**Welcome to Hathy Vision Center**

**Patient Information** Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI:\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May We Text this number? \_\_\_\_\_\_\_\_\_\_

Gender (please circle)*:* M / F Social Security#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent/Guardian (if applicable):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Race/Ethnicity: \_\_\_\_\_\_\_\_\_\_

Employer/School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Full time Part time Retired

Emergency Contact and #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to responsible party\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**1. Primary 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 Primary Memeber: self\_\_\_\_\_ spouse\_\_\_\_\_ child\_\_\_\_\_ other\_\_\_\_

(**If not patient**) Insured’s Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial\_\_\_\_

Insured’s Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Insured’s Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. 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\_\_\_\_

(**If not patient**) 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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICAL HISTORY QUESTIONNAIRE (page 1 of 2)**

PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OCULAR HISTORY**

Reason for today’s visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last eye exam (if elsewhere):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Previous Eye Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear glasses? Yes No If yes, what for: Full Time Distance Reading Other

Do you wear contact lenses? Yes No If yes, what brand:\_\_\_\_\_\_\_\_\_\_\_\_\_ What Solution:\_\_\_\_\_\_\_\_

How many days per week do you wear them? \_\_\_\_\_\_\_\_\_\_\_ How many hours per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you replace your contacts? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

From 1 to 10, how comfortable are they **when you first put them in?** 1 2 3 4 5 6 7 8 9 10

From 1 to 10, how comfortable are they  **before you take them out?** 1 2 3 4 5 6 7 8 9 10

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| VISION COMPLAINTS (please check) | YES | NO | UNSURE |  | YES | NO | UNSURE |
| Blurry Vision |  |  |  | Watery Eyes |  |  |  |
| Loss of Vision |  |  |  | Foreign Body Sensation |  |  |  |
| Double Vision |  |  |  | Eye pain/discomfort |  |  |  |
| Dryness |  |  |  | Flashes |  |  |  |
| Redness |  |  |  | Floaters |  |  |  |
| Mucous Discharge |  |  |  | Lazy eye/eye turn |  |  |  |
| Headaches |  |  |  | Glare/Light Sensitivity |  |  |  |
| Itchy Eye(s) |  |  |  | Sandy or Gritty Feeling |  |  |  |
| Sties |  |  |  | Eye Fatigue |  |  |  |

**If checked yes on above complaints, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please list any ocular medications or over-the-counter drops currently taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please describe any eye injuries or surgeries you have experienced:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Ocular History:**

(if checked yes please state relationship to patient)

* Cataracts \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Macular Degeneration \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Glaucoma \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Lazy Eye \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Blindness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Crossed Eye \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Retinal Detachment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other Eye Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Medical History:**

(if checked yes please state relationship to patient)

* High Blood Pressure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Heart Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Diabetes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Arthritis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Thyroid Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Lupus \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other Medical Conditions \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY QUESTIONNAIRE (page 2 of 2)**

**Check all that apply to you:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **CONSTITUTION** |  | **PSYCIATRIC** |  | **ALLERGIC/IMMUNOLOGIC** |  |
| Developmental Disabilities |  | ADD/ADHD |  | Seasonal Allergies |  |
| Cancer |  | Depression |  | Rheumatoid Arthritis |  |
| **EAR, NOSE, THROAT** |  | Anxiety |  | Lupus |  |
| Hearing Loss |  | Other: |  | **RESPIRATORY** |  |
| Dry throat/mouth |  | **CARDIOVASCULAR** |  | Asthma |  |
| Sinusitis |  | Hypertension |  | Chronic Breathing Disorder |  |
| Chronic Cough |  | Stroke |  | Sleep Apnea |  |
| **NEUROLOGICAL** |  | Heart Disease |  | **GASTROINTESTINAL** |  |
| Multiple Sclerosis |  | High Cholesterol |  | Chron’s Disease |  |
| Migraines |  | **ENDOCRINE** |  | Acid Reflux |  |
| Cerebral Palsy |  | Diabetes; Type: |  | Diarrhea (prolonged) |  |
| Tumor |  | Thyroid Disorder |  | **GENITOURINARY** |  |
| **MUSCULOSKELETAL** |  | **HEMATOLOGIC/LYMPHATIC** |  | Genital Disease |  |
| Osteoarthritis |  | Anemia |  | Kidney/Bladder |  |
| Muscle/Joint Pain |  | Bleeding Problems |  | Prostate Disorder |  |

**If you have any medical condition not listed, please describe:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Medications** (prescription and over-the-counter):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List any Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**List any MEDICATIONS you are Allergic to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SOCIAL HISTORY:**

Are you pregnant or nursing? \_\_\_\_\_\_\_\_\_ Do you currently smoke or use tobacco products? \_\_\_\_\_\_\_\_\_\_\_

Have you ever smoked? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If yes, how long ago did you quit?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol containing beverages? \_\_\_\_\_\_\_\_ If yes, how many daily? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use illegal or illicit drugs? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If yes, type and how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Blood Pressure Reading: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 $50 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

**SAMUEL HATHY III, 0.D.   
10400-6 San Jose Blvd.   
Jacksonville, FL 32257   
(904)880-1818**

**Notice of Privacy Practices Patient Acknowledgement**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in   
detail the uses and disclosures of my protected health information that may be made by this practice, my   
individual rights and the practice's legal duties with respect to my protected health information. This notice   
includes:

* A statement that this practice is required by law to maintain the privacy of protected health

information.

* A statement that this practice is required to abide by the terms of the notice currently in effect.
* Types of uses and disclosures that this practice is permitted to make for each of the following   
  purposes: treatment, payment, and health care operations.
* A description of each of the other purposes for which this practice is permitted or required to use or   
  disclose protected health information without my written consent or authorization.
* A description of uses and disclosures that are prohibited or materially limited by law.
* A description of other uses and disclosures that will be made only with my written authorization and   
  that I may revoke such authorization.
* My individual rights with respect to protected health information and a brief description of how I may   
  exercise these rights in relation to:
* The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights   
  have been violated, and that no retaliatory actions will be used against me in the event such as   
  a complaint.
* The right to request restrictions on certain uses and disclosures of my protected health

information, and that this practice is not required to agree to a requested restriction.

* The right to receive confidential communications of protected health information.
* The right to amend protected health information.
* The right to receive an accounting of disclosures of protected health information.
* The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon   
  request.
* This practice reserves the right to change the terms of its Notice of Privacy Practices and to

make new provisions effective for all protected health information that it maintains. I

understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient (if signed by a personal representative of patient): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_