Last Name: _____ First Name: _____

Middle Name: _____ Preferred Name: _____ ◯ Male ◯ Female

Marital Status: ◯ Single ◯ Married ◯ Separated ◯ Divorced ◯ Widowed

Social Security Number: _____-_____-_____ Date of Birth: _____

Preferred Language: _____ Race: _____

Home Phone: _____ Work Phone: _____

Mobile Phone: _____ Preferred Phone: ◯ HOME ◯ WORK ◯ MOBILE

Email: _____

Preferred Contact Method: ◯ Phone ◯ Email ◯ Patient Portal
Is it okay to leave a detailed message? ☐ YES ☐ NO
Would you like to receive email notifications? ☐ YES ☐ NO
Would you like to text messages? ☐ YES ☐ NO

Mailing Address: _____

City: _____ State: _____ Zip: _____

Seasonal Address: _____ Dates there: _____

City: _____ State: _____ Zip: _____

Pharmacy Name: _____ Location: _____

Primary Physician: _____ Location: _____ Phone: _____

Referring Physician: _____ Location: _____ Phone: _____

Guarantor Name: _____ Date of Birth: _____ SS#: _____
☐ Address – same as above ☐ Phone- Same as above ☐ Email-Same as above

Guarantor Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ ◯ Home ◯ Work ◯ Mobile Email: _____

Emergency Contact Person: _____ Relationship: _____ Phone: _____

Caretake Name: _____ Relationship: _____ Phone: _____

Spouse Name: _____ Phone: _____

Employer Name: _____ Occupation: _____

<u>Our office does NOT take any vision insurance</u> – All insurance cards must be presented.
Primary Medical Insurance: _____ Secondary Medical Insurance: _____

Release of Health Information: I give the following people listed below consent to obtain the following information and will be in effect until written notice is given to be removed:
Name: _____ Relationship: _____ ☐ Medical Information ☐ Billing Information

Name: _____ Relationship: _____ ☐ Medical Information ☐ Billing Information

☐ By checking this box, you agree to use an electronic document and an electronic signature. You understand that electronic signatures are legally binding.

Signature: _____ Date:_____

Eye Physicians & Surgeons, S.C.

1311 S. Lincoln St. Elkhorn, WI 53121 | Phone: (262) 723-4600
675 W. State St. Burlington, WI 53105 | Phone: (262) 763-7772
Fax: (262) 947-4996 | Website: https://eyephysician.com

NOTICE OF PRIVACY PRACTICES
SHORT FORM SUMMARY

This Notice is Effective as of: July 20, 2018
Reviewed: 12/17/2020

This is only a summary of our Notice of Privacy Practices. Please review the full Notice following this summary to learn how we use and disclose medical information about you and your rights concerning these uses and disclosures.

How We Use and Disclose Your Information

We will obtain your written authorization for any uses and disclosures of protected health information "PHI" not described in the Notice of Privacy Practices.

Treatment, Payment, and Health Care Operations. We may use your PHI in order to provide your medical care; to bill for our services and to collect payment from you or your insurance company; and for the general operation of our business.

We may use your PHI as otherwise authorized or required by law for such purposes as:

- public health reporting and oversight activities
- judicial, administrative, or law enforcement proceedings
- complying with workers' compensation laws
- communicating with your family or caregivers
- sending appointment reminders

You Have the Right to:

- Request certain restrictions on our use and disclosure of your PHI.
- Request communications from us by specific means or locations.
- Inspect and copy your medical record.
- Ask us to correct the information in your medical record.
- Receive an accounting of disclosures of your PHI by our practice.
- Be notified in the case of a breach of unsecured PHI.

CONTACT US

Contact our Privacy Officer with any questions, comments, or complaints or to exercise any of your rights at Eye Physicians & Surgeons - Heather 262-723-4600 heather.c@eyephysicianemail.com

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MEDICAL SERVICE AGREEMENT

I hereby authorize and consent to medical treatment by Eye Physicians & Surgeons, S.C. for me (or my dependent). I authorize Eye Physicians & Surgeons, S.C. to release my (or my dependent's) medical information to my (or my dependent) family doctor and to any insurance company, adjuster, attorney, authorized agent working on behalf of Eye Physicians & Surgeons, S.C., or other authorized party.

I understand that I am responsible for payment of all medical treatment rendered to me (or my dependent) by Eye Physicians & Surgeons, S.C., and I agree to pay all co-payments, deductibles, and non-covered services in full at the time of the visit. If I am seen at any time by an Eye Physician & Surgeons, S.C. physician without a required referral, I understand that I am financially responsible for all charges incurred. I understand that insurance authorizations are an estimation of coverage, and that final out of pocket amounts may vary based on actual insurance payment. A fee of $10.00 will be charged for all returned checks.

I understand that during my exam if a medical diagnosis is found, the exam will be considered medical and as such will be submitted to my medical insurance.

I understand that, as a courtesy to me, Eye Physicians & Surgeons, S.C., will file either a paper claim or an electronic claim, whichever is required by my (or my dependent's) insurance carrier, and I authorize payment directly to Eye Physicians & Surgeons, S.C. for the benefits otherwise payable to me under the terms of my (or my dependent's) insurance. I understand that I am responsible for maintaining current coverage information to meet filing deadlines and for the payment of any remaining balance after payment from my insurance carrier. If I fail to meet my financial obligations, I agree to pay attorney and/or collection agency fees in the amount of $10.00 of the amount due at the time the account is turned over for collection plus court costs and any additional collection fees.

I understand that with Medicare as my primary insurance, that I am required to provide my secondary insurance identification card, if applicable. When the office does not have the proper information for a secondary insurance, the secondary will not be billed, and it will be my responsibility to pay the balance, and subsequently file a claim with the secondary for reimbursement on my own.

I understand it is my responsibility to know my insurance benefits and to provide our office with accurate and current insurance information. If my specific insurance plan requires a referral, it is my responsibility to obtain the referral from my primary care physician. If I arrive for an appointment without a referral on file, I have the option to reschedule the appointment or to pay in full for all services rendered at the time of service.

One of the most important parts of your eye exam today is the refraction. This is the part of the exam by which we determine whether you can be helped in any way by a new glasses' prescription. It is also how we determine the best possible visual acuity and function of your eyes, which is essential information for us to have as we assess your eyes and look for problems, therefore making it a necessary part of the examination and not optional. This is NOT a covered service by Medicare and many other insurance plans. Should your plan pay us for the refraction, we will reimburse you accordingly. The fee for refraction varies year by year.

Patient Initial's: _____

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Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye. Frequently the drops cause a blurred vision and light sensitivity for a length of time which varies from person to person. It is not possible for your ophthalmologist to predict how much your vision will be affected. Adverse reactions such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention. If you feel like your driving may be impaired, please discuss this with the doctor prior to dilation.

I understand that a medical assistant will accompany the doctor scribing my examination.

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I authorize Eye Physicians & Surgeons, S.C. to view/import my medication history when electronically prescribing medications.

If you are a patient in a hospital or skilled nursing facility, this authorization is in effect for the period of your confinement.

I have been offered and/or received a copy of HIPAA notice of Privacy Practices, and I agree and understand.

Contact lens fittings are additional services and are not included in the cost of your eye exam. Medical insurance does not cover these contact lens related services. All contact lens related follow up appointments within 60 days are included, as are the trial lenses that are dispensed. Contact lens prescriptions are valid for one year by state law. Payment is required at the time of visit.

Standard Contact Fitting - $89.00

Specialty Contact Fitting - $178.00

All of the above authorizations are in effect until I choose to revoke them.

☐ By checking this box, you agree to use an electronic document and an electronic signature. You understand that electronic signatures are legally binding.

Patient Signature _____
(Patient signature or authorized representative)

Printed Patients Name: _____ Date: _____