HIPPA Privacy Statement

I have had the full opportunity to read the Notice of Privacy Practices from 24/7 Vision & Eye Care that is attached to the computer. (copies available)

Name_____Date_____

24/7 Vision & EYE CARE
"Clear Sight All Day, Everyday"

4444 W. Jefferson Blvd Ste.614
Cockrell Hill, TX 75211
PH (214) 333-3937

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WELCOME TO OUR OFFICE

Name_____Mid Init._____
Street _____
City_____State____Zip _____
Home Phone_____
Work Phone _____
Cell Phone _____
Email _____
Employer(School) _____
Today's Date_____Date of last exam _____
Date of Birth_____Age Sex: M F
Insurance Provider _____
Primary Member Name_____
Member SS#_____DOB _____
Member ID# (if using medical ins.) _____

***We will bill your insurance based on direct benefits.**
This does NOT guarantee payment by your insurance company

Who is primary physician? _____
Address/Phone _____
Date of last physical exam _____
Emergency Contact
Name_____Phone_____
General Health status: ( ) Excellent ( ) Good ( ) Fair ( ) Poor
Are you pregnant? ( ) yes ( ) no If yes, how many months? _____

Medical History - F= Family, S= Self

	Family	Self		Family	Self
Diabetes	[ ]	[ ]	Glaucoma	[ ]	[ ]
High Blood Pressure	[ ]	[ ]	Cataracts	[ ]	[ ]
Heart Problems	[ ]	[ ]	Loss of Vision	[ ]	[ ]
Respiratory Problems	[ ]	[ ]	Retinal Detachment	[ ]	[ ]
Headaches	[ ]	[ ]	Eye Surgery	[ ]	[ ]
Thyroid Problems	[ ]	[ ]	Lazy Eye	[ ]	[ ]
Seaal Allergies	[ ]	[ ]	Blindness	[ ]	[ ]
Stroke	[ ]	[ ]	Head/Eye Injury	[ ]	[ ]
Cancer	[ ]	[ ]	Eye Infection	[ ]	[ ]
Arthritis	[ ]	[ ]	Other Eye Diseases	[ ]	[ ]

What brings you today?
_____
_____
Do you have any special concerns?
_____

Do you currently wear glasses ( ) yes ( ) no
What would you change about your glasses
_____
_____
Do you have more than one pair? ( ) yes ( ) no
If yes for what purpose?
_____
What kind of frames or lenses are you interested in?
_____

Do you currently wear contact lenses? ( ) yes ( ) no
If Yes :
What brand do you wear? _____
What solution do you use? _____
How often do you dispose of them? _____
Do you wear them over night_____
If No:
Are you interested in contact lenses? ( ) yes ( ) no

Do you experience any of the following symptoms?

Burning	Itchiness	Watery Eyes
Discomfort	Glare or Reflection	Dryness
Headaches	Sensitivity to Light	Poor Night Vision

Other _____

Do you drink alcohol? ( ) yes ( ) no
Smoker? ( ) yes ( ) no
Illegal Drugs? ( ) yes ( ) no
Have you ever been exposed to:
Tuberculosis___HIV___Hepatitis___Chlamydia___Syphilis Gonorrhea___
Other health problems if any_____
Medications if any _____
Drug Allergies if any _____

How did you hear about our office?

Friend or Relative Yellow Pages Insurance
Previous Patient (Who?)
Drive By Other

This is a notice to inform you that 24/7 Vision Eye Care takes your privacy very seriously. Our privacy practices are posted and any information contained on this page is for our use and will not be shared with anyone for any other use other than health care operations.

WE WELCOME YOU TO OUR PRACTICE AND ASK THAT YOU KINDLY COMPLETE, OR CORRECT ALL INFORMATION.

Acknowledgment of Receipt of this Notice:

This practice is concerned about the privacy of our patients' health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your healthcare services will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide your treatment and will use and disclose your protected health information for treatment, payment and healthcare operations when necessary.
The law requires that 24/7 Vision & Eye Care make every effort to inform you of your rights related to your personal health information. By signing below I acknowledge that:

☐ I have read the privacy notice of 24/7 Vision & Eye Care and agree to continue my care with 24/7 Vision & Eye Care under said terms.

☐ I was given the opportunity to read 24/7 Vision & Eye Care Notice of Privacy Practice and declined to read it but wish to continue with my care with 24/7 Vision & Eye Care under terms of24/7 Vision & Eye Care privacy policies

Patient/Guardian Signature_____**Date** _____

Medical Insurance Policy:
As part of our services at this practice we are happy to assist patient in determining the benefits of your individual policy and in collecting your reimbursement of insurance benefits for medical / or vision services. To avoid any misunderstandings, please read the following statements carefully:

1. The legal obligations of your insurance provider are between yourself and your provider, not between this practice and your provider.
2. When your insurance provider(s) has settled your plan's covered items, a monthly statement will notify you if there were any unpaid balances, unpaid balances can include non-covered items or services. copays, deductibles, lapses, ineligibility or termination of coverage's. Unpaid balances are the sole responsibility of the patient.
3. To keep the cost of records and collections down, any patient portion amounts on your order will be due at the time of service.
4. I authorize the use of this form on all insurance submission as well as authorizing the release of information to all my insurance companies as well as the doctor to act as my agent to help me in obtaining payment from my insurance companies.
5. I authorize payment to be made directly to the doctor and permit a copy of this authorization to be used in place of the original.

INSURANCE (Medical& Vision) INFORMATION:

By signing this statement you hereby agree to be financially responsible for any and all charges incurred by you and not paid by your insurance provider. Also, you are giving 24/7 Vision & Eye Care (Lacy Eye Services, P.C.) the permission to file an insurance claim on your behalf for rendered services.

Patient/Guardian Signature_____**Date** _____

REFUND/EXCHANGE/RETURN POLICIES:

NO REFUNDS, EXCHANGES or RETURNS on optical products purchased at this office can be made, which include prescription lenses, frames, contact lenses, sun glasses, optical accessories or other optical products.

ALL RENDERED CLINICAL PROCEDURES OR SERVICES, including comprehensive eye examinations, refraction, contact lenses fitting, and medical office visits provided at this office are **NON-REFUNDABLE!!!**

Patient / Guardian Signature_____**Date** _____