Lee County Optical

PATIENT INFORMATION FORM

PATIENT NAME (Last, First, MI)_____ DATE___/___/_____

MALE___FEMALE___ AGE___ DATE OF BIRTH_____ MARITAL STAUS: S M W D

ADDRESS:_____APT #_____CITY_____STATE_____ZIP_____

HOME PHONE _____CELL:_____EMAIL_____

EMPLOYER OR SCHOOL_____ADDRESS_____

OCCUPATION OR GRADE_____WORK PHONE_____

SSN_____ WOULD YOU LIKE ACCESS TO LCO'S PATIENT'S PORTAL? YES NO

SPOUSE OR RESPONSIBLE PARTY:_____DOB_____

SSN_____ HOME PHONE_____

EMPLOYER_____WORK PHONE_____

PERSON TO NOTIFY IN EMERGENCY:_____ RELATIONSHIP:_____

ADDRESS:_____PHONE_____

WHO REFERRED YOU TO OUR OFFICE?_____

As a courtesy we will bill your primary and secondary insurance carrier if you provide all necessary information(such as insurance cards and.or completed and signed claim forms if your carrier requires it and their correct billing address). HMO co-pays are collected for each visit at visit end.

PRIMARY INSURANCE

INSURANCE NAME_____

CLAIMS ADDRESS_____

_____

POLICYHOLDER NAME:_____

SELF SPOUSE PARENT

POLICYHOLDER DOB_____

POLICYHOLDER ID_____

GROUP NUMBER_____

SECONDARY INSURANCE

INSURANCE NAME_____

CLAIMS ADDRESS_____

_____

POLICYHOLDER NAME_____

SELF SPOUSE PARENT

POLICYHOLDER DOB_____

POLICYHOLDER ID_____

GROUP NUMBER_____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN_____

Medical History

List Medication you take (including oral contaceptives, aspirin, over-the-counter medication, and home remedies)_____
_____
_____

Date of Last Eye Exam_____Doctor:_____

Do you wear contact lenses? [ ]Yes [ ]No If yes, What brand?_____
Are they comfortable?_____
Do you wear glasses? [ ]Yes [ ]No If yes, how old is your present pair of lenses?_____

Are you pregnant and/or nursing? [ ] Yes [ ] No

Family History: *Please note any family history (parent, grandparents, siblings, children; living or deceased) for the following conditions:*

Yes	No	Disease/Condition	Disease/Condition	Yes	No
[ ]	[ ]	Thyroid Disease	Hypertension	[ ]	[ ]
[ ]	[ ]	Macular Degeneration	Glaucoma	[ ]	[ ]
[ ]	[ ]	Diabetes	Retinal Detachment/ Disease	[ ]	[ ]
[ ]	[ ]	Cancer	Cataract	[ ]	[ ]
[ ]	[ ]	Strabismus	Severe Myopia	[ ]	[ ]
[ ]	[ ]	Amblyopia	Severe Hyperopia	[ ]	[ ]
[ ]	[ ]	Other	Glaucoma Suspect	[ ]	[ ]

Social History -*This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.*
[ ] I prefer to discuss my Social History information directly with the doctor.

Do you use tobacco products? [ ]Yes [ ]No
Do you Drink Alcohol? [ ]Yes [ ]No
Do you Drive?[ ]Yes [ ]No
If Yes, do you have difficulty driving? [ ]Yes [ ]No

Review of Systems: Do you currently, or have you ever had, any of the problems in the following areas: **(Circle)**

Eyes:
Itching
Diplopia
Burning
Mattering
Headaches
Loss of vision
Photophobia
Red
Floaters
Loss
Of sharpness
Flashes
Tearing
Other_____

Psychiatric:
Depression
Other_____

Integumentary:
Rosacea
Eczema
Psoriasis

Musculoskeletal:
Arthritis
Ankylosing spondylitis
Fibromyalgia
Muscular dystrophy
Osteoarthritis
Other_____

Allergic/ Immunologic:
Environmental Allergies
Lupus
Drug allergies
Rheumatoid Arthritis
Other_____

Vascular/Cardiovascular:
Vascular disease
Stroke
Heart disease
Hypertension
Congestive heart failure
Other_____

Respiratory:
Cigarette smoker
Bronchitis
Chronis obstruction
Emphysema
Asthma Other_____

Genitourinary:
Kidney disease
STD-herpes/chlamydia
Prostate disease/cancer
Other_____

Neurological:
Epilepsy
Multiple seizures
Tumor
Cerebral palsy
Other_____

Hematologic/ Lymphatic:
High Cholesterol
Other_____

Constitutional:
Developmental disorders
Cancer fatigue syndrome
Other_____

Endocrine:
Thyroid dysfunction
Hormonal dysfunction
Type 1 or Type 2 Diabetes
How long?_____
Other_____

Ear, Nose, Mouth, Throat:
Sinusitis
Dry Mouth
Hearing Loss
Laryngitis
Other_____

Gastrointestinal:
Crohn's disease
Ulcer
Colitis
Other_____

Patient Financial Responsibility Disclosure Document

Your signature below forms a binding agreement between Lee County Optical and the Patient who is receiving medical services, or the Responsible Party for minor patients (those patients under 18 years old). Responsible Party is the individual who is financially responsible for payment of medical bills.
All charges for services rendered are due and payable at the time of service.
INSURANCE: We have contracts with many insurance companies, and we will bill them as a service to you. As the responsible party, you are responsible if your insurance company declines to pay for any reason.
The person signing on behalf of the Patient as the Responsible Party must:

- Inform Lee County Optical of the current address and phone number for the patient and the responsible party.
- Present all current insurance cards prior to each offce visit.
- Verify at each visit that the information is current by signing our data sheet.
- Pay any required copay at the time of the visit.
- Pay any additional amount owing within 30 days of receiving a statement from our office. *(When Lee County Optical receives an explanation of benefits (EOB) from your insurance company, any amounts that you need to pay will be billed to you).*

Returned Check Policy
If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker(RTM), the patient or the Patient's Responsible Party will be responsible for the original check amount in addition to a $25.00 Service Charge. Once notice is received of the returned check, Lee County Optical will send out a letter to notify the Responsible Party of the returned check. If a response is not made within 15 days from the letter date by the Patient or the Responsible Party, the account may be turned over to our collection agency and a collection fee will be added to the outstanding balance – in addition to the $25.00 Check Service Charge.

Non-Payment on Account
Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient's Responsible Party, understands that Lee County Optical has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or the patient's Responsible Party, understands that they are responsible for all costs of collection.

By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services, or as the responsible party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Patient Name (Please Print) _____

Patient Signature _____ Date _____

Responsible Party Name (Please Print) _____

Responsible Party Signature_____ Date_____

Notice of Information Practices

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

You entrust us with individually identifiable health and financial information (referred to as "personal information" in the rest of this notice). You are our best and most important source of information about you and others listed on your application. We may also collect personal information about you from others, such as health care providers, employers, or insurance companies.

EXAMPLES OF INFORMATION WE MAY COLLECT AND MAINTAIN

Your name, address, telephone number, Social Security number, date of birth, income, E-mail address, policy or account number, account not permitted or required by law, will be made only balance, policy coverage, premium payment, claims with your written authorization. You may revoke history, medical information, and motor vehicle reports.

INFORMATION WE ARE PERMITTED TO USE AND DISCLOSE WITHOUT AN AUTHORIZATION

We may use and share the personal information described above, but only as permitted or required by law. Examples include, but are not limited to, the following situations:

- To affiliates, but limited to transaction and experience information.
- To those who act on our behalf. They are required to keep the information confidential.
- They are required to use the information only to provide the services we have asked them to provide. They may include payment processing companies, mailing houses, data processing companies, business consultants, system support vendors, Internet vendors, and those that provide access to provider discounts for our insureds.
- To financial institutions with which we jointly offer, endorse, or sponsor a financial product or service.
- To the individual who is the subject of the information.
- For payment, such as using details received from an insurance company to coordinate benefits.
- For payment, such as to a health care provider to identify insurance coverage or benefits.
- For treatment, such as to your health care providers to help them provide medical care.
- For health care operations, such as exchanging information with another insurance company to detect or prevent criminal activity, fraud, and material misrepresentation.
- To provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- To a group health plan sponsor.
- For public health activities, such as to prevent or control disease, injury, or disability.
- To persons involved with your care, such as a family member, when you are incapacitated or in an emergency.
- To health oversight agencies for compliance purposes.
- In response to a court or administrative order.
- In response to a subpoena, discovery request, or other lawful process by another person involved in a dispute.
- For law enforcement purposes.
- To coroners, medical examiners, or funeral directors.
- To avert a serious threat to health or safety to you, another person, or the public.
- To federal officials for intelligence, counterintelligence, and other national security activities.
- To Worker's Compensation or other programs that provide benefits for work related injuries or illness.

ALL OTHER USES AND DISCLOSURES OF PERSONAL INFORMATION

All other uses and sharing of personal information, the authorization in writing. If you do, we will no longer use or share the information for the reasons covered by the authorization -- unless we have taken action based on the authorization. We are unable to withdraw any disclosures we have already made with your authorization.

Consent to the Use and Disclosure of Health Information

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
-a means of communication among the many health professionals who contribute to my care
-a source of information for applying my diagnosis and surgical information to my bill
-a means by which a third-party payer can verify that services billed were actually provided
-and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

_____

_____

____ Accepted _____ Denied

Patient Name _____

Printed Name of Guardian_____

Signature of Patient or Guardian X _____

Date Notice Effective Date_____