

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

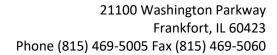
Welcome to Harrison Eye Care

Patient Information

	First				
	Title: □Mr. □Mrs. □ Ms. □Miss. □Dr. □ Other:				
Age: Date of Birth:	Marital Status: □Single □Married □ Other:				
SSN (or last 4 digits Required):	Gen	Gender: □ Female □ Male			
Address:	City	State:	Zip Code:		
lome Phone#:	Cell Phone#:	Is texting ok	? \square Yes $\ \square$ No, please do not		
-mail Address:					
Employer(or school):	Occupation (or grade in school):			
Referred by (Please select one): \Box	☐ Patient ☐ Professional ☐ Other	□None Name:_			
Communication Preference (Pleas	se select one): □Home Phone □Cel	l Phone □Text	☐ E-mail		
or improved communication may	we please send a \Box Text \Box E-mail \Box	Both to notify you of	the following?		
✓ Glasses/contact lenses re	ady for pick up				
✓ Appointment reminder/a	nnual recall notice (no more postcards!)				
• •	per year, unless emergency situation arises	s)			
·	. , ,	,			
Person financially responsible for	this account:				
low is this person related to patie	ent (Please select one): Self Spouse	☐ Father ☐ Mothe	r □Guardian □Other		
•	ent (Please select one): □Self □Spouse I full name:				
· ·	ent (Please select one): Self Spouse full name:				
If minor, parent/guardian	full name:				
If minor, parent/guardian	full name: through Vision Service Plan (VSP):	□Yes □No If yes, r	prior authorization is required		
If minor, parent/guardian Do you have vision benefits Policy Holder's Legal Name:	through Vision Service Plan (VSP):	□Yes □No If yes, p	orior authorization is required		
If minor, parent/guardian Do you have vision benefits Policy Holder's Legal Name:	full name: through Vision Service Plan (VSP):	□Yes □No If yes, p	orior authorization is required		
If minor, parent/guardian Do you have vision benefits Policy Holder's Legal Name: Policy Holder's SSN#/Unique ID: _	through Vision Service Plan (VSP): Police	□Yes □No If yes, p	orior authorization is required		
If minor, parent/guardian Do you have vision benefits Policy Holder's Legal Name: Policy Holder's SSN#/Unique ID: Primary Major Medical Insurance	through Vision Service Plan (VSP): Police:	□Yes □No If yes, p	orior authorization is required		
If minor, parent/guardian Do you have vision benefits Policy Holder's Legal Name: Policy Holder's SSN#/Unique ID: Primary Major Medical Insurance Insurance Company: Insurance ID#:	through Vision Service Plan (VSP): Police: Insurance Gro	□Yes □No If yes, p Policy Holder's Empl cy Holder's Date Of Bi oup#:	orior authorization is required loyer: irth:		
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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 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.

Print Patient's Name: ______ Patient's Date of Birth: ______

SIGNATURE: ______

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

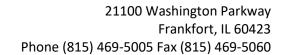


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Personal Eye Information

Patient's Name:			Patient	t's Date	of Birth	:	
Date of Last Eye Exam	:		Dilat	ted?	□ Yes	□ No	
Have you been diagnosed				ions?			
☐ Cataracts	☐ Glaucoma		☐ Macular deger	neration		☐ Retin	al detachment
☐ Severe Pain	☐ Poor distance	vision	☐ Poor Near Visi	on		☐ Blurre	ed vision
☐ Double Vision	☐ Eye Strain		☐ Floaters or Spo	ots		☐ Head	aches
\square Sensitive to Light	☐ Dry eyes		☐ Turned or lazy	eye		☐ Eyes	feel sandy/gritty
☐ Eyes burn/itch/water							
Have you had any eye ope	erations? □Yes □No	Type:				_ Wher	າ:
Have you had an eye injur	ry? □Yes □No	Describe	e:			Whei	n:
, 0	□Yes □No						
Do you wear Contact lense Additional information:							
Work/Tasks							
Typical work tasks:	☐ C omputer #of Hours		l Other				
Medical History							
Have you been diagnose	ed or do you suffer from	any of t	he following me	dical con	nditions?	? (<u>Pleas</u>	e check all that apply)
☐ Diabetes ☐ Type	I □Type II Date of Diag	nosis		A1C			☐ Diabetic Retinopathy
	☐ High Cholesterol		gic/Immunologic				☐ Constitutional
☐ Endocrine	☐ Gastrointestinal	☐ Genit	ourinary	☐ Ears/I	Nose/Thi	roat	☐ Hematologic/Lymphatic
☐ Integumentary (Skin)		□ Neur		☐ Psychi	iatric		☐ Respiratory
Please explain:							
Other health problems no	t listed above:						
Current medication(s):							
Allergies to medication	□Yes □No Which?		Rea	ctions? _			
Have you had any operation							
Family History (Please	check yes or no)						
☐ Cataracts	☐ Glaucoma	☐ Macu	llar degeneration	☐ Retina	al Detach	ment	☐ Diabetes
☐ Hypertension	☐ High Cholesterol	☐ Heart	Condition	☐ Cance	r		
Current family doctor a	ind/or primary care phy	sician:					
Name					Date	of last v	isit
			City,	. State, Zip	o		
Other health care speci				_)		
Name			City State	L 7in	bate of i	ast visit	
Address			City, State,	Zip			
Authorization I certify that I have read at accurately answered. I uncommended to release information during the period of such	derstand that providing incoming incoming the diagnosis a	correct in and the re	formation can be ecords of any treat	dangerou tment or e	s to my l	nealth. I	authorize Harrison Eye

SIGNATURE: _____ DATE: ____





Patient's Name:	Date of Bir	rth:
		th Act (HITECH) to attain Meaningful Use we
are required to capture demographic data in	ncluding your preferred language, race an	d ethnicity. This is an important part of your
medical history and will assist us during our		
Race (check one)	Ethnicity: (check one)	Preferred Language: (check one)
□ White	□ Not Hispanic or Latino	☐ English
☐ Black or African American	☐ Hispanic or Latino	☐ Spanish
☐ Hispanic	☐ Native Hawaiian/Other Pacific Islande	•
☐ Asian	☐ Decline To Specify	☐ French
☐ American Indian or Alaskan Native	_ became to speemy	☐ Decline To Specify
☐ Native Hawaiian/Other Pacific Islander		in became to specify
☐ Decline To Specify		
Acknowledgement of Privacy P	Practices and Privacy Options	
I understand that under the Health Insurance	ce Portability and Accountability Act (HIPA	A), I have certain rights to privacy regarding my
protected health information. I acknowledg	e that I received or have been given the o	pportunity to receive a copy of Harrison Eye
		ht 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 Pr	actices.
	5 0 / 11 (5	(2)
- •	on Eye Care's Notice of Privacy Practic	-
(The Harrison Ey	ye Care Privacy Policy is available for revi	ew on our <u>website</u> .)
If patient is a minor or unable to complete, ☐ Patient is a minor: years of age ☐ Patient is unable to complete/sign becau		
Release of Information (Must Select Yes or	No):	
	formation including the diagnosis, records	s; spectacle and/or contact lens prescriptions; ased to:
Name	Relationship to Pati	ent
Name	Relationship to Pati	ent
Name	Relationship to Pati	ent
\square No, Information is not to be rele	eased to anyone.	
This Delegas of Information will remain in a	ffeet wat he was in the device of the constitution of the	
made based upon my original permission ca		nderstand that uses and disclosures already
	illiot be takeli back.	
Messages Please call: ☐ My Home ☐ My Cell ☐ E-m	ail	
If unable to reach me:		
☐ You may leave a detailed messa	ge.	
☐ Please leave a message asking n	_	
 		
SIGNATURE:	DATE:	