Welcome To Our Office

Date:___________________________

Patient Name:____SSN____________________Date of Birth____________

Address________________________________City________________________State___________________Zip_______ _________

Home Number:( )_______________________Cell:( )______________________Work Number:( )______________________

Email Address:__________________________________Occupation (student)_________________Employer (grade)_____________

Primary Care Physician____Phone ( ) __________________________

Chief complaint/Reason for visit____

****If medical care is provided all DEDUCTIBLES and COPAYS are DUE AT THE TIME OF SERVICE****

Please note: We are only able to treat one problem per visit. Multiple symptoms may require multiple visits.

VISUAL HISTORY

Do you currently wear: □ Glasses □ Contacts

Do you have any problems with your current glasses or contacts? □ Yes □ No

Do you wear bifocal lenses? □ Yes □ No

Will you be needing a new/updated Contact Lens prescription today? □ Yes □ No

***Note: You will be charged a contact lens exam fitting fee. A contact lens prescription is not included In the routine eye exam. The fitting fee for a contact lens prescription is NOT usually covered by Insurance. A detailed copy of our contact lens fitting and evaluation procedures Is available on request.**

SOCIAL HISTORY

Do you use tobacco? □ Yes □ No How many years_____ Amount/day_____

Do you drink alcohol? □ Yes □ No How many years_____ Amount/day_____

MEDICAL, VISION, PRIMARY AND MEDICARE INSURANCE:

I certify that the information given by me in applying for insurance and/or Medicare payment is true and accurate. I authorize my doctor to act as my agent in helping me collect payment on my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Hill Country Vision Center on my behalf for any services and materials furnished. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. If I have other health coverage insurance (as indicated in the Item 9 of the HCFA-1500 Claim Form or the electronically submitted claim),my signature authorizes release of the about medical information to the Insurer or agency shown, and authorizes my doctor to act as my agent, as above.

PRIVACY ACT

I also certify that I have had a chance to read/obtain a copy of the Privacy Act.

______________________________ __________________________

Patient name Date

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Patient/Guardian Signature

If you would like your information released to anyone in your family, a friend, caregiver, foster parent, parent, or spouse, please list them below.

____

____

____

Medical History Questionnaire

Eye Health History:

Do you ever experience any of the following symptoms (circle all that apply to you).

Blurred Vision
Dry/Sandy Feeling
Redness
Eye lid crusting
Squinting/Blinking
Burning
Watery Eyes
Bothered by glare/ night vision
Foreign Body Sensation
Eye Fatigue/ Soreness
Discharge/ Infection
Itching

PATIENT MEDICAL/OCULAR HISTORY:

Medical History (circle all that apply)

Allergic/ Immunological
Heart Disease
Ear/Nose/Throat
High Cholesterol
Skin
Anxiety/Depression
Fever
Diabetes
Stomach/urinary/bladder
Respiratory
Headaches
Blood disorder
Thyroid
Pregnant/nursing
Hypertension
Psychiatric
Muscle/Bone

Ocular History (circle all that apply)

Cataract
Glaucoma
Lazy eye
Crossed eyes
Macular Degeneration
Other____

Eye Injuries/Surgeries (please list): ____

List any medications you are currently taking:____

____

Are you allergic to any medication? Yes No
If yes, please list____

Family Medical History Yes No
Cancer
Diabetes
Heart Disease

Family Ocular History Yes No
Blindness
Glaucoma
Macular Degeneration

Our offices are equipped with one of the most advances instrument developed for eye care

Computerized Visual Field Test. This measures the sensitivity of the nerve tissue to light for defects that might not otherwise be seen during a routine examination. It is the standard of care for early detection of Glaucoma, Macular Degeneration, Neurological diseases and Arterial diseases. There is a ***$35.00*** fee for this additional service, this test is covered by most Medical insurances with a medical diagnosis.

*************************Please sign below if you wish to have this test done.*************************

Yes, I would like to have this test done____

No, I would not like to have this test done at this time______________________________

Hill Country Vision Center

Brandon Blaker O.D. Shelly Blaker O.D. W. Steve Kroeger O.D. Jacklyn Alaquinez O.D.

January 1, 2016

Re: **Coding of Office visits for your insurance billing**

Dear Valued Patient,

All insurance plans follow national-based guidelines from the Federal Government and use the same terminology for describing your visit. How we code your visit is based on the type of visit you had as well as any problems discovered during your exam with us. We **CANNOT and WILL NOT** change the coding after your insurance claim has been submitted to your insurance company based on your request to our office if your plan does not cover either the preventative care or a problem focused visit. Some plans will pay for routine annual exams but many will not. It is the patient/insurer responsibility to know the specifics of their insurance benefits prior to your visit. You should contact the customer service number on your card to find out the details of your coverage prior to your visit with us.

We will always strive to care for you in the best manner that we know, whether or not your insurance deems it appropriate or reimbursable.

Hill Country Vision Center

Brandon Blaker O.D. Shelly Blaker O.D. W. Steve Kroeger Jacklyn Alaquinez O.D.

FINANCIAL POLICY
(updated January 1, 2016)

Payment for our services is due at the time of your visit. This includes co-payment, co-insurance, non-covered services and payment to meet your insurance deductible.
As a courtesy to you, we will file a claim to your primary and secondary insurance plans at no cost. We will work closely with your insurance company to ensure you get full and appropriate coverage. However, the patient (or legal guardian if the patient is a minor) is ultimately responsible for any charges Incurred if the insurance company does not pay. If you are not sure of your insurance financial responsibility, please contact your insurance company, in advance, to obtain this information. Any balance remaining after insurance has paid will be due upon receipt of a statement.

PRIOR BALANCE: Patients with a prior balance are expected to pay any patient balance in full before any additional services are provided. If the balance cannot be paid in full, then you must speak with our billing department to make payment arrangements prior to your appointment.

PATIENTS WITHOUT INSURANCE: We are pleased to be able to provide services to patients that do not have insurance.

MEDICARE PATIENTS: We accept Medicare assignment. You're responsible by law for the 20 percent difference between the Medicare allowable and the Medicare reimbursement, and charges for non-covered services. In addition to the statement we send you, you should also receive an explanation of benefits from Medicare indicating your portion of the amount due.

MEDICAID PATIENTS: We accept Medicaid assignment. A current Medicaid card MUST be presented at each visit. If you have exceeded the legislative Units for the year as set forth by Medicaid, you will be held responsible for the charges.

PRIVATE PAY PATIENTS: We accept assignment for many of the insurance plans active locally. If we are not a preferred provider for your plan, you will be asked to pay for the service at the time it is rendered. A claim will be filed for you. If we are a preferred provider with your plan, you will be required to pay applicable co-payments at the time of service and you are responsible for any co-insurance, deductibles and payments for non-covered services.

METHODS OF PAYMENT: We accept cash, check, Visa, Mastercard, Discover and American Express.

RETURNED CHECKS: There will be a $35.00 fee assessed for any and all checks returned for the bank for any reason.

COLLECTION PROCEDURES: Our billing department is always available to help you with questions and/or payment arrangements. Once made in writing, agreements are binding. We consider payment for services rendered to be an important part of the patient's role in the patient/physician relationship. Prompt payment for services rendered is expected and failure to comply or respond to repeated communications from our office may result in discharge from the practice and/or involvement of an outside collection agency.

MINOR PATIENTS: For all services rendered to minor patients, the adult accompanying them is responsible for payment. Even if the parents are divorced, the parent that accompanies the minor to the offices is responsible for payment, regardless of the terms of the custodial agreement.

MISSED APPOINTMENTS AND NO-SHOWS: Patients are seen by appointment and we request that you call in advance so we can reserve time for you. We make every effort to honor all time commitments and request that you extend the same courtesy to us by letting us know 24 hours in advance if you are unable to keep your appointment.

INFORMATION CHANGE: Please promptly advise us of any address, employment, phone number, marital status and/or insurance changes.

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I have read and understand the financial policy of Hill Country Vision and it's doctors and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I hereby voluntarily consent to healthcare encompassing diagnostic procedures and treatment by my physician, assistants or other healthcare providers, as may be necessary in my physician's judgment.

This form has been explained to me, and I certify that I understand its contents.

_______________________________ _________________________

Signature of patient or Guardian Date

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Patient's Name (please print)