



## Welcome to Harrison Eye Care

### Patient Information

**Legal Name:** Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_  
**Name Preference/Nickname:** \_\_\_\_\_ **Title:**  Mr.  Mrs.  Ms.  Miss.  Dr.  Other: \_\_\_\_\_  
**Age:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Marital Status:**  Single  Married  Other: \_\_\_\_\_  
**SSN (or last 4 digits Required):** \_\_\_\_\_ **Gender:**  Female  Male  
**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_  
**Home Phone#:** \_\_\_\_\_ **Cell Phone#:** \_\_\_\_\_ **Is texting ok?**  Yes  No, please do not text  
**E-mail Address:** \_\_\_\_\_  
**Employer(or school):** \_\_\_\_\_ **Occupation (or grade in school):** \_\_\_\_\_  
**Referred by (Please select one):**  Patient  Professional  Other  None **Name:** \_\_\_\_\_

**Communication Preference (Please select one):**  Home Phone  Cell Phone  Text  E-mail

For improved communication may we please send a  Text  E-mail  Both to notify you of the following?

- ✓ Glasses/contact lenses ready for pick up
- ✓ Appointment reminder/annual recall notice (no more postcards!)
- ✓ Newsletter (max 4 times per year, unless emergency situation arises)

**Person financially responsible for this account:** \_\_\_\_\_

How is this person related to patient (Please select one):  Self  Spouse  Father  Mother  Guardian  Other

If minor, parent/guardian full name: \_\_\_\_\_

**Do you have vision benefits through Vision Service Plan (VSP):**  Yes  No **If yes, prior authorization is required.**

**Policy Holder's Legal Name:** \_\_\_\_\_ **Policy Holder's Employer:** \_\_\_\_\_

**Policy Holder's SSN#/Unique ID:** \_\_\_\_\_ **Policy Holder's Date Of Birth:** \_\_\_\_\_

### **Primary Major Medical Insurance:**

Insurance Company: \_\_\_\_\_

Insurance ID#: \_\_\_\_\_ Insurance Group#: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Policy Holder's relationship to patient:  Self  Spouse  Father  Mother  Guardian  Other

Policy Holder's Social Security #: \_\_\_\_\_

### **Secondary Major Medical Insurance:**

Insurance Company: \_\_\_\_\_

Insurance ID#: \_\_\_\_\_ Insurance Group#: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Policy Holder's relationship to patient:  Self  Spouse  Father  Mother  Guardian  Other

Policy Holder's Social Security #: \_\_\_\_\_

### **ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT GUARANTEE:**

I hereby authorize Harrison Eye Care, P.C. and its agents, to release to and discuss with my insurance company, physician and/or employer, for work related injuries, any information acquired by Harrison Eye Care, P.C. in the course of my examination or treatment. I hereby authorize benefits to be paid directly to the provider. I understand that payment of charges is not contingent upon settlement from my insurance carrier and that I am responsible for any unpaid balance. By signing this form you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent in writing, except where we have already made disclosures in reference to your prior consent.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_



## **Financial Policy**

Thank you for choosing Harrison Eye Care, P.C. as your eye care provider. We are committed to providing quality service and products. Please read the following information regarding your responsibilities related to payment of services.

**Patient (“you” or “your”)** agrees to pay for all services at the time they are provided unless **Harrison Eye Care, P.C. (“we”)** has agreed to bill your insurance company.

**Proof of Insurance:** You must complete our patient information form before seeing the doctor. We must obtain a copy of your driver’s license and a valid insurance card.

**Insurance:** Harrison Eye Care, P.C. participates in various insurance plans. If you are not insured by a plan we are contracted with, payment in full is expected at each visit. If you are insured by a plan we are contracted with, but do not have an up-to-date insurance card, payment in full is required for each visit until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

**Co-Payments:** All co-payments are due at the time of service. This arrangement is part of your contract with your insurance company.

**Non-covered services:** Please be aware that some and perhaps all of the services you receive may not be covered and considered reasonable or necessary by insurers. You will receive an explanation of benefits (EOB) from your insurance company designating the amount paid and/or the patient responsibility amount. The outstanding amount not paid by insurance must be paid to Harrison Eye Care, P.C. within 30 days after written notice from your insurance company and/or Harrison Eye Care, P.C. that the claim has been denied or partially paid. If we cannot collect payment after 60 days past due, we may refer your account to a COLLECTION AGENCY where all fees incurred will be your responsibility and future services may not be provided to the patient until payment has been made. Harrison Eye Care, P.C. will remain neutral to insurance disputes between patients and insurance companies.

**No Show/Cancellation Policy:** Please be advised that appointments that are not cancelled within 24 hours will result in a \$50.00 fee for Monday through Friday appointments and \$75.00 fee for Saturday appointments. These charges will be expected to be paid prior to scheduling any future appointments.

I have read, understand, and agree with the Financial Policy outlined above.

**Print Patient’s Name:** \_\_\_\_\_ **Patient’s Date of Birth:** \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_



**Personal Eye Information**

**Patient's Name:** \_\_\_\_\_

**Patient's Date of Birth:** \_\_\_\_\_

**Date of Last Eye Exam:** \_\_\_\_\_

**Dilated?**  Yes  No

Have you been diagnosed or do you suffer from any of the following eye conditions?

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Cataracts            | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Macular degeneration | <input type="checkbox"/> Retinal detachment     |
| <input type="checkbox"/> Severe Pain          | <input type="checkbox"/> Poor distance vision | <input type="checkbox"/> Poor Near Vision     | <input type="checkbox"/> Blurred vision         |
| <input type="checkbox"/> Double Vision        | <input type="checkbox"/> Eye Strain           | <input type="checkbox"/> Floaters or Spots    | <input type="checkbox"/> Headaches              |
| <input type="checkbox"/> Sensitive to Light   | <input type="checkbox"/> Dry eyes             | <input type="checkbox"/> Turned or lazy eye   | <input type="checkbox"/> Eyes feel sandy/gritty |
| <input type="checkbox"/> Eyes burn/itch/water |   |   |   |

Have you had any eye operations? Yes No Type: \_\_\_\_\_ When: \_\_\_\_\_

Have you had an eye injury? Yes No Describe: \_\_\_\_\_ When: \_\_\_\_\_

Do you wear glasses? Yes No When: \_\_\_\_\_

Do you wear Contact lenses? Yes No Type: \_\_\_\_\_

Additional information: \_\_\_\_\_

**Work/Tasks**

**Typical work tasks:**  Computer #of Hours \_\_\_\_\_  Other \_\_\_\_\_

**Medical History**

Have you been diagnosed or do you suffer from any of the following medical conditions? (Please check all that apply)

- |   |   |   |   |  |   |
|---|---|---|---|--|---|
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Type I           | <input type="checkbox"/> Type II              | Date of Diagnosis _____                   | A1C _____                                      | <input type="checkbox"/> Diabetic Retinopathy |
| <input type="checkbox"/> Hypertension         | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Allergic/Immunologic | <input type="checkbox"/> Cardiovascular   | <input type="checkbox"/> Constitutional        |   |
| <input type="checkbox"/> Endocrine            | <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Genitourinary        | <input type="checkbox"/> Ears/Nose/Throat | <input type="checkbox"/> Hematologic/Lymphatic |   |
| <input type="checkbox"/> Integumentary (Skin) | <input type="checkbox"/> Musculoskeletal  | <input type="checkbox"/> Neurological         | <input type="checkbox"/> Psychiatric      | <input type="checkbox"/> Respiratory           |   |

Please explain: \_\_\_\_\_

Other health problems not listed above: \_\_\_\_\_

Current medication(s): \_\_\_\_\_

Allergies to medication Yes No Which? \_\_\_\_\_ Reactions? \_\_\_\_\_

Have you had any operations? Yes No Kind? \_\_\_\_\_

**Family History** (*Please check yes or no*)

- |                                       |   |   |   |                                   |
|---------------------------------------|---|---|---|-----------------------------------|
| <input type="checkbox"/> Cataracts    | <input type="checkbox"/> Glaucoma         | <input type="checkbox"/> Macular degeneration | <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Heart Condition      | <input type="checkbox"/> Cancer             |                                   |

**Current family doctor and/or primary care physician:**

Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

**Other health care specialist:**

Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

**Authorization**

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Harrison Eye Care to release information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eyecare to third party payers and/or health practitioners.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_



**Patient's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

In compliance with the Health Information Technology for Economic and Clinical Health Act (HITECH) to attain Meaningful Use we are required to capture demographic data including your preferred language, race and ethnicity. This is an important part of your medical history and will assist us during our clinical quality improvement process. Please check ONE in EACH CATEGORY.

**Race (check one)**

- White
- Black or African American
- Hispanic
- Asian
- American Indian or Alaskan Native
- Native Hawaiian/Other Pacific Islander
- Decline To Specify

**Ethnicity: (check one)**

- Not** Hispanic or Latino
- Hispanic or Latino
- Native Hawaiian/Other Pacific Islander
- Decline To Specify

**Preferred Language: (check one)**

- English
- Spanish
- Japanese
- French
- Decline To Specify

### Acknowledgement of Privacy Practices and Privacy Options

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I received or have been given the opportunity to receive a copy of Harrison Eye Care's Notice of Privacy Practices. I also understand that Harrison Eye Care has the right to change its Notice of Privacy Practices and that I may contact you at any time to obtain a current copy of the Notice of Privacy Practices.

➤ I acknowledge receipt of Harrison Eye Care's Notice of Privacy Practices (**Please initial**):   
(The Harrison Eye Care Privacy Policy is available for review on our [website](#).)

#### Medical Information Release

**If patient is a minor or unable to complete/sign, please check the following:**

- Patient is a minor: \_\_\_\_\_ years of age
- Patient is unable to complete/sign because: \_\_\_\_\_

#### Release of Information (Must Select Yes or No):

Yes, I authorize the release of information including the diagnosis, records; spectacle and/or contact lens prescriptions; examination rendered and claims information. This information may be released to:

Name

Name \_\_\_\_\_

Name \_\_\_\_\_

Specify information you would not like released: \_\_\_\_\_

No, Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing. I understand that uses and disclosures already made based upon my original permission cannot be taken back.

#### Messages

Please call:  My Home  My Cell  E-mail

If unable to reach me:

- You may leave a detailed message.
- Please leave a message asking me to return your call.
- Other: \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_