Hoover Vision Center, P.C.

PATIENT INFORMATION

(Please Print)

Date: ____/____/____ New _____ Update _____

Last name _____ First name _____ Middle _____

Preferred name _____ Date of Birth ____/____/_____ Age _____ Sex: *M / F*

Social Security _____ - ___ - _____ Drivers License # _____ Marital Status: *S / M / W / D*

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Other Phone _____ Email _____

Preferred Contact: *Home Phone / Cell Phone / Work Phone / Email / Regular Mail*

Preferred Language: *English / Spanish /* _____ Ethnicity: *Hispanic/Latino // Not Hispanic/Latino*

Race: *American Indian or Alaskan Native / Asian / Black or African American*
Native Hawaiian or Pacific islander / White

Occupation _____ Status: *Employed / Retired / Unemployed / Disabled*

Employer _____ If Student: Grade _____ School _____

Who referred you to this office ? _____

Please list any family members who are patients of this office.

Name	Relation	Age

Emergency Contact _____ Phone _____ Relationship _____

Insurance Information

Primary *(medical)* _____ Policy # _____ Group # _____

Insured Name: _____ Insured DOB _____

Secondary *(medical)* _____ Policy # _____ Group # _____

Insured Name: _____ Insured DOB _____

Vision Plan _____ Policy # _____

Insured Name: _____ Insured DOB _____

Please have insurance cards and drivers license available for receptionist to copy

Please turn this form over and complete side two

Financial Information

Is patient responsible for bill? Yes / No If not, complete the following information:

Guarantor: Last name _____ First name _____

DOB _____/_____/_____ Social Security # _____

Address _____

Home phone _____ Work Phone _____

Employer _____ Relationship _____

Note: Minors must be accompanied by an adult for examination and when picking up materials.

Collection Policy

Our doctors participate in a variety of insurance plans. As a courtesy to our patients, we will be happy to file most claims. You will be expected to pay your co-pay, deductible, and any non-covered service at each visit. For example, refractions, which are a necessary component of an eye exam, are not covered by Medicare. *If your insurance requires a referral, it is your responsibility to contact your primary care physician and obtain the referral number and any other necessary information*. If you have any questions about your insurance or account, please feel free to contact our insurance and billing coordinator.

I authorize the release of any medical information necessary to process a claim on any insurance policy listed above. I hereby assign to and authorize payment directly to Hoover Vision Center. P. C. for all benefits payable under such insurance policy. I realize that the insurance benefits may not pay all of the bill, and I agree to pay the difference or the entire bill if necessary. In the event of default in the payment of my charges, I agree to pay all cost of collection, including a reasonable attorney's fee, should the account be referred to an attorney for collection. I further agree to waive my rights of exemption as to personal property.

I understand that a finance charge of 1.5% per month shall be added to all balances over 30 days.

I have read the above policies and agree as indicated by my signature.

_____ _____

Patient or Responsible Party Signature **Date**

Medical History Questionnaire

(Please Print)

Name: _____ Date: ____/____/_____ Date of Birth: ____/____/_____

Last medical exam: ____/____/_____ Medical Doctor (name,location):_____

Last eye exam: ____/____/_____ Last Eye Care Provider:_____

Pharmacy (name, location, phone):_____

Past Eye History

Have you ever had any eye injuries? ☐ No ☐ Yes: (list)_____

Have you ever had any eye surgeries? ☐ No ☐ Yes (list)_____

List any eye drops you use :_____

Do you wear glasses? ☐No ☐Yes / How old is you present pair of lenses?_____

Do you wear contact lenses? ☐No ☐Yes / How old is your present pair of lenses?_____

Type of contact lenses: ☐Rigid ☐Soft Wearing Schedule: ☐Remove daily ☐Sleep in lenses

How often do you throw away your lenses? _____ Are your lenses comfortable? _____

Do you have or ever had any of the following eye conditions or diseases? Please check all that apply.

☐ Cataracts ☐ Glaucoma ☐ Macular Degeneration ☐ Retinal Detachment/ Disease ☐Dry Eyes ☐ Eye Infections

☐Loss of Vision/Side Vision ☐ Itchy Eyes ☐Double Vision ☐Blurred Vision ☐Flashes/Floaters ☐ Crossed Eyes

☐Lazy Eyes ☐Drooping Eyelid ☐Other _____

Past Medical History

List all medications:_____

_____

_____

Allergies: ☐None ☐ Yes(list)_____

List all major injuries, surgeries and / or hospitalizations you have had: _____

_____

Are you pregnant ? ☐No ☐Yes / Weeks _____ Are you Nursing? ☐No ☐Yes

Do you have any medical conditions? Please check all that apply. ☐Diabetes ☐ High Blood Pressure ☐Heart Disease ☐High Cholesterol ☐Thyroid Disorder ☐Autoimmune Disease (name:_____) Please list any additional medical conditions._____

_____

Family History: (Check all that apply to your blood relatives)

☐Blindness ☐Glaucoma ☐Macular Degeneration ☐Cataracts ☐Lazy Eye ☐ Retinal Disease/Detachment ☐Diabetes ☐Heart Disease ☐Stroke ☐ High Blood Pressure ☐Arthritis ☐Kidney Disease ☐Thyroid Disorder ☐Autoimmune ☐Other _____

Social History

Smoking Status: ☐ Current every day smoker ☐Current some day smoker ☐Former Smoker ☐Never smoked

☐Smoker, current status unknown ☐ Unknown if ever smoked

If smoker: How much?_____ How long? _____ When quit? _____

Alcohol Use: ☐None ☐ Occasional drinker ☐Everyday drinker Type_____ How long?_____

Drugs: ☐No ☐Yes: type/amount/how long: _____

Check if you have ever been exposed to or infected with: ☐ Gonorrhea ☐ Syphilis ☐ HIV ☐Hepatitis

OVER

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

Constitution		***Cardiovascular***		***Endocrine***	
Fatique/ Weakness	☐ Yes ☐ No	Heart attack	☐ Yes ☐ No	Thyroid (low)	☐ Yes ☐ No
Fever	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Thyroid (high)	☐ Yes ☐ No
Weight gain/loss	☐ Yes ☐ No	Stroke	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Jaw pain when chewing	☐ Yes ☐ No	High blood pressure	☐ Yes ☐ No	Pituitary Disorder	☐ Yes ☐ No
Scalp Tenderness	☐ Yes ☐ No	Irregular heart beat	☐ Yes ☐ No		
		Pacemaker/Defibulator	☐ Yes ☐ No	***Psychiatric***	
Skin		Vascular disease	☐ Yes ☐ No	Anxiety	☐ Yes ☐ No
Rashes/Sores	☐ Yes ☐ No	***Gastrointestinal***		Depression	☐ Yes ☐ No
Rosacea	☐ Yes ☐ No	Esophageal Reflux	☐ Yes ☐ No	Bipolar	☐ Yes ☐ No
Hives/Eczema	☐ Yes ☐ No	Digestive Disorder	☐ Yes ☐ No	Schizophrenia	☐ Yes ☐ No
Neurological		Ulcer	☐ Yes ☐ No	Difficulty Sleeping	☐ Yes ☐ No
Headaches/Migraines	☐ Yes ☐ No	Cirrhosis	☐ Yes ☐ No	***Immunologic***	
Seizures	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Allergies	☐ Yes ☐ No
Multiple Sclerosis	☐ Yes ☐ No	***Genitourinary***		Hay Fever	☐ Yes ☐ No
Numbness	☐ Yes ☐ No	Kidney Stones	☐ Yes ☐ No	Lupus	☐ Yes ☐ No
Tremors	☐ Yes ☐ No	Urinary Disorder	☐ Yes ☐ No	Sarcoidosis	☐ Yes ☐ No
Eyes		History of STD's	☐ Yes ☐ No	Sjogrens	☐ Yes ☐ No
Other not previous listed	☐ Yes ☐ No	***MusculoSkeletal***			
_____		Rheumatoid Arthritis	☐ Yes ☐ No		
Ear, Nose and Throat		Osteoarthritis	☐ Yes ☐ No		
Hard of Hearing	☐ Yes ☐ No	Myasthenia Gravis	☐ Yes ☐ No		
Ringing in Ears	☐ Yes ☐ No	Fibromyalgia	☐ Yes ☐ No	***Other***	
Dizziness/Vertigo	☐ Yes ☐ No	***Lymphatic/Hematologic***		Cancer	☐ Yes ☐ No
Sinus Congestion/Pressure	☐ Yes ☐ No	Anemia	☐ Yes ☐ No	_____	
Respiratory		High Cholesterol	☐ Yes ☐ No	_____	
Asthma	☐ Yes ☐ No	Easy Bruising	☐ Yes ☐ No		
Chronic Bronchitis	☐ Yes ☐ No	Aspirin Use	☐ Yes ☐ No		
Emphysema	☐ Yes ☐ No				
Cough	☐ Yes ☐ No				
Congestion	☐ Yes ☐ No				
Sleep Apnea	☐ Yes ☐ No				

Explanations:

_____ _____

Patient/Guardian Signature Date

_____ _____

Doctor Signature Date Reviewed

REFRACTION FEES AND CO-PAYMENTS

A **refraction** is an important part of an eye examination. It is the test performed which determines your prescription. It also helps us monitor the health of your eye by determining your best possible visual acuity. This aids us in monitoring cataracts, macular degeneration and other disease and aging processes in your eye. Unfortunately, **Medicare** and other **medical insurances** such as **BlueCross and BlueShield do not pay** for this service. Medical plans deem refractions as "vision services" and therefore, do not cover or pay for the refraction. Our fee for refraction is $40.00 and is collected at the time of service in addition to any co-payments your plan may require. A refraction is performed at comprehensive annual exams, final cataract post-op visits when glasses are prescribed, when a change in visual acuity has occurred, or at your request.

Vision insurances, such as VSP and VCP, **do cover** the refraction. There may be times that an additional medical test is performed on the same day as a routine eye exam, such as fundus photography. Vision insurance plans do not cover for medical tests. This portion will be filed with your medical plan. When this occurs there is a co-payment that your medical insurance requires us to collect. It will be collected on the day of service in addition to co-payments required by your vision plan.

It is our intention to provide you with quality vision and ocular health exams. It must be said that not all services that are necessary for quality care are covered by every insurance plan. We strive to be certain that you receive the full benefit of your insurance plans. Please let us know ahead of your examination as to **all your current insurance benefits.** If for any reason we are paid by a medical plan for a refraction, or a co-payment was not required, we will reimburse you accordingly once we are notified. We thank you for choosing us for your eye care services.

PATIENT ACKNOWLEDGEMENT

I have read the above information and understand that a refraction is a non-covered service by medical plans. I also understand that a co-payment maybe required from both my vision plan and medical insurance if both must be billed for separate services performed on the same day. I accept full financial responsibility for refraction fees, co-payments, co-insurance and/or deductibles and understand it is due at the time of service.

Signature _____ Date _____

Printed Name: _____

I decline (please circle) the refraction or additional medical test today. I understand that without the advised testing , the doctor may not be able to fully assess the health and function of my eyes.

Signature_____ Date _____

Printed Name _____

Hoover Vision Center, Inc.

2801 Hwy 150, Suite 101A
Hoover, AL 35244
Contact Person: Medical Records Clerk

ACKNOWLEDGEMENT OF PRIVACY POLICY AND PRACTICES

I understand that in an attempt to protect the privacy of my identifiable health information, Hoover Vision Center, Inc. (HVC) has established a *Privacy Policy* and guidelines for *Privacy Practices* within their offices. This information details the use and/or disclosure of information contained in my personal medical/optometric records kept for the purposes of diagnosis, treatment, payment and health care operations. I understand that my health information in this office is private. Hoover Vision Center does not discuss results of examinations or tests with anyone but the patient and/or guardian unless permission has been granted to do so. In accordance with HIPAA Regulations, a copy of *HVC Privacy Policy & Practices* has been made available to me while in the office today. Should I choose to have a copy, one will be given to me at no charge.

[ ] I understand and acknowledge the Privacy Policy and Practices of HVC.

Patient Name _____ Date of Birth: _____

Please list below those individuals you wish to allow us to communicate your health information if needed or requested.

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

( ) I do not grant permission to any other person besides myself.

_____ _____
Patient Signature Date

_____ _____
Guardian Signature Date

Hoover Vision Center
Office Policies

Dr. Robin L. Marbourg Dr. Abnous A. Samford

Thank you for choosing our office to provide for your eye care needs. We strive to provide our patients with quality comprehensive eye care in a timely manner. To meet our goal, we must adhere to the following office policies. Please read and initial each one and sign at the bottom showing that you have read and understand our policies.

(Initial)_____**BROKEN APPOINTMENTS** – A 24 HOUR NOTICE is required to cancel or change your eye exam appointment or a **$40 no show fee** will be billed. Three (3) broken appointments within a twelve (12) month period will result in "Day of Call Only" status. This means that going forward, you will no longer be given an appointment slot in advance. You can call on the day you desire service and ask to be worked into the existing schedule. We will do our best to accommodate that request but will do so without obligation if our schedule is already full. Consideration will be given to any ocular emergency issues/conditions.

Note: Exceptions to this policy will be determined on an individual basis, according to circumstance. We understand that illness or other unexpected emergencies arise that make it necessary to cancel an appointment with less than a 24 hour notice. Please be courteous and contact our office as soon as possible, so that we can offer that appointment to another patient in need of care.

(Initial)_____**LATE ARRIVALS** – If you arrive more than fifteen (15) minutes late for your scheduled appointment time you may be asked to reschedule. Depending on our daily schedule you may be able to be worked in. If you agree to do so, you must wait until an appointment time is available or another patient reschedules. We strive to stay on schedule and late arrivals can cause a disruption, resulting in an increase wait time for others the rest of the clinic day.

(Initial)_____**COURTESY CONFIRMATION** - Our office provides a call and/or e-mail/text method of confirmation and reminder before your scheduled appointment. Please remember this is a courtesy, and you are still responsible for keeping your scheduled appointment time. Please respond to this confirmation as soon as possible, so we can plan accordingly to meet your eye care needs.

(Initial)_____**EYE & HEALTH INSURANCE** - Please provide our office with your current eye/health insurance information before arriving for your eye exam appointment so that we may provide you with the *ESTIMATED* cost of your appointment.

(Initial)_____We file your eye/health insurance as a courtesy to you.
(Initial)_____We do not have a contract with your insurance company, only you do. We have agreed to be panel members and provide services.
(Initial)_____It is your responsibility to notify our office of any changes with your eye/health insurance carrier.
(Initial)_____**Patients are responsible for paying their copays and non-covered fees in full at time of service.**

(Initial)_____**RETURNED CHECK FEE** - There is a $30.00 returned check fee on all returned checks.

(Initial)_____**PRIVATE PAY** - Payment is due in full at the time of service

Patient/Guardian Name:_____

Signature:_____ **Date:**_____