HARRISON EYE CARE

21100 Washington Parkway
Frankfort, IL 60423
Phone (815) 469-5005 Fax (815) 469-5060

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: _____

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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 and Deductibles: All co-payments are due at the time of service. If you have not met your deductible, fees are due in full 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. 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:** _____

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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?

☐ Cataracts ☐ Glaucoma ☐ Macular degeneration ☐ Retinal detachment
☐ Severe Pain ☐ Poor distance vision ☐ Poor Near Vision ☐ Blurred vision
☐ Double Vision ☐ Eye Strain ☐ Floaters or Spots ☐ Headaches
☐ Sensitive to Light ☐ Dry eyes ☐ Turned or lazy eye ☐ Eyes feel sandy/gritty
☐ 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: ☐ **C**omputer #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)

☐ Diabetes ☐Type I ☐Type II Date of Diagnosis _____ A1C_____ ☐ Diabetic Retinopathy
☐ Hypertension ☐ High Cholesterol ☐ Allergic/Immunologic ☐ Cardiovascular ☐ Constitutional
☐ Endocrine ☐ Gastrointestinal ☐ Genitourinary ☐ Ears/Nose/Throat ☐ Hematologic/Lymphatic
☐ Integumentary (Skin) ☐ Musculoskeletal ☐ Neurological ☐ Psychiatric ☐ 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)*

☐ Cataracts ☐ Glaucoma ☐ Macular degeneration ☐ Retinal Detachment ☐ Diabetes
☐ Hypertension ☐ High Cholesterol ☐ Heart Condition ☐ 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:** _____

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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_____ Relationship to Patient_____

Name_____ Relationship to Patient_____

Name_____ Relationship to Patient_____

☐ 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:** _____