Welcome to Hathy Vision Center

Patient Information

Date: _______________

Last Name_____________________ First Name____________________ Nickname___________ MI______

Address: Street__________________________ City________________ State________ Zip___________

Home Phone_________________ Day Phone____________________ Work Phone__________________

Sex: *M F* Social Security#__________________ Marital Status_______ Date of Birth___________

Personal E-mail______________________ Relationship to responsible party___ spouse child other

Employer/School____ Full time Part time Retired

Emergency Contact________________________ Emergency Contact Phone #______________________

Guarantor's (Responsible Party) Information *(if not patient)*

Last Name__________________________ First Name_____________________________ MI__________

Address: Street_______________________ City__________________ State_______ Zip_____________

Home Phone_________________ Day Phone____________________ Work Phone__________________

Date of Birth___________ Sex: *M F* Social Security#__________________ Marital Status_______

Employer____ Full time Part time Retired

PLEASE PROVIDE ALL OF YOUR INSURANCE CARDS AND DRIVER'S LICENSE AT CHECK-IN

1. Primary Major Medical Insurance: If your visit requires medical advice, medical diagnosis, or medical treatment of a current problem, or if you have a pre-existing eye condition, we will bill your medical insurance. You will be responsible for payment according to your insurance. ________ Initial

Name of Plan_________________________________ Patient's Relationship to Insured: self_____ spouse_____ child_____ other____

Insured's Last Name_______________________________ First Name_____________________________ Middle Initial_______________

Insured's Date of Birth__________________ Insured's SS#____________________________ Insured's Employer___________________

2. Secondary Medical Insurance:

Name of Plan_________________________________ Patient's Relationship to Insured: self_____ spouse_____ child_____ other____

Insured's Last Name_______________________________ First Name_____________________________ Middle Initial_______________

Insured's Date of Birth__________________ Insured's SS#____________________________ Insured's Employer___________________

3. Vision Insurance: If your visit is for glasses or contacts, and not for medical advice, we will bill your vision plan. You will be responsible for payment according to your vision plan contract. __________ Initial

Name of Plan_________________________________ Patient's Relationship to Insured: self_____ spouse_____ child_____ other____

Insured's Last Name_______________________________ First Name_____________________________ Middle Initial_______________

Insured's Date of Birth__________________ Insured's SS#____________________________ Insured's Employer___________________

Whom may we thank for referring you to our office? ____

PAYMENT/FINANCIAL POLICY

INSURANCE

If you are covered by Medicare, Tricare, or any of our managed care plans, we will file your insurance claim. If we do not accept your insurance plan, payment in full is expected on the day services rendered.

PROOF OF INSURANCE

You are responsible for giving correct, complete, and current vision-plan and medical-plan information to Hathy Vision Center prior to the day the services are rendered. You must have your most current card and a photo ID at the time of the visit or the visit will be self-pay. If your claim is rejected or denied because you have failed to provide complete and correct information, the balance becomes your immediate responsibility. If you have more than one plan, you must give us each plan's information so that we can file the claims according to the "Coordination of Benefits" rules and regulations.

CLAIMS SUBMISSION

Hathy Vision Center will allow your insurance company(s) 30 days (time allowed by the insurance commissioner in the state of Florida) to pay or deny your claim. When requested, you must agree to provide any necessary information to your insurance company in order to process the claim.

CO-PAYMENTS, DEDUCTIBLES, and NON-COVERED SERVICES

You are responsible for any co-payments and deductibles on the day services are rendered. Any services that are not covered by your insurance plan, including Medicare, will be your responsibility on the day services are rendered. (For example a $40 refraction, which is the examination of your eyes for glasses, is usually a non-covered service by medical insurance and Medicare.)

The monies collected today are only an estimate of your share. You may owe additional monies to Hathy Vision Center after the insurance company issues its Explanation of Benefits. Please remember that ultimately, payment responsibility rests with the patient.

AUTHORIZATION

- I have read this Payment/Financial Policy in its entirely and agree to abide by every section in the policy for today's goods and services and for all FUTURE goods and services.
- I authorize the release if any medical information or other information necessary to process this claim.
- I authorize direct payment of benefits from the insurance company to Hathy Vision Center.
- I permit a copy of this authorization to be used in place of the original.
- I authorize Hathy Vision Center to release or discuss my private medical information to:

____

(no one, spouse, parent, other)

____

Printed Name

____

Signature and Date

MEDICAL HISTORY QUESTIONNAIRE

NAME:____ DATE:__________________

Last Eye Exam:__________ Eye Doctor:__________ Last Medical Exam:___________ Doctor:_________

REVIEW OF SYSTEMS: CHECK ALL THAT CURRENTLY APPLY TO YOU:

EYES

- □ Loss of Vision
- □ Blurred Vision
- □ Distorted vision/halos
- □ Loss of side vision
- □ Double vision
- □ Dryness
- □ Mucous discharge
- □ Redness
- □ Sandy or gritty feeling
- □ Itching/burning
- □ Foreign body sensation
- □ Excessive tearing/watering
- □ Glare/light sensitivity
- □ Eye pain/soreness
- □ Chronic Infection of eye/lids
- □ Sties
- □ Flashes/floaters in vision
- □ Tired eyes
- □ I have had eye surgery before
  Kind_______________

EARS/NOSE/THROAT

- □ Allergy/Hay Fever
- □ Sinus Congestion
- □ Chronic Cough
- □ Dry Throat/Mouth
- □ Runny Nose

HEMATOLOGIC/LYMPHATIC

- □ Anemia
- □ Bleeding Problems

ENDOCRINE

- □ Thyroid/other glands

BONES/JOINTS/MUSCLES

- □ Rheumatoid arthritis
- □ Muscle Pain
- □ Joint Pain

ALLERGIES: (please list)

____
____
____
____
____

RESPIRATORY

- □ Asthma
- □ Chronic breathing disorder
- □ Emphysema

VASCULAR/CARDIO

- □ Diabetes
- □ Heart disease
- □ High blood pressure
- □ Vascular disease
- □ Stroke
- □ High cholesterol

GASTROINTESTINAL

- □ Diarrhea, prolonged
- □ Constipation

GENITOURINARY

- □ Genital disease
- □ Kidney
- □ Bladder

PSYCHIATRIC

- □ Any Disorder: (please list)

____

YOUR MEDICAL HISTORY:

List medications you are allergic to:

____

List all medications you take (or provide a copy of your medication list):

____

List all eye drops you use (prescription and over-the-counter):_________________________________

Are you currently under a doctor's care? Yes No (Reason)_____________________________________

Are you pregnant or nursing? Yes No

Do you wear glasses? Yes No

Do you wear contacts? Yes No

If yes, do you sleep in your contacts? Yes No

Would you like a change in your eye color? Yes No

Are you interested in LASER correction? Yes No

Do you have difficulty when driving? Yes No

Do you use tobacco products? Yes No

Do you drink more than 2 alcohol containing beverages per day? Yes No

Do you use street drugs or drugs prescribed to someone else? Yes No

FAMILY HISTORY: Check medical conditions that relatives have and indicate their relationship to you

- □ Glaucoma
- □ Lazy eye
- □ Blindness
- □ Crossed eye
- □ Retinal detachment
- □ Other eye disease
- □ Cataracts
- □ Macular degeneration
- □ Arthritis
- □ Heart disease
- □ Lupus
- □ Other medical conditions
- □ Cancer
- □ High blood pressure
- □ Thyroid disease
- □ Diabetes
- □ Kidney disease