PATIENT INFORMATION

Please provide all requested information- Please print

Last Name:___________________________ First Name:________________________ DOB:____/_____/____ Sex: M F

Address:_______________________________________ City:_____________________ State:_______ Zip:___________

Telephone: (______)_____________________ Status: ☐Single ☐Married ☐Divorced ☐Widowed

Email:______________________________________ SSN:_______________________________________

Employer:____

Race: ☐ American Indian/Alaska Native ☐ Asian
☐ Black/ African American ☐ Hispanic
☐ Native Hawaiian/Pacific Islander ☐ White

Ethnicity: ☐ Hispanic/Latino
☐ Not Hispanic/Latino
☐ Native Hawaiian/Pacific Islander

Responsible Party: _____________________________________ Relationship:____________________________

Referring/Primary Care Physician:____

Emergency Contact:____ Telephone: (_____)___________________

Medical Insurance: _________________________Policy Number:_________________ Group Number:______________

Policy Holder:____ DOB:____/____/____ Relationship:_________________

2nd Medical Insurance: ______________________Policy Number:_________________ Group Number:______________

Policy Holder:____ DOB:____/____/____ Relationship:_________________

Vision Insurance: __________________________ Policy Number/SSN:__________________

Policy Holder:____ DOB:____/____/____ Relationship:_________________

MEDICATIONS ☐ **NONE**

List **ALL** medications that patient is currently taking including over-the-counter, or provide staff with medication list

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ALLERGENS: Medication allergies. ☐ **NONE** **Environmental or food allergies.** ☐ **NONE**

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Is the patient **pregnant**? ☐Yes ☐No **Nursing**? ☐Yes ☐No

SOCIAL HISTORY: Check ☑ Yes (Y) or No (N) for the following questions. If yes, check all details that apply.

Substance	Y	N	Details
Tobacco			☐Cigarette ☐Tobacco ☐Cigar ☐Every day ☐Some days ☐Former
Illicit Substances			
Alcohol			☐Less than 1 drink a day ☐1-2 drinks per day ☐3 or more drinks per day

SIGNATURE ON FILE

IF YOU HAVE MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to Neena Singhal James, LLC (d.b.a. 20/20 Eye Care), for services furnished by 20/20 Eye Care. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payments be made and authorize release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500-2007 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. 20/20 Eye Care accepts the charge determination of the Medicare carrier as the full charge, and I am responsible for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

IF YOU HAVE A SECONDARY INSURANCE: I understand that if a secondary policy or other health insurance is indicated in Item 9 of the HCFA 1500-2007 form or elsewhere on the approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to 20/20 Eye Care, if possible, or otherwise to me.

RELEASE OF INFORMATION TO INSURANCE: 20/20 Eye Care may disclose all or any part of my medical record and/or financial ledger to insurance companies of which I am the policy holder which are under contract to 20/20 Eye Care for reimbursement for services rendered.

IF YOU HAVE OTHER INSURANCE: I understand that 20/20 Eye Care maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. 20/20 Eye Care has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by 20/20 Eye Care if I belong to a plan that does not appear on the above mentioned list.

POSSIBLE NON-COVERED SERVICES: I understand that 20/20 Eye Care contracts with health care service plans (i.e., HMO’s, PPO’s) relate only to items and services which are “covered” by health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. The undersigned agrees to cooperate with 20/20 Eye Care Centers.

STANDARD FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by 20/20 Eye Care, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to 20/20 Eye Care for payment. If an account is sent to a collection agency or an attorney for collection, I agree to pay collection expenses and reasonable attorney’s fees as established by the court and not by a jury in court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other part liable to the patient, is hereby assigned to 20/20 Eye Care. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to 20/20 Eye Care. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

NO SHOW FEE: I understand that if I do not show up for my scheduled appointment that I am subject to a $25 fee that will be billed to me.

ELECTRONIC STATMENTS: I understand that if I have a balance on my account that my statement will be sent by mail, text, or email.

CONSENT TO TREATMENT: I authorize the physicians of 20/20 Eye Care, their technicians and other health care providers under their direction to provide diagnostic evaluation and treatment. I agree to pupillary dilation for the purpose of examination, which could affect driving and up close work. I understand that no guarantee has or will be made to me regarding any possible result or cure based on my examination and/or treatment.

IF YOU HAVE A CONTACT LENS FITTING: Yearly contact lens fitting fees are not included in the cost of the eye health exam. Depending on the complexity of the fitting, these fees range from $55.00 - $900.00. The fitting fees will be determined by your optometrist after they evaluate your eyes. I hereby verify that I understand I will always have been given the option for a copy of my contact lens prescription and I will always the right to be given (in a HIPAA compliant format) a copy of your contact lens prescription.

POSSIBILITY OF MEDICAL IMAGING AND/OR PROCEDURES: If determined in your best interest by the doctor(s) in the exam room, the doctor may perform services or imaging for diagnostic or treatment purposes. I consent for certain imaging/procedures to be performed and filed to my medical insurance company.

X____ Date:____________________

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _________________________ Date of Birth: _____________

Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information and when we need your written authorization to do so. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party. I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards. I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party) and that I may have the right to refuse to sign this authorization. I can receive a copy of this signed authorization upon request. A copy of this authorization is as valid as the original.

My signature below authorizes the optometrists at Neena Singhal James, LLC (DBA 20/20 Eye Care) to discuss, disclose, or send correspondence regarding my health information and conditions with the following recipient(s):

Primary Physician/Office(s): _________________________________

Family/Friend Name:______________________________________

Relation to Patient: ___________________________________

Signature: ______________________________ Date: ___________________

My signature below authorizes the optometrists at Neena Singhal James, LLC (DBA 20/20 Eye Care) to request copies (via fax) of my previous eye care records from the following office(s):

Office Name:_______________________________ Optometrist Name:______________________

Phone Number: ________________________ Fax Number:____________________________

Signature: ______________________________ Date: ___________________