PATIENT INFORMATION

Title (circle one): Dr. Mr. Mrs. Ms.

First Name: _____ M.I. _____ Last Name: _____

D.O.B _____ Age: _____ Full SSN: _____

Street Address or P.O. Box: _____ APT # _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Preferred (check one): ☐ HOME ☐ CELL ☐ WORK

E-mail: _____ *E-mail addresses will NOT be used for any marketing or spam mail, and a secure connection will always established during transmission to protect the confidentiality of your private health information

Responsible Party (if not patient): _____

Relationship: _____ Contact Phone: _____

Marital Status (circle one): Single Married Divorced Separated Widowed

How did you hear about us?

☐ Referred by Dr. _____

☐ Insurance ☐ Internet ☐ D Magazine ☐ Family/Friend ☐ Other: _____

HIPAA PRIVACY & CONFIDENTIALITY POLICY

We are committed to providing you with quality, personal healthcare. As a part of our professional relationship, it is important that you understand our Patient Confidentiality Policy. Agreement with these policies is required for all medical services provided through Saland Vision.

Patient Confidentiality

Last Name: _____ First Name: _____ M.I.: _____

Please list all family or other personal representatives, and their relationship to you, who may receive information about your medical condition and/or treatment. (i.e. Pick up rx, reports, financial info, appointments, etc.)

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____

Privacy Practice Acknowledgement

I understand that I have certain rights to privacy regarding my confidential health information.

- The right to inspect and receive a copy of your health information
- The right to receive an accounting of disclosures of health information.
- The right to restrict certain uses and disclosures of your health information (i.e. family members, friends, etc.)
- The right to obtain paper copy of this notice from us at any time.

I understand that my health information may be used to:

- Conduct, plan, and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers such as health insurance companies, guarantor, and/or patient.
- Conduct normal healthcare operations such as quality assessment and physical certifications.

I acknowledge that I have received and understood this policy and Saland Vision has the right to change its **Notice of Privacy Practices** from time to time and that I may contact Saland Vision at any time if I have any questions. I understand that I may request in writing that you restrict how my private information is used or disclosed. I also understand that you are not required to agree to my requested restriction, IF MY REQUEST CONFLICTS WITH FEDERAL OR STATE LAW.

_____ _____

Patient Signature Date

FINANCIAL POLICY

The following outlines the financial policies that our office follows. We encourage you to discuss your account, and ask any questions. Your understanding of our policy early on in your treatment process will prevent most concerns and issues in the future.

INSURANCE

- All co-payments and/or coinsurances will be collected at time of service.
- We will file claims on all visits and procedures to your **medical** insurance.
- Accounts will be balanced to match the insurance explanation of benefits (EOB) and any remaining balance will be forwarded to you, the patient.
- You are responsible for **ALL** balances **NOT** paid by your insurance.
- **Please remember insurance coverage is a contract between the patient and the insurance company. The ultimate responsibility for understanding your insurance benefits and for payment to your doctor rests with you.**

REFERRALS

- You are required to know whether or not your insurances require a referral, and obtain that referral before you are scheduled to visit our office.
- We will require payment in full on day of service if you do not obtain a referral.

NON-COVERED SERVICES

- Insurance companies will only pay for services that they find "reasonable and necessary".
- You are responsible for payment of any services denied by insurance.

REFRACTION SERVICE & FEES

- Refraction is the process of determining if there is a need for eyeglasses, and is an **essential** part of an eye exam. It is considered a routine vision service and performed on all comprehensive annual eye exams.
- Most medical insurance plans, including Medicare, **DO NOT** cover routine refractions.
- The fee for refractions is **$65.00** and is collected at the time of service.

PAYMENT

- Payment must be made by: Cash, Check, Credit/Debit Card, and Money Order.
- Cards accepted: **VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER, and CARECREDIT.**
- **A fee in the amount of $75.00 will be charged for all returned checks.**

PAST DUE ACCOUNTS

- Account balances should be handled promptly, and will be considered past due after 120 days with an outstanding balance. All past due accounts will be turned over to a collection agency, and a fee of 20% of past due balance will be added to your account.
- We will require full payment before seeing the physician for any future services.

Print Patient Name:_____ Date:_____

Patient Signature: _____

CREDIT CARD ON FILE – POLICY

Saland Vision requires keeping your credit/debit card on file as a convenient method of payment for the portion of services your insurance doesn't cover, but for which you are liable.

Your credit card information is kept confidential and secure. Payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

I authorize Saland Vision to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐ Amex ☐ Visa ☐ MasterCard ☐ Discover

Credit Card Number: _____

Exp. Date: _____

Cardholder Name: _____

Signature: _____

I (we), the undersigned, authorize and request Saland Vision to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by Saland Vision.

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to Saland Vision in writing and the account must be in good standing.

Patient Name (Print): _____

Patient Signature: _____

Date: _____

SALAND VISION

ROUTINE VISION SERVICES

A refraction is the process to determine if there is a need for corrective lenses. This is an essential part of the eye exam and is considered routine service. However, most medical plans, including Medicare, do not cover routine refractions. Our fee is **$65.00** and is collected along with your co-pay. If you buy prescription glasses or contacts from our optical shop, the refraction fee is waived.

Have you noticed a change in your vision lately? ***(Please circle one)***

YES NO

Do you have blurry vision? ***(Please circle one)***

YES NO

Are you interested in getting a glasses prescription? ***(Please circle one)***

YES NO

Do you want a contact lens prescription? ***(Please circle one)***

YES NO

Are you concerned that your cataracts are affecting your vision? ***(Please circle one)***

YES NO

NOTICE: *If you answered "Yes to the last question, the doctor recommends a refraction. This is the process to determine what prescription goes into your glasses. If you need cataracts surgery, your insurance* ***requires*** *a refraction to prove that it is a medical necessity. Without a refraction, your insurance will not pay for your surgery.*

The above information is true to the best of my knowledge. I authorize my medical insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance outstanding. I also authorize Saland Vision or my insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian Signature **Date**

SALANDVISION

REVIEW OF SYSTEMS

Please circle all applicable choices.

CARDIOVASCULAR	HEENT	MUSCULOSKELETAL	RESPIRATORY	BLOOD PRESSURE CONTROL
Chest pain	Dizziness	Back pain	Cough	Good control
Irregular heartbeat	Hearing loss	Joint pain	Trouble breathing	Borderline control
Shortness of breath	Hoarseness	Muscle aches	Wheezing	Poor control
	Ringing in ears	Stiffness		Unknown control
	Sore throat	Swelling		

CONSTITUTIONAL	HEMATOLOGIC	NEUROLOGICAL	SKIN	DIABETES CONTROL
Fatigue	Bleeding	Balance Problems	Hair loss	Good control
Fever	Bruising	Headache	Rash	Borderline control
Night sweats	Tender nodes	Numbness	Skin lesions	Poor control
Weakness		Tingling		Unknown control
Weight loss				

GENITOURINARY	METABOLIC	PSYCHIATRIC	ALLERGY	PREGNANCY
Genital discharge	Cold intolerance	Anxiety	Itching	First trimester
Genital lesions	Excess hunger	Depression	Hives	Second trimester
Painful urination	Excessive thirst	Insomnia	Chronic runny nose	Third trimester
Urgency	Frequent urination	Irritability	Seasonal allergies	
	Heat intolerance	Nervousness		