Date: _____ Chart #_____

Welcome to Harrisburg Eye Clinic!

So that we can effectively meet your needs, please complete all the information below.

Patient Information

Name: _____
First Middle Last

Date of Birth (mm/dd/yyyy): _____/_____/_____ Soc Sec#: _____

Address: _____
Street City State Zip

Home Phone: _____ Work Phone: _____ Cell Phone:_____

Marital Status (Circle One): Single Married Divorced Widowed Separated

Employer/Address: _____ Phone: _____

Email Address:_____
(In the future, may we confidentially communicate with you through this email address? Yes No

Parent/Guardian Information (if patient is a MINOR)

Parent/Guardian's Name: _____
First Middle Last

Date of Birth(mm/dd/yyyy): _____/_____/_____ Soc Sec#: _____ Relationship to patient:_____

Address: _____
Street City State Zip

Home Phone: _____ Work Phone: _____ Cell Phone:_____

Employer: _____

Emergency Contact

Contact Person: _____
First Middle Last

Home Phone: _____ Work Phone:_____ Cell Phone:_____

How did you learn about Harrisburg Eye Clinic?

Physician _____ _____
Name

Patient _____ _____
Street City State Zip

Other _____ _____
Phone number

Harrisburg Eye Clinic

Notice of Payment Policies and Procedures

Payment Policy: It is customary to pay for professional services when rendered. For your convenience, we accept major credit cards, checks or cash.

Insurance: Please read and sign below if you have insurance with: Medicare, Medicaid, an HMO/PPO/POS or State Agency or Worker's Comp, and the Physician are contracted with your carrier. Present your insurance card along with any required referrals/authorizations to the Receptionist/Registrar.

Medical/ Surgical Benefits Assignment and Release of Medical Benefits Information Agreement: I request payment of my authorized insurance benefits be made for charges on my behalf to Harrisburg Eye Clinic for any unpaid medical/surgical procedures performed now or in the future. I also authorize Harrisburg Eye Clinic to release medical information to my insurance company (ies) or agent, now or in the future, for claim consideration purposes. I understand that payment for services does ultimately remain my responsibility.

Non-Covered Services: The filing of a claim for any service rendered DOES NOT GUARANTEE PAYMENT from your insurance company. You will be financially responsible for these services. Also, having more than one insurer DOES NOT necessarily mean that your services are covered 100%. Secondary insurers will pay as a function of what your primary carries pays. We may bill your secondary as a courtesy. You are responsible for any balances after your insurance(s) have cleared.

Divorced Decrees: This office is NOT a party to your divorce decree; adult patients are responsible for their bill at the time of service. The responsibility for minor's rests with the accompanying adult.

Minor Patients: For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved Credit Card, or payment by cash or check at the time of service has been verified.

Eye Exam: I agree to and understand that my eye(s) must be dilated in order for the doctor to thoroughly check the retina of the eye. I agree to and understand that my eye may need to be patched as part of the treatment of my condition. I understand that if my pupils are dilated or my eye is patched after the exam, I may not be able to sagely operate a motor vehicle and that the staff and doctors of Harrisburg Eye Clinic suggest that I evaluate my need for alternative transportation and the decision is solely mine, therefore I will not hold Harrisburg Eye Clinic responsible.

The contents of this document will remain in effect unless revoked by me in writing.

_____	_____
Name if Patient (Print)	Name of Witness (Print)
_____	_____
Signature of Patient	Signature of Witness
_____	_____
Date	Date

_____

Signature of Patient Representative/ Relationship

Date: _____ Chart #_____

Harrisburg Eye Clinic

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

1. **How we may use and disclose your health information**. We use health information about you for treatment, to get paid for treatment, for administrative purposes, and to evaluate the quality of care that you receive. For example, your health information may be shared with other providers to whom you are referred. Information may be shared by paper, mail, electronic mail, fax, or other methods. We may use or disclose your health information without your authorization for several reasons. If you sign an authorization to disclose information, you a can later revoke it to stop any future disclosures.

2. **Your rights**. In most cases, you have the right to look at or get a copy of your health information that we use to make decisions about you. You may request that we limit disclosure to family members, other relatives, caregivers, or close personal friends who may or may not be involved in your care. If you request a list of certain types of disclosures of your information that we have made. If you believe that your health information is incorrect or information is missing, you have the right to request that we correct the existing information or add the missing information.

3. **Our Legal Duty**. We are required by law to protect the privacy of your health information, provide this notice about our privacy practices, follow the privacy practice that are described in this notice, and seek your acknowledgement of receipt of this notice. We may change our privacy policies at any time. Before we make a significant change in our policies, we will change our notice. The notice will be prominently displayed at our office. You can also request a copy of our notice at any time.

4. **Privacy Complaints**. If you are concerned that we have violated your privacy rights, our privacy policies, or if you disagree with a decision we made about access to your health information, you may contact our privacy officer, you may send a written complaint to the U.S Department of Health and Human Services. Our privacy office can provide you with the appropriate address upon request.

If you have any questions or complaints please contact: Leonora San Miguel, Privacy Officer, 7438 Harrisburg Blvd, Houston, Texas 77011 (713) 928- 3375

Acknowledgment of receipt of Notice of Privacy Practices. Please sign and print your name and provide the date below to acknowledge that you have received the Notice of Privacy Practices.

Signature: _____

Printed Name: _____ Date: _____

Harrisburg Eye Clinic

Refraction Policy

During your visit, refraction (prescription for glasses) may be performed to determine your need for glasses or to evaluate if any further visual improvement can be achieved. This is necessary and essential portion of your eye exam and in some cases, it is the sole reason for the appointment.

The Center for Medicare and Medicaid Services (CMS) use a system – The Resource Based Relative Vale Scale (RBRVS) – to determine the fees for all Medicare Services, including the refraction. Most other insurance companies use this same system to set their payment schedules. However, the refraction is considered a NON-COVERED service by Medicare and some insurance companies.

Please be aware it is the responsibility of the patient to pay for the refraction. Effective January 16, 2012, our office charges 98$ for the procedure, but it provides a prompt pay price of $35.00 to the patient when paid at the time of service. The refraction fee, based on the RBRVS is in addition to the fee for the eye exam and is in addition to the patients' co-payment.

I have read the above information and understand I may be charged a prompt pay price of $35.00 at the time of service. If billing is required, the full charge of $98.00.

Contact Lens Policy

The glasses prescription you receive from Harrisburg Eye Clinic is NOT a contact lens prescription. A qualified contact lens fitter must fit the contact lenses. Our Optical Department or one of your choice may fit the contact lenses. There is a fee for this service, which varies greatly depending on the type of contact lenses that are right for you, if you have been fitted before, and other individual factors. After your contact lens specification and services are paid for you will receive a copy of your contact lens specification.

I have read and understood the above refraction and contact lens policy.

_____ _____

Patient or Guardian's Signature Date

Date: _____ Chart #_____

Harrisburg Eye Clinic

Patient History Record

Medical History: Please answer the following questions (Circle YES or NO; if YES please explain)

1. Have you ever had any eye disease (e.g. glaucoma, cataract, retinal detachment, "lazy" eye, etc.)?
   YES NO
   _____

2. Have you ever had an EYE surgery (including injections or lasers)?
   YES NO
   _____

3. Have you ever had any OTHER surgeries?
   YES NO
   _____

4. Have you ever been treated for any medical conditions (e.g. diabetes, high blood pressure, arthritis, infections, cholesterol, thyroid, asthma, etc.)?
   YES NO
   _____

5. Have you ever been hospitalized?
   YES NO
   _____

6. Do you use any EYE medication?
   YES NO
   _____

7. Do you take any OTHER medications?
   YES NO
   _____

   _____

8. Do you have any drug or food allergies or sensitivities?
   YES NO
   _____

Family History:

Do any medical or eye diseases run in your family? (Diabetes, high blood pressure, cancer, glaucoma, macular degeneration)?
YES NO
_____

Social History:

Do you smoke? YES NO If YES, how much? _____
Do you drink alcohol? YES NO If YES, how much? _____
What is your occupation? _____

Review of Systems: Do you currently have any of the following problems? (Circle YES or NO; if YES please explain)

1. Chronic fever, unexpected weight loss/ gain, fatigue, night sweats?
   YES NO
   _____

2. Skin problems (e.g. rashes, excessive dryness, etc.)?
   YES NO
   _____

3. Ear/nose/throat problems (e.g. hearing loss, sinus problems, sore throat, etc.)?
   YES NO
   _____

4. Respiratory problems (e.g. shortness of breath, wheezing, coughing, etc.)?
   YES NO
   _____

5. Heart problems (e.g. chest pain, irregular heart-beat, etc.)?
   YES NO
   _____

6. Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea, vomiting)?
   YES NO
   _____

7. Urinary problems (e.g. pain or discomfort, blood in urine)?
   YES NO
   _____

8. Musculoskeletal problems (e.g. Muscle aches, joint pain, diarrhea, vomiting.)?
   YES NO
   _____

9. Neurological problems (e.g. numbness, weakness, headaches, dizziness, etc.,)?
   YES NO
   _____

10. Bleeding or bruising problems?
    YES NO
    _____

11. Psychiatric problems (e.g. depression anxiety, ADHD, ADD, etc.)?
    YES NO
    _____

12. Other?
    _____

I verify that the information provided is complete and accurate.

Patient Signature: _____ Date: _____

Date: _____ Chart #_____

Harrisburg Eye Clinic

Consent Form

I give permission for the following people to have access to my protected health information. I understand that this consent can be revoked at any time, except to the extent that disclosure made in good faith has already occurred in reliance on this consent. The revocation must be in writing and delivered to Harrisburg Eye Clinic.

Family Members:

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

Others (Friends, Caregivers, etc):

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

_____	_____
Patient Signature	Date