STEPHENS
COUNTY
EYE CLINIC

1020 Big A Road ♦ Toccoa, GA 30577 ♦ 706-886-0111

WELCOME TO OUR OFFICE

Stephens County Eye Clinic **Kevin Vanderhoef, O.D.**

The information in this confidential case history form is critical to the evaluation of your vision and health.

Today's Date _____

Last: _____ **First:** _____ **MI:**_____

Street: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Day Phone:** _____

Cell Phone: _____ **Email Address:** _____

How do you wish to be reached: Telephone: _____ **Email:** _____ **Postal:**_____

Date of Birth: _____ **Age:** _____ **Sex: Male**____ **Female**____

Height: _____ **Weight:** _____

Race: White __ **Hispanic** __ **African American** __ **Asian** __ **Native Hawaiian** __ **Other**__

Preferred Language: __ **English** __ **Spanish**

Patient's Social Security Number: _____

Employer (or School): _____

Occupation (or Grade): _____

Spouse (or Parent's Name): _____**Spouse (or Parent's Work):** _____

VERY IMPORTANT! NEW PATIENTS ONLY:

Who may we thank for referring you to our office?
Name of friend or relative: _____ **Doctor:** _____

If not referred, how did you choose our office for your needs?
Saw Sign/Building: _____ **Yellow Pages: Which Directory:** _____
Newspaper/Radio/TV: _____ **Other** _____

STEPHENS
COUNTY
EYE CLINIC

1020 Big A Road ♦ Toccoa, GA 30577 ♦ 706-886-0111

STEPHENS COUNTY EYE CLINIC

IS THIS VISIT WORK RELATED: YES ____ NO ____ DATE OF INJURY: _____
HOW DID THE ACCIDENT OCCUR? _____

PLEASE GIVE US YOUR INSURANCE CARDS TO COPY. THIS INFORMATION WILL ASSIST US IN FILING YOUR INSURANCE, BUT DOES NOT RELIEVE YOU OF YOUR OBLIGATION TO PAY ANY BILL INCURRED FOR SERVICES.

MY SIGNATURE BELOW INDICATES THAT ALL INFORMATION COMPLETED IS TRUE TO THE BEST OF MY KNOWLEDGE. ADDITIONALLY, I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS A CLAIM. I REQUEST PAYMENT OF GOVERNMENT OR PRIVATE INSURANCE BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT ON A CLAIM. THIS AUTHORIZATION IS VALID UNLESS I NOTIFY THE PHYSICIAN OF A CHANGE.

SIGNATURE: _____ DATE: _____

STEPHENS
COUNTY
EYE CLINIC

1020 Big A Road ♦ Toccoa, GA 30577 ♦ 706-886-0111

HIPPA PRIVACY AUTHORIZATION

PATIENT NAME: _____ D.O.B: _____

I HAVE AGREED TO LET CERTAIN INDIVIDUALS PARTICIPATE IN DISCUSSIONS AND DECISIONS RELATED TO MY MEDICAL CARE. THEREFORE, I HEREBY GIVE PERMISSION FOR STEPHENS COUNTY EYE CLINIC/FRANKLIN COUNTY EYE CARE, DR. VANDERHOEF, AND HIS STAFF TO DISCLOSE MY PERSONAL MEDICAL INFORMATION TO THE FOLLOWING INDIVIDUALS.

NAME: _____ RELATIONSHIP TO PATIENT: _____
PHONE NUMBER: _____

NAME: _____ RELATIONSHIP TO PATIENT: _____
PHONE NUMBER: _____

NAME: _____ RELATIONSHIP TO PATIENT: _____
PHONE NUMBER: _____

NAME: _____ RELATIONSHIP TO PATIENT: _____
PHONE NUMBER: _____

CONDITIONS FOR DISCLOSURE:

_____ THE PRACTICE MAY DISCLOSE MY PERSONAL HEALTH INFORMATION TO THE INDIVIDUALS ABOVE ONLY IN MY PRESENCE.

_____ THE PRACTICE MAY DISCLOSURE MY MEDICAL INFORMATION TO INDIVIDUALS ABOVE IN DISCUSSIONS IN MY PRESENCE AND WHEN I AM NOT PHYSICALLY PRESENT, INCLUDING DISCLOSURES BY TELEPHON, FACSIMILE, EMAIL, OR REGULAR MAIL.

_____ OTHER CONDITIONS FOR DISCLOSURE: _____

THIS PERMISSION WILL REMAIN IN EFFECT UNTIL SUCH TIME THAT THE PATIENT LISTED ABOVE NOTIFIES US IN WRITING.

PATIENT SIGNATURE: _____ DATE: _____

STEPHENS
COUNTY
EYE CLINIC

1020 Big A Road ♦ Toccoa, GA 30577 ♦ 706-886-0111

STEPHENS COUNTY EYE CLINIC

Consent to use disclosure health information for treatment payment, and health care options

PATIENTS NAME: _____ D.O.B: _____

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office. We have a comprehensive Notice of Privacy Practices that describes the uses and disclosure in detail. You are free to refer to this notice at any time before you sign this Consent Form. As described in our Notice of Privacy Practices, the use and disclosure of your health information for th treatment purposes not only includes care and service provided here, but also disclosure of your health informationas may be necessary or appropriate for purposes of follow-up care from another health professional. Similarly the use and disclosure of your health information for purposes of payment includes (1) our submission of health informationto a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to a third party payer or insurer for claims review, determination of benefits and payment; (3) our submissionof your health information to auditors hired by third party payers and insurers; and (4) other aspects of payment decribed in our Notice of Privacy Practices will be updated whenever our privacy practices changes. You can get an updated copy here at the office.

When you sign this document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perfom health care operations. You can revoke this consent in writing at any time unless we already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent. You have the right to ask us to restrict the uses of disclosures made for purposes of treatment, payment, or health care operations, but as described in our Notice of Privacy Practices, we are not obligated to agree to suggested restrictions. If we do agree, however, the restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for a restriction.

I have read this consent and understand it. I consent to the use and disclosure of my health information for the purposes of treatment, payment, and health care operations.

SIGNATURE: _____ DATE: _____
If signing as a person representative of the patient, describe the relationship to the patient and the source of the authority to sign this form:

Relationship to patient: _____ Print Name: _____

STEPHENS
COUNTY
EYE CLINIC

1020 Big A Road ♦ Toccoa, GA 30577 ♦ 706-886-0111

INSURANCE AND YOUR VISIT

Please specify below how you prefer to have your insurance billed for today's visit:

_____ Bill my medical insurance using any medical diagnosis codes that apply.

_____ Bill my medical insurance using routine code, as I am covered under my medical plan for routine benefits once per year.

_____ Bill my routine vision insurance (Eyemed, VSP, Spectera, or any other vision plan)

Due to timely filing regulations with insurance companies, if the insurance I present is NOT correct, I also understand that I may be responsible for the full fee of my visit for today.

I understand that it is my responsibility to provide accurate & up to date insurance information.

If any special testing is required today, I understand that my MEDICAL insurance will be billed and not my routine vision. I understand that I am responsible for any referral required from my primary care physician. I also understand that Dr. Vanderhoef may or may not be a provider for my insurance plan.

Patient's Signature _____

Date _____

STEPHENS
COUNTY
EYE CLINIC

1020 Big A Road ♦ Toccoa, GA 30577 ♦ 706-886-0111

BASELINE FUNDUS PHOTO

At today's visit Dr. Kevin will be checking the health of your eye's retina. He would like to take a picture of the back of your eyes; the optic nerve and macula.

It gives a baseline picture for him to reflect back on next year when you return for your annual eye exam.

The photo is ***OPTIONAL***, with a cost of $15 that is ***not*** covered by your insurance. Would you like to take advantage of this today?

Yes ___ No ___

Patient's Initials _____

STEPHENS
COUNTY
EYE CLINIC

1020 Big A Road Toccoa, GA 30577 706-886-0111

Patient Information Form

Name: _____

Reason for Visit: Exam ☐ Problem ☐ Post Op ☐ Other ☐

Y	N

☐ ☐ Have you had any illness in the past 2 weeks?
Fever (chronic or new), runny nose, cough, shortness of breath, nausea, vomiting or diarrhea?

☐ ☐ Have you been near anyone with these symptoms?

☐ ☐ Have you traveled outside of the US?

☐ ☐ Have you tested positive for Coronavirus or been near anyone who has tested positive and if so what dates?

☐ ☐ Are you a health care worker who has taken care of any Coronavirus patients and if so, have you been tested?

Please wear mask for your appointment.