Low Vision Services, PLC.

Patient Registration (please print all responses)

Patient Name

____

Last First Middle Initial

Date of Birth ____________________ Gender M F

Address

____

City ___________________State _______________Zip__________

Home Phone ________________________

Cell Phone _________________________

Email Address ______________________________________

Martial Status:

Married Single Widowed Separated Divorced

Ethnicity:

Hispanic/Latino Caucasian Black Asian Other

Employment Status:

Retired Unemployed Working Student

Emergency Contact Information

Name ____

Relationship to Patient ____________________________

Phone____

Insurance Information
Primary Insurance Name ___________________________

City ___________State________________Zip____________

Policy/ID # ___________________

Group # ____________________ Effective date__________

Subscribers name__________________________________

Subscribers Date of Birth___________________________

Subscribers Relationship to Patient__________________

Secondary Insurance Name __________________________

City ___________State________________Zip____________

Policy/ID # ________________________

Group # ____________________Effective date__________

Subscribers name__________________________________

Subscribers Date of Birth___________________________

Subscribers Relationship to Patient__________________

Medicare and medical insurances do not pay for refractions (CPT code 92015), glasses or for visual aids that might be prescribed. The fee for a refraction is $45 and will collected at the time of service or billed to you.

I hereby authorize the release of any information necessary for filling any insurance and direct payment to Low Vision Services, PLC for any amounts due under my present policy/policies. This authorization is valid for current and subsequent treatment unless I submit a written revocation. I will advise Low Vision Services, PLC of any changes in my insurance coverage.

I understand that payment and/or co-pay is expected at the time of service, and that insurance is filed as a courtesy to me. I understand that I am financially responsible for charges not paid by this authorization. Should collection actions become necessary, I understand that I will be liable for all cost, including reasonable attorney fees associated in collecting the unpaid balance owing on my account.

I also authorize Low Vision Services, PLC to talk with and exchange information with other medical professionals regarding my condition.

Signature ___________________________________

Date _______________

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. This form is a "friendly" version. A more complete text is is available from the U.S. Department of Health and Human Services. www.hhs.gov

Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you

other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Signature ______________________________Date____________

General Health Questions:
Smoking Status

Everyday Occasional Former Never

Allergies to medications

List____

Issues Impacting your health	YES	NO
Heart Disease	Y	N
High Blood Pressure	Y	N
Lung Disease	Y	N
Diabetes	Y	N
Ulcer or Stomach Disease	Y	N
Kidney Disease	Y	N
Liver Disease	Y	N
Anemia or other blood disease	Y	N
Cancer	Y	N
Osteoarthritis, Degenerative Arthritis	Y	N
Back Pain	Y	N
Rheumatoid Arthritis	Y	N
Hearing Impairment	Y	N
Obesity	Y	N
Stroke	Y	N
Partial Paralysis	Y	N
Speech Problem	Y	N
Thyroid Disease	Y	N
Parkinson's Disease	Y	N
Depression	Y	N
Dementia	Y	N

Medications

Ocular History

Do you have a diagnosed eye condition(s), list:

List any eye surgeries or treatments you have received:

Is there a family history of eye disease:

What activities are limited most by your vision loss:

List any rehabilitation you have received for your vision:

List any magnifiers or visual aids that you use:

Do you need to drive and maintain a driver's license?

What is your main functional goal for today's visit: