Logan Eye Care Center

Patient Information (Please Print) **Today's Date:**____/____/____

Patient's Name: ______________________________ E-mail Address: ______________________

Sex: Male or Female (Please Circle) Date of Birth:___/___/___ Age: ______________

Address:____________________________________ City:__________ State:_______Zip:________

Home Phone: ________________ Business Phone: ________________ Cell Phone:________________

Minor Married Single Divorced Widowed (Please Circle) SS Number:______________________

If patient is a minor: Mother's Name:____________________Father's Name:__________________

Employer: ________________________________Occupation: ________________________

Student: Yes or No Grade:__________ School: ______________________________

How or by whom were you referred to our office: ______________________________________

Primary Physician:______________________________ Phone Number:____________________

Address:____________________________________City:__________ State:______ Zip:________

Primary Insurance:

Primary Insurance Provider: ______________________________Phone Number: ______________

Policy/ID Number: ___________________________________ Group Number: ______________

Name of Policy Holder: ________________________________ Relationship: ______________

Policy Holder SS Number: ______________________________ Policy Holder DOB: ____/____/____

Policy Holder Employer: ____

Responsible Party:

Guarantor/Name of person responsible for this account: ______________________________

Relationship of Guarantor to Patient: Self Parent Other (Please Circle)

Authorization:
I certify that I have read and understand the information on the FRONT and BACK of this form, and have answered the questions accurately to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I understand and agree to be financially responsible of all services rendered on my behalf or my dependents.

X ____

Signature of patient or parent (if minor) **Date**

Date of last eye exam: ____/____/____ Doctor: ______________________________

Do you wear glasses: Yes or No How old are the lenses? ______________________________

Do you wear contact lenses: Yes or No

If yes, what kind? Soft Hard RGP Disposable Daily Wear Extended Wear

Are you interested in contacts? Yes or No

Are you interested in Laser Vision Correction? Yes or No

Do you have or have had any of the following medical conditions? If yes, please explain, including the date, diagnosis and **ANY MEDICATIONS YOU ARE TAKING.**

Medical Condition (Family history of any of the following)	**Medications**
Y N Eye Injuries:	
Y N Eye Surgery:	
Y N Loss of Vision:	
Y N Glaucoma:	
Y N Macular Degeneration:	
Y N Cataracts:	
Y N Retinal Detachment:	
Y N Diabetic Eye Disease:	
Y N Lazy Eye:	
Y N Dry Eyes:	
Y N Neurological/Anxiety/Depression:	
Y N Anemia/blood disorders:	
Y N Seasonal or general allergies:	
Y N Diabetes:	
Y N Arthritis, Lupus, or autoimmune disease:	
Y N Heart disease or chest pain:	
Y N High Blood Pressure:	
Y N Elevated Cholesterol:	
Y N Thyroid Condition:	
Y N Cancer:	
Y N Respiratory:	
Y N Any fever, weight loss/gain:	
Y N Skin:	
Y N Gastrointestinal:	
Y N Ears, Nose, Mouth &Throat:	
Y N Genitourinary:	

Social History:

Y N Do you have difficulty driving during the day or at night?

Y N Do you drink alcohol? How many drinks per day? ________

Y N Do you smoke? How many packs a day? ________

Do you …. (Please circle Y or N)

Y N Work on a computer? If yes, how many hours a day? ________

Y N Participate in recreational sports: If yes, please list: ________

Y N Do you do a lot of reading? If yes, how many hours a day? ________

Y N Want information on Laser Vision Correction?

X ____

Doctor's Signature/History reviewed by Dr. Wells with patient **Date**

Logan Eye Care Center

Financial and Insurance Policy

Thank you for choosing Logan Eye Care Center as your vision care provider. As a part of our services, we request you read and sign the following financial policy prior to services being rendered. Patient or responsible party must complete our information and insurance for before seeing Dr. Thad Wells.

- **Full payment, co-payment, percentages and/or deductibles are due that the time of services rendered.** We accept cash, checks, Visa, MasterCard. If you are purchasing eye wear or contacts, payment is due prior to any order being processed. ________ **Initials**
- **Office Policy:** Insurance is billed as a courtesy to our patients; however, the patient is the final responsible party. If your insurance has not paid within **60 days** you will be notified. Returns or cancellations are made at the discretion of the office administrator and office credit will be issued in lieu of refunds. Please make your selection carefully.
- **Minor Patients (under the age of 18):** The adult accompanying a minor (patient/guardian) is responsible for full payment at the time of service. For unaccompanied minors, payment arrangements need to be made in ADVANCE and we must have parents or guardians written permission prior to treatment of a minor.
- **Returned Checks:** A $40.00 service charge will be applied to your account for returned checks. No returned checks will be redeposited. All balances must be paid in cash or by credit card. One attempt will be made to collect this debt from the patient, if not collected within 5 days of the returned check, the account will be turned over to collection agency. We request a copy of your driver's license if you wish to make payments by check.
- **Spectacle Prescription:** Patients have 30 days follow-up care from the date of the fitting to make any changes in the prescription necessary . However, the Optician will be happy to check the prescription of your glasses against your prescription given by Dr. Wells at any time.
- **Eye wear and contact lens prescriptions that are filled elsewhere are not warranted by Logan Eye Care Center.**
- **Contact Lens Patients:** Additional time and testing is required for the fitting and evaluation for contact lenses. Additional professional fees will be applied, and are generally not covered by your insurance company. Patients have 60 days follow-up care from the date of the fitting to make any changes in the prescription necessary. A contact lens prescription is only valid **one year from the exam date** and cannot be filled once expired. Once disposable contacts have been ordered and received by the patient, they cannot be returned.
- Eyeglass and contact lens prescriptions (when requested) are faxed by the end of each business day. ______ **Initials**

Please realize that:

1. **Your insurance is a contract between you, your employer and the insurance company. We are not a party in the contract.**
2. **You are responsible for all charges that are denied/not covered by your insurance company. Not all services are covered under insurances – glasses, contact lenses and/or contact lens fitting or evaluations and some procedures covered by Dr. Wells.**
3. **Although we verify your coverage through your insurance company with each and every patient, verification of benefits is not a guarantee of payment from your insurance company. We request that you present a copy of your insurance card for our records if necessary or any discount plans that are being utilized.**

______________________________________ ______________________________________

Patient or legally authorized individual signature Date

____

Printed name if signed on behalf of the patient

CONSENT TO LEAVE MESSAGES/SHARE INFORMATION FROM LOGAN EYE CARE CENTER

I understand that my healthcare information is protected. I understand that, in order for us to leave detailed messages containing specific information on my voicemail or answering machine, I need to give permission for us to do so.

Consent for Leaving Messages

I give permission for messages to be left the phone number(s) below:

☐ Cell # ____________________ ☐ Home # ____________________ ☐ Work # ____________________

☐ I prefer not to have voicemail messages from the office

Regarding the following:

☐ Appointment Reminder/Changes ☐ Account Payment/Balances ☐ Cost Estimates

Consent for Shared Information

Under the HIPAA Privacy Law we are permitted, and we may make professional judgment, that certain disclosures are in your best interests even without a signature. I understand that information is limited to verbal discussions and that no paper copies of my protected healthcare information will be provided without my signature on a Release of Information Form.

The name(s) listed below are the relatives or friends to who I grant permission for Dr. Thad Wells and staff to verbally discuss my care using their best judgment and grant them permission to disclose vision information that is relevant to my care or relevant for payment.

☐**YES** ☐**NO**

	NAME	RELATIONSHIP	PHONE NUMBER
1.			
2.			
3.			

Regarding the following:

☐ Appointment Reminder/Changes ☐ Account Payment/Balances ☐ Cost Estimates

It will be my responsibility to keep this information up to date, as I recognize that relationships may change over time. This consent will be considered valid until such time that I revoke it in writing. I reserve the right to revoke it at any time.

____________________ ____________________ ____________________

Printed Name (Patient/Parent) Signature (Patient/Parent) Date

Acknowledgment of Notice of Privacy Practices

Logan Eye Care Center
105 Robins Way Ste 206 Russellville KY 42276
270-726-2022

The law requires that Logan Eye Care Center make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

____I was given the opportunity to read, have read or had explained to me Logan Eye Care Center's Notice of Privacy Practice prior to any services offered.

____I have read or had explained to me prior to any services offered Logan Eye Care Center's Notice of Privacy Practice and do not wish to continue my care with Logan Eye Care Center under said terms.

___ The Notice of Privacy Practice could not be read due to the emergent nature of the care and will be acquired when possible

I authorize Logan Eye Care Center to release my personal health information to the following individuals:

____

____

My vision plan requests that all diagnoses related to any medical condition I may have be released to them. As a non-traditional disclosure, release of this information requires my specific authorization:
___ I authorize the release of medical information to my vision plan
___ I do not authorize release of medical information to my vision plan

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I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

____________________________________ ________________________
Patient Signature Date

If you are signing as a personal representative of the patient, please indicate your relationship. If you are signing for a minor, you attest that you have legal authority to make medical decisions for the minor. Please indicate any other parent, step-parent, guardian or other individual(s) authorized to make medical decisions for the minor.

____

____________________________________ ____
Representative Signature Relationship to Patient Other individual(s) authorized

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