Summit Eye Care
OF WISCONSIN

Patient History Information

Fill in all blanks, sign, and date

Name: _____ _____ _____
(LAST) (FIRST) (MIDDLE)

Address:_____ City: _____ State: _____ Zip Code: _____

Sex: _____ Race: _____ Date of Birth: _____ Age: _____

Home Phone: _____Cell Phone: _____ Email: _____

Preferred Contact: ❑ Text ❑ Email ❑ Phone Call Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widow

Language Spoken: _____

How were you referred to our office? _____
(Doctor, Friend/Family, Web/Radio, Drive-by)

Emergency Contact Information

Emergency Contact Name: ___ _____ Relationship to Patient: _____

Emergency Contact Phone: _____ Emergency Contact Cell/Other Phone: _____

Responsible Party Name (required if patient is a minor): _____ Relationship to Patient: _____

Insurance Policy Holder Information

Insurance Subscriber Name: _____ Subscriber Relationship to Patient: _____

Subscriber Date of Birth: _____

Medicare Beneficieries: If you are covered by Medicare, we will file claims to your primary and secondary insurance for you. You should present a valid Mediacre card. We accept assignment, but you are responsible for any deductible, co-insurance, or non-covered services.

Signature_____

Eye and Medical Care Provider Information

Current Optometrist or Ophthalmologist: _____ Date of Last Visit: _____

Primary Care Physician/Medical Doctor: _____ Phone: _____

Preferred Pharmacy_____

Conditions of Registration

Many insurance plans do not provide 100% coverage for a medical bill. Each plan has its own set of rules, exclusions, and services. It is your responsibility to be familiar with your specific benefit plan. If you are unsure of your coverage for a particular medical procedure or test, you should call the customer service telephone number on your insurance card before scheduling the appointment or procedure. Co-payments are due at the time of service for all appointments with our physicians. It is your responsibility to understand when your insurance requires a co-payment for medical services. For in-clinic testing procedures, we will process the claim through your insurance company first and if necessary, you will be billed for the co-pay later. If you have questions about your co-payments, contact your insurance company. I certify that I have read and agree to Summit Eye Care payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. A $30.00 returned check fee will be charged for checks returned due to insufficient funds. I choose to receive communications from Summit Eye Care by text or voice at the number or address stated above, including but not limited to communications about appointments, feedback, treatment and payments.

Patient/Responsible Party Signature:_____ **Date:**_____

Please see back

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PRIVACY NOTATION / CONSENT OF DISCLOSURE

By signing this authorization, I authorize Summit Eye Care to share the selected information with the following individuals (such as spouse, parent, son/daughter, etc.):

- ❑ Appointment Details
- ❑ Medication Information
- ❑ Medical/Surgical Information
- ❑ Billing/Financial Information
- ❑ Any/All Information
- ❑ Decline

Individuals authorized to receive selected information and relationship:

Name: _____ Relationship to Patient: _____
Name: _____ Relationship to Patient: _____
Name: _____ Relationship to Patient: _____
Name: _____ Relationship to Patient: _____

By signing this form, I am giving my permission to this facility to contact me for appointments, services or education that may be of interest to me. I recognize that I may sign at the time of my appointment.

Patient Name (print):_____DOB:_____
Patient Signature: _____ Date: _____
Patient Representative / Signature: _____Relationship to Patient: _____

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Patient Health Information Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information. Your information may be stored electronically and if so is subject to electronic disclosure.

How We Use & Disclose Your Patient Health Information

Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.

Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment or disclose your information to payors to determine whether you are enrolled or eligible for benefits. We will submit bills and maintain records of payments from your health plan.

Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, arranging for legal services and to assess the care and outcomes of your case and others like it.

Special Uses and Disclosures Following a procedure, we will disclose your discharge instructions and information related to your care to the individual who is driving you home from the center or who is otherwise identified as assisting in your post-procedure care. We may also disclose relevant health information to a family member, friend or others involved in your care or payment for your care and disclose information to those assisting in disaster relief efforts.

Other Uses and Disclosures We may be required or permitted to use or disclose the information even without your permission as described below:

Required by Law: We may be required by law to disclose your information, such as to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.

Research: We may use or disclose information for approved medical research.

Public Health Activities: We may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.

Health oversight: We may disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.

Judicial and administrative proceedings: We may disclose information in response to an appropriate subpoena, discovery request or court order.

Law enforcement purposes: We may disclose information needed or requested by law enforcement officials or to report a crime on our premises.

Deaths: We may disclose information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.

Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.

Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.

Business Associates: We may disclose your health information to business associates (individuals or entities that perform functions on our behalf) provided they agree to safeguard the information.

Messages: We may contact you to provide appointment reminders or for billing or collections and may leave messages on your answering machine, voice mail or through other methods. In any other situation, we will ask for your written authorization before using or disclosing identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. Subject to compliance with limited exceptions, we will not use or disclose psychotherapy notes, use or disclose your health information for marketing purposes or sell your health information, unless you have signed an authorization.

Individual Rights You have the following rights with regard to your health information. Please contact the Contact Person listed below to obtain the appropriate form for exercising these rights.

□ You may request restrictions on certain uses and disclosures. We are not required to agree to a requested restriction, except for requests to limit disclosures to your health plan for purposes of payment or health care operations when you have paid in full, out-of-pocket for the item or service covered by the request and when the uses or disclosures are not required by law.

□ You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.

□ In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for copies.

□ You have the right to request that we amend your information.

□ You may request a list of disclosures of information about you for reasons other than treatment, payment, or health care operations and except for other exceptions.

□ You have the right to obtain a paper copy of the current version of this Notice upon request, even if you have previously agreed to receive it electronically.

Our Legal Duty We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect. We are required to notify affected individuals in the event of a breach involving unsecured protected health information.

Changes in Privacy Practices We may change this Notice at any time and make the new terms effective for all health information we hold. The effective date of this Notice is listed at the bottom of the page. If we change our Notice, we will post the new Notice in the waiting area. For more information about our privacy practices, contact the person listed below.

Complaints If you are concerned that we have violated your privacy rights, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person

If you have any questions, requests, or complaints, please contact:

Jane Moore
Practice Administrator
262-253-4000

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ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES (NPP)

A Notice of Privacy Practices (NPP) is provided to all patients. The Notice of Privacy Practices identifies: 1) How medical information about you may be used or disclosed; 2) Your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) Your rights to complain if you believe your privacy rights have been violated; and 4) Our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read and the foregoing, received a copy of the Notice of Privacy Practices if requested, and is the patient, or the patient's personal representative.

Patient Name (print):_____DOB:_____

Patient Signature: _____ Date: _____

Patient Representative (print): _____Relationship to Patient: _____

Patient Representative Signature: _____Date: _____

FOR INTERNAL USE ONLY

Employee Name (print):_____

Employee Signature: _____ Date: _____

If applicable, reason patient's written acknowledgment could not be obtained

☐ Patient was unable to sign

☐ Patient refused to sign

☐ Other _____

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REFRACTION POLICY

ACKNOWLEDGEMENT
I hereby acknowledge and understand that during the course of my treatment certain procedures may need to be performed that **most insurance companies, including Medicare, do not cover**.

Why is it necessary?
Refraction is sometimes necessary depending on the patient's diagnosis and/or visual complaints presented that day. For example, if a patient is experiencing blurred vision or a decrease in visual acuity on the eye chart, refraction is necessary to see if this is due to a need for corrective lenses or due to a medical problem.

Our office policy is to charge **$50.00** for this procedure in addition to the office visit.

Follow-up care and changes are included for **90 days** from the initial exam date, not to exceed 2 follow-up visits without additional costs. Follow-up visits beyond this time are subject to a fee.

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. Co-pays and deductibles are separate from, and not included in, the refraction fee.

Print Name:	DOB:
Patient Signature	Date

Note: Refractions are listed under exclusions, with Medicare benefit policy 100.02, Section 90:

"Routine physical checkups: eye glasses, contact lenses and eye examinations for the purpose of prescribing, fitting or changing eye glasses, eye refractions by whatever practitioner and for whatever purpose performed."

You may find additional information online at cms.hhs.gove/manuals

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CONTACT LENS EXAM AGREEMENT

Patient Name _____ **Date** _____

The process of acquiring and obtaining a contact lens prescription involves the evaluation and management of a properly fitted lens. In addition to the comprehensive eye exam, the fitting process includes:

1) Measuring the curvature and size of the cornea to determine proper fit of the contact lens.
2) Determining the parameters, lens type and prescription for you.
3) If needed, insertion of a diagnostic lens to evaluate fit, coverage and movement.
4) Follow-up care and changes are included for **90 days** from the initial exam date, not to exceed 3 follow-up visits without additional costs. Follow-up visits beyond this time are subject to a fee.

As with any medical device, there are some potential risks involved. The risks are sight-threatening complications for patients who choose extended wear lenses, those who do not replace their lenses according to the replacement schedule given, and those who do not use proper disinfecting solution and contact lens care.

Always remove your lenses immediately if you experience any of the following, unexplained conditions: eye pain or redness, any unusual discomfort, watering or discharge from the eye, decreased vision or sensitivity to light. If the problems do not resolve right away, make an appointment to be seen at our clinic or another specialist as soon as possible.

CONTACT LENS REMINDERS

DO	DON'T
• Wash your hands before inserting/removing your lenses • Clean and disinfect lenses as directed • Replace lenses as prescribed, and replace lens case every 3 months • Call our office if you experience any unusual symptoms or problems	• Do not wear your lenses longer than prescribed • Do not wear your lenses if you have red eye or loss of vision • Do not reuse disinfecting solution • Do not use tap water for cleaning • Do not wear lenses if you notice a chip or tear in them

FITTING FEE POLICY

New Patient: $60 (Spheres – Excluding Monovision), $70-$120 (Toric – astigmatism, Monovision, Toric, Bifocal, Rigid Spheres)
Established Patient: $50 (Spheres – Excluding Monovision), $70-$120 (Toric – astigmatism, Monovision, Toric, Bifocal, Rigid Spheres)

Contact lens prescription will not be released until the Fitting Fee is paid in full and contact lens prescription is finalized.
If for any reason the patient wishes to discontinue wearing contact lenses during the initial period after dispensing of the lenses, the FITTING FEE IS NON-REFUNDABLE.

Contact lens fitting services are typically considered *cosmetic*, and charges cannot be submitted through MEDICAL insurances. It is the patient's responsibility to provide any VISION INSURANCE information prior to the evaluation and/or contact lens order.
Contact lens order must be paid in full before the order will be placed.

Contact lens purchases can be returned for a refund within 30 days of purchase. Only **unopened** boxes are eligible for return.

By signing below, you acknowledge that you have read and understand the risks, benefits and policy.

_____ _____
Patient Signature Date