GREENWOOD
VISION CARE

Scleral Lens Fitting Referral Form

Dr. Olivia Jahnke OD

Patient Name____

Date of Birth____________________Patient Phone #________________________

Address____

City/State/Zip____

Patient Vision Insurance______________________________________

Referral Reason:

- ☐ KERATOCONUS
- ☐ PMD
- ☐ DRY EYE
- ☐ OTHER

Referring Dr.____

Phone #____________________________Fax #____________________________

622 N Madison Ave. Suite 9 Greenwood IN 46142 ◆ Ph: 317-653-5872 ◆ Fax: 317-893-4388

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VISION CARE

Patient Information Record

Patient's Last Name____________________ First Name ________________________ MI __________

Address __________________________________City ______________ State _____ZIP __________

Home Phone _________________________ Work Phone ______________________________________

Cell Phone _________________________ E-mail ____

Social Security No. ____________________ Birth Date _____________ Sex ☐ M ☐ F Age ________

Occupation & Employer ____

Marital Status ________________________

Name of Spouse or Nearest Living Relative ________________ Relationship _____________________

Phone Number _______________ Address (if different that above) _________________________________

How did you hear about us? ☐ Patient Referral, If so, who? ___________________________________

☐ Website ☐ Facebook ☐ Instagram ☐ Google ☐ Other: ________________

*** Part of your Annual Eye exam requires Retinal Photography. Dr. Richard and/or Dr. Jahnke will determine whether we can bill this service medically or not. If we cannot bill it to your medical insurance the charge for this test is $39.00**

Financial Responsibility

We are happy to file insurance claim forms or take assignment on your medical/vision plans of which state you are a member. We will do all we can to help receive maximum benefits, however, in the event that the plan sponsor determines that you are ineligible for coverage at the time of service, or makes a determination that you are eligible for a reduced level of coverage, by signing this statement you hereby agree to be financially responsible for any and all charges incurred by you and not paid by the plan sponsor.

____ ____________________

Signature of patient or person acting on patient's' behalf Date

____ ____________________

HIPPA Consent Signature (Policy on Back side of page) Date

622 N Madison Ave. Bldg E Ste.9 Greenwood, IN 46142 Phone 317-893-4441 Fax 317-893-4388

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.
The notice contains a patient's rights section describing your rights under law. You ascertain that by your signature that you have reviewed our notice before signing the consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allowed for these of information for treatment, payment or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.