

Previous Patient Registration Form

			HEALTH H	IISTC	RY		建筑是张 。
Name:				DOB	:	Date:	S .
Occupation: Employer:							
Reason for visit today:							
Any concerns about your visi	on:						
If you don't currently wear co	ontacts, are	you int	erested in contacts to	day?:	□ Y	□ И	
Date of Last Visit to Primary Care Doctor:				_ Do	ctor: _		
Are you currently having any	y problems	s with th	e following?				
Double Vision Mucous Discharge Floaters in vision		Ito Ey In	edness ching we pain or soreness fection of eye or lid			Stye or Chalazion Flashes in vision Other: Date of Oper	-
Have you had any eye operate Have you been diagnosed wi					Catara		ation
☐ Other eye problems (Pleas						• •	*
						ne last 12 months? 🗆 Y	4
If yes, please explain			<u> </u>				
Have you or anyone in your							
Glaucoma	□ Y		Relation:				
Retinal Detachment		□N					
Macular Degeneration		\square N					
Other Eye Condition		\square N	Relation:			Explain:	
High Blood Pressure	\square Y	\square N	Relation:				
Diabetes	\square Y	\square N	Relation:				
Diabatas Tuma Law II.	Doto	of Diag				st Blood Sugar: Da	ıta:
						ider control? \square Y \square N La	
						der control. — 1 — 1 — Ed	
V2 V3 V3 V4							
Medication Allergies:							•
Do you have one problems	with any c	of these	evetame? (ahaal hav	for al	l that	annly)	
Do you have any problems very Headaches Ear	/Nose/Thr		(15)	iorai			estinal \square
	Nervous		Musculoskeletal	_	n 🗆	Mental ☐ Glands ☐	csiniai 🗆
Allergic/Immunologic				SKI	ı U	Montai 🗆 Olalius 🗆	
		0.555	oss/Gaiii 🗆				

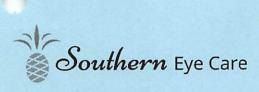
FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have vision and/or medical insurance, we wish to help you receive your maximum allowable benefits. To achieve this, we need your understanding of and assistance with our financial and payment policy. PLEASE PROVDE BOTH YOUR VISION AND MEDICAL INSURANCE CARDS AT EACH VISIT.

Payment for services is due at the time services are rendered. We accept cash, or credit card (Visa, MasterCard and Discover). Insurance plans vary considerably, and we cannot predict or guarantee what part of our services will or will not be covered. It is the responsibility of the patient to provide accurate and timely insurance information at the time of service. Inaccurate or untimely information given to the staff that results in denial or noncoverage by your insurance company results in the guarantor being responsible for payment. If your insurance carrier is not one with which we participate, you are responsible for payment in full. In addition, any services performed that are not covered by your insurance are the responsibility of the guarantor. _____Initial

While the filing of insurance claims is a courtesy that we extend to our patients, all charges not covered by your insurance company are your responsibility. Please understand that insurance policies are a contract between the policy holder and the insurance company. Our office is not a party of that contract. Every effort will be made to **estimate** your co-payments, deductibles, and covered services. We at no time guarantee what your insurance will or will not pay on each claim. We will cooperate fully with the regulations and requests of your insurance company that may assist in accurately filing your claim. Disputes or denied claims should be directed to your insurance carrier and/or employer. If your insurance company has not made payment within 30 days, we will ask you to contact your insurance company to make sure payment is expected. Ultimately, you are responsible for any unpaid balance. All patient balances that remain delinquent after 90 days, with no response to our requests for payment, may be referred to a collection agency. Should it become necessary to turn your account over to a collection agency, additional fees will be added to your balance.

I have read the above Financial Policy, I understand and agre	e to it.
Pa <mark>tient or Guardian Signature:</mark>	Date:
Medicare: Payment is required at the time of service for all deductibles, con Please be aware that each year, starting January 1, resets your deductible. Minors: Minors will not receive treatment without a parent or guardian production production another party will be bringing child for their appointment. The parent or guardian production payment at time of service. In case of divorce, regardless of decree, the passet You acknowledge you will be considered a "self-pay" patient if Initial	Initial esent. Arrangements must be made with our office PRIOR to exam if uardian accompanying a minor is responsible for co-insurance or full arent bringing the child is responsible for payment. Initial
VISION VS. ME	DICAL EXAM
If your routine vision exam reveals a medical condition or disease related to Unfortunately, the doctor cannot tell if medical eye conditions exist before the priority and will be filed with your medical insurance. Medical visits of as any follow up appointments. Your routine vision exam will be reschedularision insurance plan cannot be billed for medical eye conditions (i.e. dwill be monitored and billed separately, often at a separate visit from y which we participate, you will be advised of what the self-pay rate will be form	you are thoroughly examined. Any acute medical condition will become ften include specialist copays, and will apply to any medical visits as well ed after the medical condition has resolved. Furthermore, your primary iabetes, glaucoma, amblyopia, strabismus, etc.). Medical conditions our routine vision exam. If your medical insurance is not one with or your treatment.
PATIENT HIPAA	CONSENT FORM
I acknowledge I have been offered or received a copy of the Southern Eye Ceye Care, O.D., PLLC is a healthcare provider and may share my informati Notice of Privacy Practices should be amended, modified or changed, I will contact the Privacy Officer at 919-556-1530.	on for treatment, payment, and healthcare operations. I understand if the
Patient or Guardian Signature:	Date:
CONSENT FOR RELEASE/ SHA	RING OF MEDICAL RECORDS
I agree to grant access, or allow Southern Eye Care, O.D., PLLC to discuss	
Patient or Guardian Signature: This authorization is valid for one year from date signed, unless I revoke this authorization. I understand that once My Health Information	Date: is authorization, or unless and earlier date is specified here: n is disclosed as requested in this authorization, My Health Information
may no longer be protected by federal and state privacy laws and potentially	y may be re-disclosed by the person who is receiving my information.



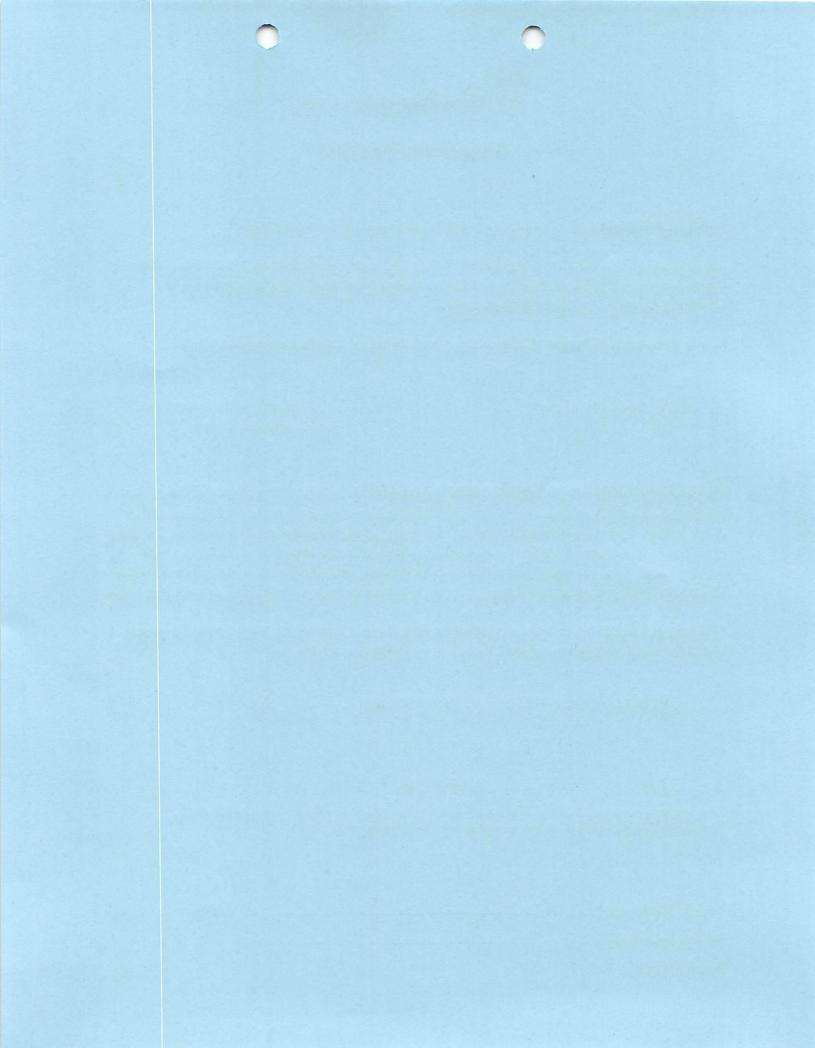
Additional Services

Retinal Imaging - Please see the description on the following page.

Because we feel this test is so important, the fee has been discounted to \$25.00 if we are performing it as a preventative service rather than a diagnosed medical condition. A screening photo is not covered by insurance. Medical Photos (i.e. Diabetic), if insurance doesn't apply, are discounted to \$55.00. YES I would like photos I would like to discuss the photos with the doctor. Pupillary Distance Measurement (PD) Ordering your glasses on line? You will be asked for this measurement. This is an estimated measurement in millimeters of the distance between the center of your eyes. It is a necessary measurement to manufacture your eye glasses, if you plan to order your glasses on-line. This is a one-time measurement for adults (it may vary for children over-time due to growth), and can be done for you today for a \$10.00 fee. This measurement is not covered by insurances nor included in a routine eye exam. **We do not recommend ordering glasses online if you are ordering a lined bifocal, no line bifocal or have a high prescription. Please see us with any questions. YES (Measure my PD for an additional \$10.00) NO PD (Staff initial) *Please be aware that Southern Eye Care, O.D., PLLC, Kris J. Roy, O.D., and staff are not liable/responsible for the outcome of eye glasses ordered on-line. Patient Name(print): Date:

Patient Signature:

(Parent if minor)



Assumption of the Risk and Waiver of Liability Relating to Coronavirus/COVID-19

The novel coronavirus, COVID-19, has been declared a worldwide pandemic. CO	VID-19 is
extremely contagious and is believed to spread mainly from person-to-person of	ontact.

Therefore, Southern Eye Care O.D., PLLC has put in place preventative measures to reduce the spread of COVID-19; however, Southern Eye Care O.D., PLLC cannot guarantee that you or your family will not become infected with COVID-19.

By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that myself or my family may be exposed or infected by COVID-19 by receiving eye care services at Southern Eye Care and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I understand the risk of becoming exposed to or infected by COVID-19 at Southern Eye Care may result from the actions, omissions, or negligence of myself and others, including, but not limited to, employees, student interns, and other patients.

I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to myself or my family (including, but not limited to, personal injury, disability, and death) illness, damage, loss, claim, liability, or expense of any kind that I or my family may experience or incur in connection with my time at Southern Eye Care. On my behalf, and on behalf of my children, I hereby release, covenant not to sue, discharge, and hold harmless Southern Eye Care, its employees, agents, and representatives of and from the claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any claims based on actions, omissions, or negligence of Southern Eye Care, its employees, agents, and representative, whether a COVID-19 infection occurs before, during, or after my visit(s) to Southern Eye Care.

Signature of patient	Date	
Print name of Patient/Parent/Guardian	Name of child if minor	

Patient Screening Form:

Have you had any of the following in the last 14 days:

Have you had any fever or flu-like symptoms? ☐ yes ☐ no				
Shortness of breath, cough, fatigue, GI upset, loss of taste or smell? \Box yes \Box no				
Are you in contact with any confirmed COVID-19 positive patients? \Box yes \Box no				
Have you traveled in the past 14 days to any regions affected by COVID-19? \Box yes \Box no				
Patient/Parent signature:	_ Date:			
For office use only:				
Temperature: Date: Time:				
Took initials				