EYE CONCERN, INC.
PATIENT REGISTRATION SHEET

Date: _____ **Office you prefer:** *Mesa* _____ _____

PATIENT FULL NAME: _____ **BIRTHDATE** _____
LOCAL ADDRESS: _____
CITY, STATE, ZIP: _____
PERMANENT ADDRESS (*if different*) _____
EMAIL ADDRESS: _____

SS#: _____-_____-_____ **SEX: M**____ **F**____
PHONE: Home (____) _____ **Cell** (____) _____
EMPLOYER _____ **Wk** (____) _____

SPOUSE NAME _____ **PHONE** (____) _____

EMERGENCY CONTACT NAME _____
PHONE NUMBER (____) _____ **Cell** (____) _____

RESPONSIBLE PARTY (*if other than patient*) _____
Relationship to Patient _____
Address _____
Home Phone (____) _____ **Wk Phone** (____) _____
Employer _____ **SSN#** _____

EYE DOCTOR/SURGEON _____ **ph#** _____
PRIMARY CARE PHYSICIAN _____
WHOM MAY WE THANK FOR REFERRING YOU?
_____

CURRENT HEALTH INSURANCE _____
ID# _____ **GROUP #** _____
INSURANCE PHONE #: _____

Our office will need a copy of your current insurance card and driver's license, proof of POA if applicable. Thank you.

*IF PATIENT IS A MINOR PLEASE COMPLETE THE FOLLOWING

MOTHER'S NAME _____ Home Phone (____)_____
Wk Phone (____)_____ Cell/Pager(____)_____
SSN# _____ EMPLOYER: _____

FATHER'S NAME _____ Home Phone (____)_____
Wk Phone (____)_____ Cell/Pager (____)_____
SSN# _____ EMPLOYER: _____

Eye Concern

EYE HISTORY

Patient Name:_____ Date filled out: _____

Visit is for:

_____ Right Eye
_____ Left Eye
_____ Both Eyes

Your Eye Color:

_____

Do you have an implant?
Yes _____ No _____
If yes, what type?
_____ Iowa
_____ Allen
_____ Sphere
_____ Silicone
_____ Plastic
_____ Hydroxyapatite
_____ Other

Do you wear glasses? ___ Yes ___ No
Date of last prescription: _____

Prescription eye medications?
Please List:

_____
_____

Do you wear an artificial eye now?
Yes _____ No _____
Date made: _____
Made by: _____

Your eye(s) is/are:

_____ Enucleated (removed)
_____ Blind
_____ Phthisical (shrunken)
_____ Microphthalmos
_____ Eviscerated
_____ Exenterated

Lost eye due to:
_____ Trauma _____
_____ *Date of Injury
_____ Disease _____
_____ Birth Defect
Date eye was removed: _____
Date of last eye surgery: _____
Other eye related surgeries:_____

_____
_____

Are you in good health? _____
Do you have any of the following:

_____ Heart Disease
_____ Stroke
_____ High Blood Pressure
_____ Diabetes
_____ HIV (aids)

Any family history of:

_____ Cataracts
_____ Glaucoma
_____ Detached Retina
_____ Diabetes

Are you allergic to:

_____ Medications
_____ Anesthesia

If so, please list:

_____
_____

EYE CONCERN, INC

Consent for Treatment and Authorization to Release Information

I, _____, hereby authorize **Eye Concern** through its appropriate personnel, to perform or have performed upon me the appropriate assessment and treatment procedures.

I further authorize **Eye Concern** to release to appropriate agencies, such as the State Insurance Commissioner, any information acquired in the course of my examination and treatment. I understand that **Eye Concern** follows HIPAA regulations with regard to the protection of my medical information.

Patient/Guarantor: _____ **Date:** _____

I hereby grant Eye Concern, Inc. permission to photograph my face and eyes. It is understood that these photographs may be used by Eye Concern, Inc. for medical, educational, and scientific purposes; as well as displayed for portfolio purposes, i.e. on the Internet.

Signature _____ Date _____

EYE CONCERN, INC
Statement of Financial Responsibility/AOB

The **Eye Concern, Inc.** appreciates the confidence you have shown in choosing us to provide for your prosthetic eye care. We are working to provide the highest quality ocular prosthetic care for your benefit. Any contract we have, therefore, is directly with **you**, the patient. All ocular prosthetic services provided for you in this office are charged directly to you, and you are responsible for payment of such services. We do not render services on the assumption that your charges will be paid by your insurance carrier.

INSURANCE
We share a relationship with certain insurance companies. Please ask if your insurance is one of them. We are a ***NON-PARTICIPATING MEDICARE APPROVED PROVIDER***, and as such are *NOT REQUIRED* to accept Medicare assignment. You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at the time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies or takes back any monies provided, you will be fully responsible to resolve the charges in a timely manner.

It is your responsibility to know what your insurance does and does not cover along with any pre-authorizations, to be able to receive reimbursement from your insurance carrier. Insurance verification or pre-authorization is *not* a guarantee of payment for the services you receive. The insurance carrier determines the benefit payments. In the event of denied or delayed insurance claims, payment in full will be your responsibility within sixty (60) days of the date of service. If for any reason we do carry a balance on your account, interest will accrue @ 10% annually, beginning 30 days from the date of service and will continue until the balance is paid in full.

Please let us know immediately if there is any change in your insurance coverage ***prior*** to your appointment. We are not liable for misdirected claims due to incorrect insurance information. If you do not inform us of any medical insurance ***before*** services are rendered, we will assume no coverage exists. We cannot retro claims, post authorize claims, or refund fees once service has been rendered.

RETURNED CHECKS
A service charge of $30 will be applied on all returned checks. If it is not resolved in a timely manner, and is subsequently sent to collections, the amount due may be double the amount of the check plus all collection fees as permitted by law. No post dated checks will be accepted.

FORM FEES
Any additional forms brought into the office for us to fill out such as Disability, FMLA forms, Leave of Absence Forms, etc. will be subject to a 25.00 to 50.00 charge. The fee is due at the time the form is presented to the office. The forms will not be filled out until the fee is paid. Please allow up to 7 (seven) business days for the completion of the forms. **We will also charge you the actual cost for postage if you have the copies mailed to you.** No postage charge will apply if you pick up your records. There will be no charge for records sent directly to another physician or health care provider involved with your continuity of care.

MINOR CHILDREN

If treatment is to be rendered for a minor child, the parents or legal guardian are responsible for payment at the time of service. If someone else is accompanying the child, please be sure they are prepared with the payment at the time of service. If an adult other than the parent/guardian is accompanying the child, they will need to stay in the waiting room during the appointment unless a signed letter is given to us, stating that we may discuss the progress of the minor child with them.

COURTEOUS CARE

Eye Concern and staff strive to give quality and courteous care. We ask that you please remember sometimes emergencies do arise and your appointment can be delayed. Your patience is greatly appreciated. We will do all we can to meet your expectations. Patients who exhibit abusive language, rude or inappropriate behavior will be asked to leave and seek care elsewhere.

PATIENT RESPONSIBILITY

I understand that I am responsible for all costs associated with my ocular prosthetic treatment. After 30 days, any unpaid balances will be assessed interest (0.83% per month) and a late charge of 1.5% of the total balance due each month until the balance is paid in full. Account balances with inactivity after 45 days will be considered delinquent and subject to collections unless prior arrangements have been made. Should my account become delinquent and fees arise from trying to recover this balance, I agree to pay all collection fees, court costs and/or attorney fees.

Your signature below acknowledges that you have read, understand, and agree to abide by our office policies.

YOUR SIGNATURE ON THIS DOCUMENT WILL SERVE AS A SIGNATURE ON FILE FOR ASSIGNMENT OF BENEFITS (AOB) FOR ANY AND ALL SERVICES RENDERED.

Patient Name: _____ **DOB:** _____
(Please Print)

Signature: _____ **Date:** _____

Guarantor Signature: _____ **Date:** _____
(If Guarantor is not the Patient)

HIPAA Privacy Rule Receipt of Notice of Privacy Practices Written Acknowledgement Form

Acknowledgement of receipt of Information Practices Notice (164.520(a))

I, _____, (patient's name) understand that as a part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination, ocular prosthetic care, and any plans for evaluation for future care. I acknowledge that I have given the opportunity to view a copy of this facility's Notice of Privacy Practices which provides a description of the uses and disclosures of my health information.

I acknowledge that a copy of the CMS Medicare DEMPOS Supplier Standards was made available to me prior to signing this form. (Medicare patients only)

I acknowledge that a copy of the Statement of Patient Rights was made available to me prior to signing this form.

X_____/Date:_____
(Signature of Individual or Legal Representative)

Printed Name of Legal Representative

Name: _____

On Behalf of: _____
(Patient Name and Date of Birth)

Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barrier prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify)

_____

_____ _____
Privacy Official Date

Eye Concern

The Finest in Ocular & Facial Prosthetics

"Our Eyes Match Your Eyes"

John L. Hadlock
BCO, BADO, FASO
Board Certified Ocularist

Effective: 01 January 2023

RE: Eye Concern's Missed or Cancelled Appointments Policy

I _____ understand there is a missed appointment charge for appointments cancelled or missed without giving 24 to 48 hours' notice to Eye Concern. Missed appointments without adequate notice will be charged a $50.00 fee for office visits (24-hour notice) and $150.00 for procedures (48-hour notice). I have also been notified and understand that this charge is $50.00 for each and every "missed" appointment, (new eye appointments counts as 3 missed appointments). By signing this paper, I agree to these terms.

Signed by:_____

Date: _____

For Office Use Only:

Witnessed by: _____

Date: _____

PERSONAL REPRESENTATIVE AUTHORIZATION FOR MEDICAL RELEASE FORM

I authorize John Hadlock, BCO, Eye Concern, Inc. and staff to speak to the following family members or my personal representative regarding:

☐ All medical information, including but not limited to records pertaining to examinations, treatments, consultations, billing records, x-rays and reports, history, laboratory findings, admissions and discharge reports, treatment records, diagnosis and prognosis and records, nurse's and doctor's notes, and any other non-medical information in my file.

☐ Only the following types of information:

_____

_____

The above medical information shall only be released to the following persons:

Family Member / Personal Representative	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

I understand that I may terminate this Medical Authorization form. I must notify John Hadlock, BCO, Eye Concern, Inc. in writing regarding termination and effective date.

This authorization shall remain valid (check one):

☐ Until revoked in writing.

☐ Until _____ , 20____

I know that I am entitled to receive a copy of this agreement.

Sign: _____

Print: _____

Date: _____

CONFIDENTIAL