5221 S. Coulter St. Amarillo, TX 79119

Thank you for choosing EyeCare Plus for your eye care needs! Enclosed is the paperwork required by our office. Complete each section and sign/initial each highlighted area. Please be sure to complete the insurance portion of the form completely. Medical insurance can be billed for any medical diagnosis such as red eye, swelling, dry eye, cataracts, glaucoma, macular degeneration, etc.

Please arrive *no later* than 15 minutes before your scheduled appointment and bring the enclosed forms completed, photo ID, medical and vision insurance cards, and a list of medications if applicable. If you have any questions, please contact our office at (806) 358-3594.

Thanks again!

Doctor: _____

Patient: _____

Date & Time: _____

EyeCare plus
your first choice in eye care

5221 S. Coulter St. Amarillo, TX 79119
PH: (806) 358-3594 FAX: (806) 457-1660

Date: ___/___/____ **Name**: _____ **Nickname**:_____ **DOB**: ___/___/____

Gender: M F **Marital Status**: _____ **SS#**: _____-_____-_____

Mailing Address: _____ **City**:_____ **State**: _____ **Zip**:_____

Employer/School: _____ **Occupation/Grade**:_____

Home Phone: (_____) _____-_____ **Cell Phone**: (_____) _____-_____ **Can we text you**? Y / N

Work Phone: (_____) _____-_____ **E-mail address**: _____

Guarantor's Name: _____ **DOB**: _____/_____/_____ **Phone**: (_____) _____-_____

Emergency contact: _____

Preferred Language? ☐English ☐Spanish ☐ Other **Communication Preference?** ☐ E-mail ☐Postal ☐Telephone

Race? ☐American Indian or Alaska Native ☐Asian ☐African American ☐White ☐Pacific Islander ☐Other:_____

Ethnicity? ☐ Hispanic or Latino ☐ Pacific Islander ☐ Not Hispanic or Latino

How did you hear about us?: ☐ Insurance Company ☐ Advertisement ☐Internet ☐Walk-In ☐Referred, who?_____

Our office will re-check spectacle prescriptions at no charge within **30 days** from the time of initial examination. After that time period, there is a **$35.00** office visit fee for re-checks. **Initial**:____

***If you do not tell us you have a vision plan or medical insurance BEFORE services are rendered, we will assume no coverage exists. If you discover you have medical insurance or a vision plan after services or products are rendered, it is your responsibility to file your own claim for reimbursement.** We will NOT back file claims, post authorize, or refund fees.

____ SELF PAY (NO INSURANCE WILL BE FILED)

Policy Holder's information: Full Name:_____ DOB: ___/___/____

Mailing Address:_____

SS#: ____-____-_____ Relationship to patient: _____ Employer:_____

Vision Plan Name: _____ ID: _____ Group #:_____

Our office is a medical facility. Your medical insurance will often cover advanced testing and treatment of the eyes. If the doctor determines the need for additional medical testing or treatment, we will need medical insurance information.

Medical Insurance Name: _____ ID: _____Group #: _____

Secondary Insurance/Supplement Plan:

Name: _____ ID: _____Group #: _____

Signature of Subscriber: _____

YOUR SIGNATURE GIVES EYECARE PLUS AUTHORITY TO FILE ALL INSURANCES ON YOUR BEHALF.

I have received the **Notice of Privacy Practices**, and I have been given an opportunity to review it. (Guardian sign if patient is under age 18)

Name: _____ Relationship to patient:_____ Date: _____/_____/_____

Signature: _____

EyeCare Plus – Medical History Form

Name:_____ Date Of Birth:_____/_____/_____

Purpose for today's visit:_____

Are you currently experiencing the following?

Headaches Blurry Vision Trouble seeing at night Double Vision Burning Eye Injury Itching

Sunlight Sensitivity Pain Tearing Dry Eye Foreign Body Other:_____

Have you ever been diagnosed or treated for the following?

Corneal Abrasion Cataracts Lazy Eye Retinal Detachment Blindness

Floaters/Flashes Eye Trauma Glaucoma Iritis/Uveitis Macular Degeneration

Contact Lens Wearers:

Do you wear a specialty fit contact lens? (Gas Permeable (hard), Scleral lens, or SynergEYES?) YES NO

If yes, what type of lens do you currently wear? _____

Check ***ALL*** that apply:

	Yourself	Family		Yourself	Family
AIDS/HIV	_____	_____	HEPATITIS (Type A, B, or C)	_____	_____
ARTHRITIS	_____	_____	MIGRAINES	_____	_____
ASTHMA	_____	_____	PACEMAKER	_____	_____
AUTOIMUNE DISORDER	_____	_____	SEIZURES/EPILEPSY	_____	_____
BLEEDING DISORDER	_____	_____	SHINGLES	_____	_____
CANCER: _____	_____	_____	STROKE	_____	_____
DIABETES (TYPE 1 OR 2)	_____	_____	THYROID DISORDER	_____	_____
HEART DISEASE	_____	_____	TUBERCULOSIS	_____	_____
HYPERTENSION	_____	_____		_____	_____

OTHER:_____

FAMILY HISTORY: Macular Degeneration Blindness Glaucoma Retinal Detachment

Alcohol Use? Y / N **Tobacco Use**? Y / N

Primary Care Physician:_____

Pharmacy:_____ Location:_____ (Example: CVS on 34th & Western)

Please list **ALL** current medications: *(if you prefer, we can make a copy of your list.)*

_____

_____

_____

Medication allergies:_____

_____

_____

ADVICE AND CONSENT POLICY

The dedicated doctors and staff at EyeCare Plus are honored that you have put your trust in us. We pledge to provide you with unparalleled vision care through the latest technology and products with the highest level service you and your family deserve. We are committed to your vision care and quality of life. We pride ourselves in helping you see better today and preserving that vision for your future.

About your insurance:

There are two types of health insurance that will help pay for your eye care services and products. You may have both types, and EyeCare Plus accepts most insurance plans in both categories: 1) **Vision plans** (such as VSP, EyeMed and others) and 2) **Medical insurances** (such as Blue Cross/Blue Shield, Medicare and others).

- Vision plans only cover routine vision wellness exams, along with eyeglasses and contact lenses. Vision plans *do not cover medical eye care* (the diagnosis, management or treatment of eye health problems).
- Medical insurance (or health insurance) *must* be used for medical eye care.
- If you have both types of insurance plans, it may be necessary for us to bill some services to one plan and some services to the other. We will follow a procedure called "coordination of benefits" to do this properly and to minimize your out-of-pocket expense.
- If some fees are not paid by your insurance, we will bill you for them (such as deductibles, co-pays, or non-covered services as allowed by the insurance contract.)
- In the event of default in the payment of my charges, I agree to pay any collection agency fees and all costs and expenses, including reasonable attorney fees, we incur in such collection efforts.

PATIENT NAME:_____ DATE OF BIRTH:___/___/___

_____ ____/____/____

Patient or Guarantor Signature **Date**

This signed form is valid until revoked

5221 S. Coulter St. Amarillo, TX 79119-6676 PH: (806) 358-3594 FAX: (806) 457-1660

Revised June 7, 2019

Contact Lens Policy

Your exam charge today includes the following:

A Comprehensive Eye Examination (spectacle prescription), corneal health and contact lens analysis (trial pair of contact lenses), proper training of insertion and removal, and 2 free follow-up evaluations within **60 days**.

In addition to your routine fees and copays, fees for the contact lens analysis run between $65-$125 - which may or may not be covered by your insurance.

Please read each statement

- In some instances, more than two follow-up evaluations may be required for best results. In these cases, a **$35.00** office fee will be charge for subsequent visits.
- All contact lenses must be *paid in full* prior to ordering boxes.
- Specialty lenses (Gas Permeable, SynergEyes, CRT, or Scleral) require a $150.00 non-refundable fee.
- Contacts not picked up within **30 days** will be returned to the manufacturer with a **25% restocking fee** assessed.
- Disposable contact lenses are non-refundable. In certain cases unopened, undamaged boxes may be returned but a **25% restocking fee** will be assessed.
- Trial lenses dispensed 30 days after the initial exam are only available **ONE TIME** a year from date of exam and will be subject to a $10.00 dispensing fee.

EYEMED VISION INSURANCE

If you have coverage under an EyeMed vision plan, please be aware that there may be an additional charge for the contact lens analysis due to changes in EyeMed's claims filing procedure.

I have read and understand the terms of this policy.

_____ Date Of Birth: _____

(Patient Name)

_____ _____

(Signature – Guardian if patient under 18) (Date)

This policy remains in effect until changed or updated.

Revised 11-13-2018

Notice of Privacy Practices - HIPAA

1. Our Pledge Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. The notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. Our Legal Duty

Law Requires Us to:

A. Keep your medical information private.
B. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
C. Follow the terms of the current notice.

We Have the Right to:

A. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
B. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices

A. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. Use and Disclosure of Your Medical Information

The following section describes different ways that we use and disclose medical information. Not every use of disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided.

For Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

For Payment: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

For Health Care Operations: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

Additional Uses and Disclosures: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Facility Directory: Unless you notify us that you object, the following medical information about you will be placed in our facility directories: your name; your location in our facility; you condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation to others who contact us and ask for information about you by name.

Notification: We may use and disclose medical information to notify of help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief: We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising: We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

Research in Limited Circumstances: We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective correctional institutions and other law enforcement custodial situations, and for government programs provided public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to

jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contraction or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped form legal custody.

Workers Compensation: We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders: We may use and disclose medical information for purposes of sending you appointment postcards or otherwise remind you of your appointments.

Alternative and Additional Medical Services: We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

4. Your Individual Rights

You Have a Right to:

A. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information provided you may also request access by sending a letter to the contact person provided. If you request copies, we will charge you $0.50 for each page, and postage if you want the copies mailed to you. Contact us using the information provided for a full explanation of our fee structure.

B. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment and health care operations and other specified exceptions.

C. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).

D. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means of at different locations must be made in writing to the contact person provided.

E. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.

F. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person provided.

Questions and Complaints

If you have any questions about this notice or if you think that we may have violated you privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. You may contact us to submit a complaint or submit requests involving any of your rights in section 4 of this notice by writing to the following address:

EyeCare Plus

5221 S Coulter St

Amarillo TX 79119

We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.