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PATIENT INFORMATION

NAME: (Last)_____ (First)_____ (MI)____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____ M____ F____

MAILING ADDRESS: _____

CITY: _____STATE: _____ ZIP: _____

MARITAL STATUS *(CIRCLE ONE)*: SINGLE MARRIED WIDOWED DIVORCED OTHER

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

EMAIL ADDRESS: _____

REFERRAL INFORMATION

REFERRING OPTOMETRIST: _____ PHONE NUMBER: _____

PRIMARY CARE PHYSICIAN: _____ PHONE NUMBER: _____

PARENT OR GUARDIAN INFORMATION

NAME: (Last)_____ (First)_____ (MI)____

DATE OF BIRTH:_____ SOCIAL SECURITY #:_____ M____ F____

VISION INSURANCE INFORMATION

VISION INSURANCE: _____ INSURANCE ID #: _____

POLICY HOLDER: _____ POLICY HOLDER SSN #: _____

POLICY HOLDER DATE OF BIRTH: _____ RELATIONSHIP TO PATIENT:_____

PHARMACY INFORMATION

PHARMACY NAME: _____ PHONE NUMBER: _____

INSURANCE AUTHORIZATION / PAYMENT POLICY

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. The patient is responsible for all fees, regardless of insurance coverage. If your insurances do not pay after 90 days, we will bill the patient for the remaining balance.

PATIENT SIGNATURE:_____ DATE: _____

MEDICAL AUTHORIZATION INFORMATION

So that we may submit an insurance claim for services covered under your policy, we must have your authorization to release medical information to your carrier:

COMMERCIAL INSURANCE:

I hereby authorize release of any and all information necessary to file a claim with my insurance company and assign benefits otherwise payable to me, to the doctor indicated on the claim. I understand that I am financially responsible for the payment of any amount not covered by my insurance carrier. A copy of this signature is as valid as the original.

PATIENT SIGNATURE: _____ DATE: _____

MEDICARE:

I request that payment of authorized Medicare benefits to be made on my behalf to the doctor indicated on the claim for any services furnished by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, including supplemental insurance agents, any information needed to determine these benefits of benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 form is completed, my signature authorized release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and any non-covered service. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

I understand that an eye refraction is a non-covered Medicare charge, and therefore I am responsible for the payment of this charge.

I understand that all physicians at Huffman & Huffman, P.S.C. are committed to safeguarding patient privacy and that a full disclosure of their privacy practices is available to me.

I hereby authorize Medicare to furnish to the above named doctors any information regarding my Medicare claims under Title XVIII of the Social Security Act.

PATIENT SIGNATURE: _____ DATE: _____

Medical History Questionnaire

Name: _____ Today's Date ___ /___ / ___ Last Eye Exam ___ / ___ / ___

Birth Date: ___ / ___ / _____ Name of Medical Doctor _____ Pharmacy _____

Medical History

Do you have any food or drug allergies? ___ No ___Yes If yes, explain:_____
_____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies): _____
_____
_____
_____

List all major injuries and surgeries you have had: _____
_____

List any eye conditions or diseases that you have or have had in the past such as: crossed eyes, lazy eye, drooping eyelids, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury? _____

Are you pregnant and/or nursing? ___ No ___Yes
Do you wear glasses? ___ No ___ Yes
Do you wear contact lenses? ___ No ___ Yes If yes, how old is your current pair of lenses? _____
Type of contact lenses?___ Rigid ___ Soft ___ Extended Wear ___ Other Are they comfortable? ___Yes___No

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

Disease / Condition	No	Yes	Relationship to you	Disease / Condition	No	Yes	Relationship to you
Blindness	___	___	_____	Diabetes	___	___	_____
Cataracts	___	___	_____	Heart Disease	___	___	_____
Crossed Eyes	___	___	_____	High Blood Pressure	___	___	_____
Glaucoma	___	___	_____	Kidney Disease	___	___	_____
Retina / Macula	___	___	_____	Lupus	___	___	_____
Cancer	___	___	_____	Thyroid Disease	___	___	_____

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

___ Yes, I would prefer to discuss my Social History information directly with my doctor.

Do you drive? ___ No ___ Yes
Do you use tobacco? ___ Never ___ Former Smoker ___ Current Smoker
Do you drink alcohol? ___ Never ___ Rarely ___ Occasionally ___ Frequently ___Daily

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor; if you prefer:

Have you been having any of the following problems with the problems with your eyes?

___ Loss of Vision/Side Vision
___ Blurred Vision
___ Distorted Vision/Halos
___ Double Vision
___ Dryness
___ Mucous Discharge
___ Redness
___ Itching
___ Burning
___ Foreign Body Sensation
___ Excessive Tearing/Watering
___ Glare/Light Sensitivity
___ Eye Pain or Soreness
___ Bumps on Lids
___ Flashes/Floaters in Vision
___ Tired Eyes

Are you being treated for any of the following health problems?

___ High Blood Pressure
___ Heart Disease
___ Thyroid Disease
___ Graves Disease
___ High Cholesterol
___ Diabetes
___ Arthritis

Review of Systems

Do you currently have any of the following problems?

Cardiovascular
___ Chest Pain
___ Irregular Heartbeat
___ Shortness of Breath

Ear, Nose & Throat
___ Dizziness
___ Hearing Loss
___ Hoarseness
___ Ringing in Ears
___ Sore Throat

Musculoskeletal
___ Back Pain
___ Joint Pain
___ Muscle Aches
___ Stiffness
___ Swelling

Respiratory
___ Cough
___ Trouble Breathing
___ Wheezing

Constitutional
___ Fatigue
___ Fever
___ Night Sweats
___ Weakness
___ Weight Loss

Hematologic
___ Bleeding
___ Bruising
___ Tender Nodes

Neurological
___ Balance Problems
___ Headache
___ Numbness
___ Tingling

Skin
___ Hair Loss
___ Rash
___ Skin Lesions

Genitourinary
___ Genital Discharge
___ Genital Lesions
___ Painful Urination
___ Urgency

Metabolic
___ Cold Intolerance
___ Excess Hunger
___ Excessive Thirst
___ Frequent Urination
___ Heat Intolerance

Psychiatric
___ Anxiety
___ Depression
___ Insomnia
___ Irritability
___ Nervousness

Allergy
___ Itching
___ Hives
___ Runny Nose
___ Seasonal

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you may get access to this information. ***PLEASE READ IT CAREFULLY.***

Dr James Huffman, Dr Mark Huffman, Dr Sarah Huffman, Dr Amy Henson, Dr Hannah Huffman, Dr Matt Magee and Dr Holly Pendel are dedicated to protecting your medical information. We are required by law to maintain the privacy of protected health information and to provide you with this notice of our legal duties and privacy practices with respect to protected health information.

How your medical information will be used and disclosed:

We will use your medical information as part of rendering patient care. For example, your medical information may be used by the doctor treating you, by the business office to process your payment for the services rendered, by our collection agent, and by administrative personnel reviewing the quality of care you receive. We may also use and/or disclose your information in accordance with federal and state laws for the follow purposes:

- Disclosure to Department of Health and Human Services
- Law Enforcement
- Coroners, Medical Examiners and Funeral Directors
- Public Safety
- Business Associates
- School for confirming child was present for a visit
- Interpreters
- Persons involved in your care
- Notification to a family member or person of your choice
- Appointment recall cards and letters
- As required by law

Patient Rights:

- Access to your medical record
- Restrictions about uses and disclosures
- Right to receive an accounting of disclosures made after 04/14/2003
- Request a copy of this notice
- Right to complain to us and/or the Department of Health and Human Services

A more detailed description of our privacy practices is available upon request. If you would like further information regarding your rights, you may contact Loretta Huffman at (606)877-1877 or Jan Schantz at (606)679-7461.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Notice of Privacy Practices for this office

PATIENT SIGNATURE: _____ DATE: _____

Authorization for Release of Information to Family Members

Patient Name: _____

Patient Date of Birth: _____

Under the requirements of HIPPA, we are not allowed to release medical and billing information to anyone without the patient's consent. If you wish to have your information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Huffman & Huffman, PSC to release my medical and/or billing information to the following individual(s):

1. Name:_____

   Relation: _____

2. Name:_____

   Relation: _____

3. Name:_____

   Relation: _____

I understand that I have the right to revoke this authorization at any time in writing. I understand that the revocation will not apply to information that has already been released prior to the revocation.

Signature: _____ Date: _____

REFRACTION WAIVER NOTICE

Your medical insurance (Medicare or Private) does not pay for all health care costs. Your insurance company only pays for "covered benefits". Some items and services are not considered benefits and will not be paid.
When you receive an item or service that is not an insurance benefit, you are responsible to pay for it.

Medicare and most private insurance companies **WILL NOT PAY** for:

- **Refraction** (Measurements to determine the prescription for eyeglasses) Out of pocket cost is $20.00

The purpose of this notice is to help you make an informed decision about whether or not you want to receive this service.
Before you make a decision about your options, you should read this entire notice carefully.
The Medicare benefits guide specifically excludes this service and majority of private insurance companies follow this position.

_____ YES, I elect to receive these services. I understand the above statements and I understand that payment is due at the time of service.

_____ NO, I defer these services and understand that I will not be able to have a glasses prescription given to me, unless I resign this form electing to receive services.

_____ _____

Patient Signature Date

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I hereby acknowledge that I, the patient, am responsible to provide the Check In Staff with my correct Insurance information as well as notifying the Check Out Staff which Insurance I wish for them to bill.

If I choose to bill my vision insurance, I understand that if a medical condition is found, it will be necessary for me to return on another day for evaluation and treatment. I understand that this means NO medical services will be rendered at the time of a vision exam, including any prescriptions for ANY medications.

If medical treatment is necessary on the day of the original visit, I understand that my medical insurance WILL be billed today.

I also understand that when my medical insurance is billed that any refraction charge that may be charged that day will become my responsibility.

Huffman & Huffman, P.S.C. can <u>NOT</u> bill a vision and medical insurance for the same visit.

_____ _____

Patient Signature Date