SOUTHERN KENTUCKY EYE CENTER REGISTRATION FORM

Today's Date: _____

PATIENT NAME
DOB **SS#** **Sex ( )Male ( ) Female**
MARTIAL STATUS ( ) SINGLE ( ) MARRIED ( ) WIDOWED ( ) DIVORCED ( ) CHILD N/A
HOME PHONE #
CELL PHONE#
MAILING ADDRESS
CITY **ST** **ZIP CODE**
EMAIL ADDRESS
SPOUSE'S NAME **PHONE #**
EMERGENCY CONTACT
NAME AND RELATION
PHONE#
GUARANTOR NAME OR PARENT INFORMATION IF PATIENT IS A CHILD
NAME
RELATION
PHONE#
POA (Power of Attorney)
NAME
PHONE#
PRIMARY CARE DOCTOR
CARDIOLOGIST
OPTOMETRIST
PHARMACY
EMPLOYER INFORMATION
EMPLOYER
PHONE#

OFFICE POLICY AGREEMENT SOUTHERN KENTUCKY EYE CENTER, PSC (SKEC)

CO-PAYS, DEDUCTIBLES, AND PAST DUE BALANCES ARE TO BE PAID AT THE TIME OF VISIT. I certify that I have the above coverage and assign directly to SKEC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by my insurance company. I authorize the use of my signature on all insurance submissions and any insurance related matters. SKEC may use my health care information and may disclose such information to my insurance, their agents, and their internet-based portals for the purpose of obtaining payment for services and determining insurance benefits, co-pays, deductibles and coinsurance amounts or the benefits payable related services. Services rendered to minor/dependent patients. We will look to the adult accompanying the patient for payment on the date of service. In cases of separation or divorce, when presenting insurance cards for a dependent enrolled under a subscriber other than you, please be prepared to supply the subscriber's name/address/phone/date of birth and social security number. We request that you inform the subscriber that their insurance has been used. *If your account becomes delinquent and collection proceedings occur, and you will be 100% liable for any collection fees, attorney and court costs incurred by Southern Kentucky Eye Center to collect said fees from the responsible party. **Returned checks are subject to a $30.00 administrative charge.** * I have read and understand the financial policy of Southern Kentucky Eye Center, PSC regarding payments and insurance. I agree to pay for services and tests not covered by my insurance plan. I also understand that I am responsible for following my insurance plan's regulation, policies and procedures. If my account becomes delinquent and SKEC must use an outside agent for collections I will be responsible for any additional fees that are charged to SKEC for the collection of my account balance.

Signature:_____Date:_____

REFRACTION SERVICE AND FEE Please read and understand before signing. A refraction is the method to determine the best visual acuity achievable of an individual. It is the first step in determining whether an individual has a potentially harmful medical condition relating to their eyes and vision. Also, a refraction is the process of determining if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and necessary to write a prescription for glasses or contact lenses. For these reasons, refraction will be performed at every eye examination. Most medical insurance plans, including MEDICARE, do NOT cover refractions or routine eye examinations. Medicare allows that we charge separately for that portion of the examination, since it is non a covered service. Our office fee for a refraction is **$20.00** and this fee is collected at the time of service, in addition to any co-payment your insurance plan may require. Should your plan pay us for the refraction, we will reimburse you accordingly. If you have any questions regarding Medicare and insurance policies or procedures, please do not hesitate to ask. We will do our best to assist you. Patient Acknowledgement: I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service and understand that payment is due at the time of service. I understand that any co-payment, co-insurance or deductible I may have are separate from and NOT included in the refraction fee.

Signature: _____Date: _____

Dilation of the Pupils: Due to a widening of the pupil, dilating drops may blur your vision for about 4-6 hours, and in some cases longer. Because dilation will vary for everyone it is not possible for us to know how much your vision will be affected. Driving may be difficult after an examination and we recommend that you have someone to drive you. If you still choose to drive while your eyes are dilated, Mark A. Henry, M.D., and Southern Kentucky Eye Center, cannot be held liable/accountable for any damages or accidents that may occur due to the dilation.

Signature: _____Date: _____

Southern Kentucky Eye Center

HIPAA COMPLIANCE PATIENT CONSENT FORM SOUTHERN KENTUCKY EYE CENTER

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 THE LAW. YOU ASCERTAIN THAT BY YOUR SIGNATURE THAT YOU HAVE REVIEWED OUR NOTICE BEFORE SIGNING THIS 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 HEALTH CARE 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 ALLOWS FOR THE USE OF THE INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS. BY SIGNING THIS FORM, YOU CONSENT TO OUR USE AND DISCLOSURE OF YOUR PROTECTED HEALTH CARE 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 RE RETROACTIVE.

CONSENT TO WIRELESS TELEPHONE CALLS AND EMAIL USAGE

IF AT ANYTIME I PROVIDE A WIRELESS TELEPHONE NUMBER OR EMAIL ADDRESS, AT WHICH I MAY BE CONTACTED, I CONSENT TO RECEIVE CALLS OR TEXT MESSAGES, INCLUDING, BUT NOT RESTRICTED TO COMMUNICATIONS REGARDING BILLING AND PAYMENT FOR ITEMS AND SERVICES, UNLESS I NOTIFY, SKEC TO THE CONTRARY IN WRITING. IN THIS SECTION, CALLS AND TEXT MESSAGES INCLUDE, BUT IS NOT RESTRICTED TO PRE RECORDED MESSAGES, ARTIFICIAL VOICE MESSAGES, AUTOMATIC TELEPHONE DIALING DEVICES OR OTHER COMPUTER ASSISTED TECHNOLOGY, OR BY ELECTRIC MAIL, TEXT MESSAGING OR BY ELECTRONIC MAIL, TEXT MESSAGING OR BY ANY OTHER FORM OF ELECTRONIC COMMUNICATION FROM THE OFFICE, AFFILIATES, CONTRACTORS, SERVICERS, CLINICAL PROVIDERS, ATTORNEYS, OR ITS AGENTS INCLUDING COLLECTION AGENCIES. I CONSENT TO RECEIVE PORTAL INSTRUCTIONS, STATEMENTS, BILLS, MARKETING MATERIAL FOR NEW SERVICES AND PAYMENT RECEIPTS AT THE EMAIL ADDRESS FROM THE OFFICE OF SKEC.

BY SIGNING THIS FORM, I UNDERSTAND THAT:

PROTECTED HEALTH INFORMATION MAY BE DISCLOSED OR USED FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATION.

THE PRACTICE RESERVERS THE RIGHT TO CHANGE THE PRIVACY POLICY AS ALLOWED BY LAW.

THE PRACTICE HAS THE RIGHT TO RESTRICT THE USE OF THE INFORMATION BUT THE PRACTICE DOES NOT HAVE TO AGREE TO THOSE RESTRICTIONS.

THE PATIENT HAS THE RIGHT TO REVOKE THIS CONSENT IN WRITING AT ANY TIME AND ALL FULL DISCLOSURES WILL THEN CEASE.

THE PRACTICE MAY CONDITION RECEIPT OF TREATMENT UPON EXECUTION OF THIS CONSENT.

- **MAY WE PHONE,EMAIL, OR SEND A TEXT TO YOU TO CONFIRM APPOINTMENT:**
- **[ ]YES [ ] NO**
- **MAY WE LEAVE A MESSAGE ON YOUR ANSWERING MACHINE AT HOME OR ON YOU CELL PHONE:**
- **[ ]YES [ ]NO**
- **MAY WE DISCUSS YOUR MEDICAL CONDITION WITH ANYONE OTHER THAN YOURSELF:**
- **[ ]YES [ ]NO**

IF YES PLEASE NAME OF THE ALLOWED TO RECEIVE YOUR MEDICAL INFORMATION

1.

2.

3.

4.

5.

SIGNATURE: _____ **DATE:** _____/_____/_____

Southern Kentucky Eye Center Medication List

PATIENT NAME: _____ DOB: _____

ARE YOU **ALLERGIC** TO ANY MEDICATION: __**YES** ___**NO**

IF YES PLEASE LIST MEDICATION AND REACTION:

_____

PLEASE LIST ALL OCCULAR (EYE) MEDICATION YOU ARE CURRENTLY TAKING

MEDICATION	FREQUENCY	EYE (RIGHT) or (LEFT)

PLEASE LIST ALL MEDICATION YOU ARE CURRENTLY TAKING

MEDICATION	DOSAGE	PRESCRIBING PROVIDER

PRIMARY CARE PROVIDER: _____

CARDIOLOGIST: _____

OPTOMETRIST: _____

PHARMACY NAME_____