoulafamilyvisioncare.com ----------Willie Thomas, O.D.-------Kellie Hadnot O.D.-------

Patient Name: _____ Female / Male

Date of Birth:_____

Address:_____ E-mail:_____

City:_____ State:_____ Zip:_____

Cell Phone:_____ Work Phone:_____ Home Phone:_____

Yes☐ No☐ Would you like to receive text message updates and appointment reminders?

By providing phone numbers, including mobile/cell number, you authorize Family Vision Care to contact you by means of the numbers listed for any activity involving our services to you, including but not limited to: appointment information, glasses and contact lens orders/services, and resolution of your account balance. None of your information will be shared with any party other than those in-house or a contracted party necessary to complete your services.

We are required to obtain your permission to submit a bill to your insurance company.

Your insurance coverage, including benefits and eligibility, is a private agreement between your insurance carrier and yourself. Our office agrees to submit a bill to your insurance on your behalf. By providing your signature below, you permit us to submit claims to your insurance company on your behalf. You are responsible for any charges not covered by your insurance carrier. The information obtained by our office is required for verification with most insurance companies. We ask that you present your insurance card so that we may make a copy for our records.

If you do not wish to provide any information, including Social Security Numbers, we do not require it. We will simply bill you directly and you may submit the claim to your insurance carrier.

If your name is not the 'primary insured' name on the account, please provide the name, date of birth, and Social Security number of the person who is named 'primary insured' on the account. We protect this information as we do all personal/medical information shared with our office.

Financially Responsible Party:_____ Relationship:_____
(If other than patient) (to patient)

Party listed as 'Primary Insured':_____ Relationship:_____
(If other than Patient) (to patient)

Date of Birth (Primary Insured):_____

Social Security Number (Primary Insured):_____

Employer:_____ Job Title:_____

Spouse:_____ Spouse's Employer:_____

Signature:_____
(I have read and understand the above information and all information provided is accurate.)

Date:_____

Reviewed: Date & Initial:_____
Reviewed: Date & Initial:_____
Reviewed: Date & Initial:_____
Reviewed: Date & Initial:_____

Whom may we thank for referring you to us?_____

Our Financial Policy

PAYMENT IS EXPECTED AT THE TIME OF SERVICE FOR EMERGENCIES OR FIRST-TIME VISITS TO OUR OFFICE

After your first visit, the following options are available.

Please initial the plan (or plans) you would like to use:

_____ 1. Payment at each visit:
A **5%** discount is offered for cash or check payments made at the time services are rendered. Discount does not apply to Insurance copayments.

_____2. Credit Card:
Visa, MasterCard, Discover, or American Express may be used to make payment. No cash discount is offered if a credit card is used.

_____3. Vision Insurance:
In most cases, the entire cost of your services is not covered by your vision insurance company; therefore, financial arrangements will have to be made prior to treatment.

_____4. Care Credit Plan:
Care Credit is an optometric / medical / dental financing company that will loan you the money to pay for vision services. This is an agreement between you and Care Credit that must be set up in advance, and is separate from Family Vision. Please ask us for more details if you are interested in this plan.

_____5. Monthly Billing:
Payment in full within 30 days unless payment schedule has been pre-arranged. Accounts with balance for more than 60 days may be sent to collections services.

BROKEN APPOINTMENTS WITHOUT A 24 HOUR NOTICE MAY BE CHARGED A FEE!

I,_____, certify that I will be responsible for payment of professional services rendered on my account and, should this account have to go through the collection process, I will also be responsible for any legal fees.

_____ _____

Signature Date

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HIPAA COMPLIANCE

Background

HIPAA, a government law, was originally designed to provide insurance portability; meaning that if a person had one job and started another they could not be declined on insurance benefits for a pre-existing condition. HIPAA was also designed to simplify insurance claims and claims submissions. HIPAA also strives to give privacy to patients. It applies to Family Vision and every practitioner regardless of the size of the medical practice or medical specialty.

Notice of Privacy Practices

At Family Vision, we take every precaution to preserve the rights of our patients. It is our utmost goal to maintain privacy and confidentiality of the information you share with us concerning your medical history and current medical condition.

Sharing Protected Health Information

If necessary, Family Vision reserves the right to share information with warranted specialists. Best judgment will be used when sharing relevant information with appropriate medical specialist. Our office reserves the right to dispense your glasses, contacts, or other products to someone other than yourself (family members, etc) if, after professional judgment, it is deemed to be in your best interest. If necessary, we will release information to insurance companies to bill for our services; to a public authority for the prevention or control of disease; to a government authority, court, or law enforcement to report child abuse or domestic violence; to comply with health oversight activities such as audits, investigations, and inspections; or to the USDA to demonstrate HIPAA compliance. We realize that this information is strictly confidential and will be treated as such. Professional and ethical judgment will be used in preserving your medical records.

Incidental Disclosure

Incidental disclosure is when a patient accidentally sees another patient's chart. To comply with HIPAA and avoid incidental disclosure, all patient documents are placed inside charts when not in use by the doctor or staff. There are no diagnoses, records of past prescriptions, or medical and allergy history on the outside of the chart. All demographic information, personal, family, and social history are inside the closed file. Furthermore, Family Vision has used dependable clips to affix these documents to the file to avoid losing pages when the file is in transit. In the lab or optical, our employees talk in hushed tones to preserve privacy and avoid all references to any medical condition that was discussed privately in the exam room.

Correspondence

Family Vision seeks to honor your privacy through correspondence. Exam reminders are sent through US mail on postcards, but do not reveal any information that may be private to you. For example, we will not send a card telling you it is time for your glaucoma check, diabetes eye check, or macular degeneration follow up. The cards will be general in nature stating that it is time for you to schedule another appointment. We would prefer to contact you personally by phone to confirm appointments, or let you know that your contacts or glasses orders are complete, but in the event we receive an answering machine, we will leave messages unless you give us explicit direction not to. If you do not wish to receive messages on your answering machine, please indicate at check-in. This permission is asked for when setting the initial appointment. For previous patients, written permission will be documented.

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HIPAA COMPLIANCE

Patient Name_____

Your Rights

You have the right to refuse treatment or doctor and staff recommendations of any kind. You have the right to refuse information that may apply to you such as verbal education, pamphlets, or other literature. If you verbally refuse treatment, documentation will be noted in your medical chart. We will not require additional refusal forms to be signed. If you have any questions, please ask at the time of refusal, so that you may better understand the ramifications of the treatment being declined. All treatments offered by our doctors are in the patient's best interest and if you refuse treatment, you understand that refusal may result in negative consequences, including but not limited to loss of vision, permanent blindness, and in extreme cases, death. You have the right to access your exam records and other protected health information. We will not turn over the original record, but copies will be made available upon your request. You have the right to request a restriction or limitation of our use of your protected health information. By law, we are not required to fulfill your request if we feel it may limit our ability to provide health care services to you. However, if we do agree to your requested restriction, we will honor the restriction until you agree to terminate the restriction. You may submit a written request for restriction on the use and disclosure of protected health information to our privacy officer. Please specify the details of what information you want to limit, how you want us to limit it, and to whom you want the restrictions to apply. You have the right to amend your protected health information if you believe the information we have about you is incorrect.

We acknowledge that Family Vision is not perfect in maintaining total and complete privacy, but the doctor and staff have been well trained in preserving privacy, and as funds become available, we will continue to make modifications to ensure even more privacy. Complaints can be addressed to Dr. Thomas or to the US Department of Health and Human Services, Office for Civil Rights. 200 Independence Ave. S.W., Washington, D.C. 20201 or at www.hhs.gov/ocr/hipaa/

I have read the above disclosures and understand my rights to privacy as a patient at Family Vision Care.

_____ _____

Signature Date

Name:_____ Date:_____

Personal Medical History (ROS)

Have you had any health problems with any of the following body systems?

*** Constitutional**
- Y / N Fever
- Y / N Weight Loss

*** Eyes**
- Y / N Eye Surgery
- Y / N Eye Infection
- Y / N Eye Disease

*** Ears, Nose, Mouth, Throat**
- Y / N Hearing Loss
- Y / N Sinus Trouble

*** Cardiovascular**
- Y / N Stroke
- Y / N Heart Disease
- Y / N High Blood Pressure

*** Respiratory**
- Y / N Asthma
- Y / N Emphysema
- Y / N Shortness of Breath

*** Gastrointestinal**
- Y / N Ulcer / Heartburn

*** Endocrine**
- Y / N Diabetes
- Y / N Liver Disease / Hepatitis

*** Musculoskeletal**
- Y / N Muscle / Bone Disorder

*** Genitourinary**
- Y / N Kidney Disease
- Y / N Infectious disease
- Y / N Are You Pregnant?

*** Integumentary**
- Y / N Skin, Breast

*** Neurological**
- Y / N Head or Spinal Injury
- Y / N Nerve Disorder

*** Psychiatric**
- Y / N Depression
- Y / N Anxiety
- Y / N Nervous Disorder

*** Hematologic / Lymphatic**
- Y / N Anemia

*** Allergic / Immunologic**
- Y / N Seasonal Allergies
- Y / N Arthritis
- Y / N Swollen Glands / Nodes

*** Other** _____

_____

Please explain any "Yes" responses given above:

_____

_____

_____

_____

Please list any medications (and dosage) you currently use:

_____

_____

_____

Are you allergic to any medications? If so, which medications?

_____

Past Ocular History

When was your last eye exam? _____ What was the Doctor's name? _____

Do you wear glasses or contacts? (Y / N) What type? _____

Family Medical History

Have any members of your family been diagnosed with the following conditions? If so, who?

- Y / N Diabetes_____
- Y / N Heart Disease_____
- Y / N Cancer_____
- Y / N Stroke_____
- Y / N Macular Degeneration_____
- Y / N Glaucoma_____
- Y / N Retinal Disease_____
- Y / N Cataract_____
- Y / N Lazy / Crossed Eye_____
- Y / N Other_____

Social History

Do you:

Y / N Smoke: _____

Y / N Drink:_____

Personal History

What is your occupation?_____

Hobbies:_____

(Future Changes to ROS / PFSH recorded on the back of this sheet)