New and Established Patient Information

Today's Date: _____

Name: _____ Date of Birth_____

Address: _____

City: _____ State: _____ Zip Code:_____

Social Security #_____ Present Employer: _____

***Best phone # to reach you: _____

_____ Cell _____ Home _____ Work

E-Mail Address:_____

Alternate Phone #:_____

Alternate Contact Person_____

(Please Check) _____Spouse _____Child _____Friend _____Parent/Guardian _____Family Mbr.

Medical Insurance: _____ Vision Insurance; _____

Family Doctor: _____ Local Pharmacy: _____

Are you interested in contacts today? _____ Yes _____ No

If *Yes*, please be aware that there is a BASIC CONTACT LENS EVALUATION AND MANAGEMENT FEE - $120.00 New Pt per year $60.00 Established per year.

Please sign to acknowledge this policy: _____

****ATTENTION PATIENTS REQUIRING A REFRACTION TODAY****

Refraction is a vision test that is used to determine your prescription for glasses/contact lens and is normally NOT covered by medical insurance. It is NOT covered by Medicare. Cost is $30.00 and is NOT part of your co-pay. All co-pays, coinsurance, deductibles and refraction costs are due on date of service.

Initial here to acknowledge this policy: _____

Vision Source of Newport

Drs. Foster, Steele, Eisenhower and Taylor
1823 Crowe Ln.
Newport, TN 37821
423-623-3875
Fax: 423-623-2977

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the named health care provider to release the information or records specified to upon request in person or by mail to the address specified at the time of the request.

_____ _____

PCP: (Family Dr.) **Patient Name:**

_____ _____

Phone: **Fax:** **S.S. # & DOB**

PCP Address

Name and address of person(s) or category of person to whom this information will be sent:

DRS. CHARLES FOSTER, KURT STEELE, EMILY EISENHOWER AND GRAHAM TAYLOR

Please send:

******** ***Last Office Visit Note*** _____-___ ******** ***Medical History*** _____

******** ***Medication List*** _____ ******** ***Allergies*** _____

Authorization to discuss health information

By initialing here X_____ I authorize _____to discuss my health information with my attorney, or a government agency listed here:

Attorney Firm Name or Government Agency Name

Reason for release **Date or event on which this authorization will expire:**

_____ _____

If not the patient, name of person signing form: _____

Patient or Representative **Date**

I also understand that: I am required to sign this authorization and that my health care or payment for care will NOT be affected by my refusal.

Federal privacy regulations will no longer apply to the information disclosed and that may re-disclose the information.

Name of Representative (PRINT) **Relationship to Patient**

I am entitled to receive a copy of this authorization. A copy of this authorization may be utilized with the same effectiveness as the original

Drs. Foster, Steele, Eisenhower and Taylor
1823 Crowe Ln.
Newport, TN 37821

Date: _____

Patient Name: _____
Date of Birth: _____

Advance Beneficiary Notice of Non-Coverage (ABN)

NOTE: If insurance does NOT pay for items listed below, you as the patient may have to pay. Medicare and other insurance companies do not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare/and or your insurance company may not pay for the following:

Items that may not be covered:	Reasons not Covered: Estimated Cost:
• Examination – New pt	Deemed Non-Covered
• Examination – Est. pt	Exclusion
• OCT	Maximum Benefit Reached
• Tear Lab	Non-Participating Provider
• Fundus Photo	
• Visual Field	
• Optomap Screening	
• Refraction	

WHAT YOU NEED TO KNOW:
- Read this notice, so you can make an informed decision about your care
- Ask us any questions that you may have after you finish reading
- Choose an option below about whether to receive the items listed above

NOTE: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare/Other insurances cannot require us to do this.

Options: Check only one Box. We cannot choose a box for you.

Option 1. I want the item listed above. You may ask to be paid now, but I also want Medicare/Insurance carrier billed for an official decision on payment, which is sent to me on a Medicare/Insurance Summary Notice. I understand that if my insurance doesn't pay, I am responsible for payment, but I can appeal to my insurance carrier by following the directions on the Summary Notice. If my insurance does pay, you will refund nay payments I made to you, less co-pays or deductibles.

Option 2. I want the item listed above, but do not bill Medicare/Insurance Co. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

Option 3. I don't want the item listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if my insurance will pay.

This notice gives our opinion, not an official Insurance decision. If you have other questions on this, please call the number listed on the back of your insurance card.

SIGNATURE:_____ DATE:_____

Acknowledgement of Receipt of Privacy Practices (HIPAA)

In the course of providing service to you, we create, receive and store health insurance 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 healthcare operations involving our office. The Notice of Privacy Practices you have been given describes these uses and disclosures in detail.

I acknowledge that I have been informed of the Notice of Privacy Practices for Drs. Foster, Steele and Eisenhower

_____ _____

Patient Signature (guardian if under 18) Date

I acknowledge that I have been informed of the Notice of Privacy Practices and have elected to NOT receive a copy.

_____ _____

Patient Signature (guardian if under 18) Date

About Your Insurance

There are two types of health insurance that will help pay for your eye care services and products. You may have both and our practice accepts both:

1. Vision Care Plans (such as VSP and Eye-med) 2. Medical Insurance (such as BCBS and Medicare)

- Vision care plans ONLY cover routine vision exams and may cover some materials (such as glasses or contacts) Vision plans only cover basic screening for eye disease. They do not cover diagnosis, management or treatment of eye diseases.
- Medical insurance must be used if you have any eye health problem or systemic health problem that has ocular complications. Your doctor will determine if these conditions apply to you, but some are determined by your case history.
- If you have both types of insurance plans, it may be necessary for us to bill some services to one plan and other services to the other. We will use coordination of benefits to do this properly and to minimize your out of pocket expense.
- We will bill your insurance plan for services if we are a participating provider for that plan. We will try to obtain advanced authorization of your insurance benefits so we can tell you what is covered. If some fees are not paid by your plans, we may bill you for any unpaid deductibles, copays or non-covered services as allowed by the insurance contract.

I have read and agree with these policies:

Patient Signature (guardian if under 18) _____ Date _____

Insurance signature on File

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits and I authorize payment of these benefits directly to Drs. Foster, Steele, Eisenhower and Taylor on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Center of Medicare and Medicaid Services and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in item 9 of the CMS-1500 Claim Form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

Patient Signature (guardian if under 18) _____ Date _____

Vision Source of Newport

Jeff Foster, O.D. Kurt Steele, O.D Emily Eisenhower, O.D. Graham Taylor, O.D.
1823 Crowe Lane, Newport TN 37821 • (423) 623-3875

HIPPA CONSENT FORM

Drs. Foster, Steele, Eisenhower & Taylor Family Optometry provide this Consent to Comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA)

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your protected health information is kept private.

This is a summary of consent for the privacy practices and patient care at Drs. Foster, Steele, Eisenhower & Taylor Family Optometry and serves as a condensed version of our Notice of Privacy Practices. You have the right to review our Notice before signing this Consent upon request. The terms of our Notice may change and you may obtain a revised copy by contacting our office.

If you ever believe your privacy right has been violated, you may file a complaint with the Compliance Officer of Drs. Foster, Steele, Eisenhower & Taylor Family Optometry or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing complaints.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY.

How will we use or disclose your information? Here are a few samples:

- For vision, medical eye treatment and referral
- To obtain payment and file insurance
- In emergency situations
- For appointment as recall reminders
- To run our practice more efficiently and ensure all our patients receive quality care
- For research and education
- Prevent serious threats to health safety
- For organ and tissue donation
- For worker's compensation programs
- In response to certain requests arising out of lawsuits or other disputes

You have certain rights regarding the information we may obtain about you. The rights include:

- The right to inspect and copy
- The right to amend
- The right to an accounting of disclosures
- The right to request restrictions
- The right to a paper copy of this notice
- The right to request confidential communication

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. Drs. Foster, Steele, Eisenhower & Taylor Family Optometry may condition treatment upon the execution of this Consent. Additionally, by signing this form, you acknowledge that by presenting yourself as a patient or child you consent for vision and medical eye care by the doctors and staff of Drs. Foster, Steele, Eisenhower & Taylor Family Optometry. You hereby grant full authority to the optometrists and their respective assistants to administer and perform any and all drugs, treatments, tests or diagnostic procedures to or upon me, which may be advised necessary.

By signing below, I agree that I have read and understand the privacy policy which protects my medical information from being given out without my consent.

Patient Name_____

Signature _____ Date _____

Relationship (if other than patient) _____

I give my consent to discuss or release my medical information to

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

If you do not want your medical information given to anyone, please read and sign below:
I <u>DO NOT</u> give my consent to discuss or release my medical records or medical information to anyone other than myself.

Signature _____ Date _____