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

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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: ____________________

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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: ______________

"Keeping Your Family in Sight"

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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.

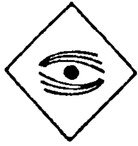
When you sign this document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perfom health care operations. You can revoke this consent in writing at any time unless we already treated you, sought payment 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:** ________________________



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INSURANCE AND YOUR VISIT

Medical or Routine

One of the most challenging issues in an optometric office is whether your exam will be billed through your medical or vision plan. Your medical insurance may cover a medical eye problem, but not pay for the exam if it is a routine eye exam. If you have a medical problem (eye infection, diabetes, glaucoma, macular degeneration) your visit is considered a medical problem and will be billed to your medical plan.

The type of eye exam you have is determined by the reason for your visit or your chief complaint, as well as your diagnosis. Routine vision exams usually produce final diagnoses such as nearsightedness or astigmatism, while medical eye exams produce diagnoses such as "conjunctivitis". Most insurance companies focus on the reason for your visit.

Vision plans provide coverage for routine exams, glasses, and contact lenses. Examinations that are billed towards a patient's medical insurance plan, can still utilize their materials benefits for eyewear and contact lenses through their vision plan.

Please check one of the following on how you prefer to have your insurance billed for today

_________ 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, Superior Vision & Avesis)

_________ Self-Pay

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.

If I have a Medicare Advantage Plan, I understand Stephens County Eye Clinic are not a contracted provider but will file my visit as a courtesy. I understand that Stephens County Eye Clinic do not file Medicaid as a secondary insurance and that I am responsible for all co pays and deductibles.

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 _______________

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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 ________