ADVANCED VISION CARE *"WELCOME TO OUR OFFICE"*

PATIENT INFORMATION, PLEASE FILL OUT COMPLETELY

DATE_____

NAME _____ NAME YOU LIKE TO BE CALLED _____

BIRTH DATE_____ AGE_____ GENDER ❑ MALE ❑ FEMALE

SOCIAL SECURITY # _____

ADDRESS _____ CITY _____ ZIP_____

HOME PHONE_____ WORK PHONE _____

EMAIL _____ CELL PHONE _____

EMPLOYER/
SCHOOL _____ GR. _____ OCCUPATION _____

REFERRED TO OFFICE BY _____ OR THROUGH:

❑ SIGN/LOCATION ❑ YELLOW PAGES ❑ ADVERTISING ❑ INSURANCE PLAN

OTHER FAMILY MEMBERS LIVING AT HOME:

IF CHILD, NAME OF FATHER_____ MOTHER_____

SPOUSE _____

CHILDREN _____

IF NOT COVERED BY INSURANCE, NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____

MEDICAL INSURANCE INFORMATION

NAME OF MEDICAL INSURANCE _____

INSURED'S NAME _____ INSURED'S BIRTHDATE _____

ADDRESS ❑ SAME AS ABOVE _____ CITY_____ ZIP_____

PHONE: HOME _____ WORK _____

RELATIONSHIP TO PATIENT: ❑ SELF ❑ SPOUSE ❑ CHILD ❑ OTHER, EXPLAIN _____

_____

VISION INSURANCE INFORMATION

NAME OF VISION INSURANCE _____

INSURED'S NAME_____ LAST 4 DIGITS OF SOCIAL SECURITY #_____

ADDRESS ❑ SAME AS ABOVE _____ CITY_____ ZIP_____

PHONE: HOME _____ WORK _____

RELATIONSHIP TO PATIENT: ❑ SELF ❑ SPOUSE ❑ CHILD ❑ OTHER, EXPLAIN _____

_____

PLEASE GIVE YOUR INSURANCE CARDS TO THE RECEPTIONIST SO THAT WE MAY MAKE COPIES

NAME OF YOUR PRIMARY CARE PHYSICIAN _____

OFFICE LOCATION_____ PHONE _____

_____ DATE_____

Signature of Patient (or parent if minor)

THANK YOU FOR GIVING US THIS INFORMATION.

PROTECTED HEALTH INFORMATION

I authorize Advanced Vision Care to share my medical information with _____

(relationship) _____

Signature _____

MEDICARE PATIENTS ONLY: Please Read and Sign

I Request that payment of authorized Medicare benefits be made either to me or on my behalf to Advanced Vision Care for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

_____ DATE _____

Signature of Patient or Authorized Person

DO YOU HAVE SUPPLEMENT INSURANCE? ❑ YES ❑ NO

SUPPLEMENTAL INSURANCE NAME _____

PATIENT RESPONSIBILITY

If we are submitting a claim for services to your Medical Insurance:

Many medical insurance plans now have patient deductibles, copays, and coinsurance for special tests, including refractions, and office visits. **You are responsible for any charges your insurance notifies us of after your claim has been processed and/or denied. We will bill you for these charges after being notified by your insurance company. These fees are due within 30 days of billing.**

_____

Signature of Patient or Authorized Person Date

ADVANCED BENEFICIARY NOTICE (ABN) Refractive Services

Highmark Security Blue and Freedom Blue
Medicare and some Medicare Advantage Plans

The refraction is the part of the eye examination performed by your doctor to determine the prescription power for your eyeglasses and/or contact lenses.

Medicare and your medical insurance carrier does not consider refraction services medically necessary, thus your medical insurance carrier will allow billing of tests for ocular health assessment but not the cost of a refraction. You can have a refraction done today at your own expense in addition to your copay for the ocular health assessment. The fee is $30.

☐ I agree to have this service done today and understand there is a $30 fee.
☐ I do not want this service done today.

_____

Patient Signature Date

Medical History Questionnaire

Name: _____ Today's Date: _____/_____/_____

Address: _____ Phone: _____

_____ Work Phone: _____

Birth Date: _____/_____/_____ Social Security #: _____/_____/_____ Last Eye Exam: _____/_____/_____

Name of Medical Doctor: _____ Dr.'s Phone: _____

Last Medical Exam: _____/_____/_____

Medical History

Do you have any allergies to medications? ❑ no ❑ yes If yes, explain: _____

_____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

_____

_____

_____

List all major injuries, surgeries and / or hospitalizations you have had: _____

_____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: _____

Are you pregnant and / or nursing? ❑ no ❑ yes

Do you wear glasses? ❑ no ❑ yes If yes, how old is your present pair of lenses? _____

Do you wear contacts? ❑ no ❑ yes If yes, how old is your present pair of lenses? _____

Type of contact lenses: ❑ Rigid ❑ Soft ❑ Extended Wear ❑ Other Are they comfortable? ❑ yes ❑ no

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE / CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	❑	❑	❑	_____
Cataract	❑	❑	❑	_____
Crossed Eyes	❑	❑	❑	_____
Glaucoma	❑	❑	❑	_____
Macular Degeneration	❑	❑	❑	_____
Retinal Detachment/Disease	❑	❑	❑	_____
Arthritis	❑	❑	❑	_____
Cancer	❑	❑	❑	_____
Diabetes	❑	❑	❑	_____
Heart Disease	❑	❑	❑	_____
High Blood Pressure	❑	❑	❑	_____
Kidney Disease	❑	❑	❑	_____
Lupus	❑	❑	❑	_____
Thyroid Disease	❑	❑	❑	_____
Other _____	❑	❑	❑	_____

✳ *Please turn this form over and complete side two* ✳

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

❑ Yes, I would prefer to discuss my Social History information directly with my doctor (check box)

Do you drive? ❑ no ❑ yes If yes, do you have visual difficulty when driving? ❑ no ❑ yes If yes, please describe:

Do you use tobacco products? ❑ no ❑ yes If yes, type/amount.how long:

Do you drink alcohol? ❑ no ❑ yes If yes, type/amount.how long:

Do you use illegal drugs ? ❑ no ❑ yes If yes, type/amount.how long:

Have you ever been exposed to or infected with: ❑ Gonorrhea ❑ Hepatitis ❑ HIV ❑ Syphilis

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES	?
CONSTITUTIONAL			
Fever, Weight Loss Gain	❑	❑	❑
INTEGUMENTARY (Skin)	❑	❑	❑
NEUROLOGICAL	❑	❑	❑
Headaches	❑	❑	❑
Migraines	❑	❑	❑
Seizures	❑	❑	❑
EYES			
Loss of Vision	❑	❑	❑
Blurred Vision	❑	❑	❑
Distorted Vision/Halos	❑	❑	❑
Loss of Side Vision	❑	❑	❑
Double Vision	❑	❑	❑
Dryness	❑	❑	❑
Mucous Discharge	❑	❑	❑
Redness	❑	❑	❑
Sandy or Gritty Feeling	❑	❑	❑
Itching	❑	❑	❑
Burning	❑	❑	❑
Foreign Body Sensation	❑	❑	❑
Excess Tearing/Watering	❑	❑	❑
Glare/Light Sensitivity	❑	❑	❑
Eye Pain or Soreness	❑	❑	❑
Chronic Infection of Eye or Lid	❑	❑	❑
Sties or Chalazion	❑	❑	❑
Flashes/Floaters in Vision	❑	❑	❑
Tired Eyes	❑	❑	❑
ENDOCRINE			
Thyroid/Other Glands	❑	❑	❑

	NO	YES	?
EAR, NOSE, MOUTH, THROAT			
Allergies/Hay Fever	❑	❑	❑
Sinus Congestion	❑	❑	❑
Runny Nose	❑	❑	❑
Post-Nasal Drip	❑	❑	❑
Chronic Cough	❑	❑	❑
Dry Throat/Mouth	❑	❑	❑
RESPIRATORY			
Asthma	❑	❑	❑
Chronic Bronchitis	❑	❑	❑
Emphysema	❑	❑	❑
VASCULAR / CARDIOVASCULAR			
Diabetes	❑	❑	❑
Heart Pain	❑	❑	❑
High Blood Pressure	❑	❑	❑
Vascular Disease	❑	❑	❑
GASTROINTESTINAL			
Diarrhea	❑	❑	❑
Constipation	❑	❑	❑
GENITOURINARY			
Genitals/Kidney/Bladder	❑	❑	❑
BONES / JOINTS / MUSCLES			
Rheumatoid Arthritis	❑	❑	❑
Muscle Pain	❑	❑	❑
Joint Pain	❑	❑	❑
LYMPHATIC / HEMATOLOGIC			
Anemia	❑	❑	❑
Bleeding Problems	❑	❑	❑
ALLERGIC/IMMUNOLOGIC	❑	❑	❑
PSYCHIATRIC	❑	❑	❑

If you answered YES to any of the above or have a condition not listed, please explain and list medications:

Doctor's Signature

Date

ADVANCED VISION CARE
A MEMBER OF VISION SOURCE

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Dr. Mindy A. McKee
Dr. Joseph D. Falbo
Dr. Rachel L. Penney
Dr. Robert J. Hartsock
OPTOMETRISTS

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

Patient Name: _____

In the course of providing service to you we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office.

We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail. You are free to refer to this Notice at any time before you sign this consent document. As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and services provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of information to a billing agent or vendor for processing claims or obtaining payment, our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; our submission of your health information to auditors hired by third-party payers and insurers, among other aspects of payment described in our Notice of Privacy Practices. Our Notice of Privacy Practices will be updated whenever our privacy practices change. You can get an updated copy here at the office or from our website.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform health care operations. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent. We can decline to serve you if you elect not to sign this consent form.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment, or health care operations, but as described in our Notice of Privacy Practices, we are not obligated to agree to theses suggested restrictions. If we do agree, however, the restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for a restriction.

I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

_____ _____

Dated Patient Signature

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

_____ _____

Relationship to patient Print Name and Source of Authority