RIVERTON VISION CENTER P.C.

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B.J. BALLARD, O.D. C.C. FRAZIER, O.D. J.M. HINKLE, O.D.

WELCOME TO RIVERTON VISION CENTER

In preparing for your upcoming appointment visit with our office on _____,

_____ at _____ with Dr._____, we have enclosed

documentation that needs to be completed. Please have these forms filled out, you can mail them back or bring them with you to your appointment. This will enable us to better prepare for the registration process.

We will also need you to bring the following:

- Your insurance cards, this includes primary and secondary, so that we may make a copy for our files (We need copy to file and bill member insurance) This includes vision insurance, medical insurance, Medicare, and Medicaid.
- Current glasses and/or information on current contact lenses, we can request records from your previous provider before your appointment with a sign release of information..
- A complete written list of your medications prescription and non prescriptions and the reason you take them. Ie: Atenolol for high blood pressure, Xalatan for glaucoma
- Reminder: You may be dilated, so you may need a driver (cautionary information)
- Any other health history that may help the Doctor

If you have any questions, please feel free to call our office.

Thank you for choosing Riverton Vision Center. We look forward to being an integral part of your eye care health.

Dr. Ballard, Dr. Hinkle, and Dr. Frazier

WELCOME TO RIVERTON VISION CENTER, P.C.

Patient's Name: _____ _____ _____ Today's Date:_____
(First) (M.) (Last)
Date of Birth: _____ SSN: _____ Male/Female
Address: _____ City: _____ State: ____ Zip: _____
Occupation/Grade: _____ Employer/School: _____
Home Phone: (___)_____Work Phone: (___)_____ Cell Phone: (___)_____
Email Address:_____
Marital Status (check one): __Single __ Married __Divorced __ Widowed
Spouse's Name:_____ If minor: Parent's Name:_____
Family member responsible for account:_____
Relationship to patient: _____ Occupation: _____
Employer: _____ Work Phone: (___)_____ SSN: _____

Examination fees are due upon completion of services. Fees not paid by insurance and any incurred collection fees are the responsibility of the patient.
Preferred method of payment (check one): ___Cash ___Check ___ Credit Card
Do you have a Vision Plan? __ Yes __ No
Do you have a Medical Plan? __ Yes __ No
There are two types of health insurance that will help pay for your eye care services and products. You may have both and our practice accepts both:

1. Vision care plans (such as VSP)
2. Medical Insurance (such as BCBS, and Medicare)

- Vision care plans only cover routine vision exams along with eyeglasses and contact lenses. Vision plans only cover a basic screening for eye disease. They do not cover diagnosis, management or treatment of eye diseases.
- Medical insurance must be used if you have any eye health problems or systemic health problem that has ocular complications. Your doctor will determine if these conditions apply to you, but some are determined by your case history.
- If you have both types of insurance plans it may be necessary for us to bill some services to one plan and other services to the other. We will use coordination of benefits to do this properly and to minimize your out-of-pocket expense.
- We will bill your insurance plan for services if we are a participating provider for that plan. We will try to obtain advanced authorization of your insurance benefits so we can tell you what is covered. If some fees are not paid by your plan, we will bill you for any unpaid deductibles, co-pays or non-covered services as allowed by the insurance contract.

Insurance Company: _____ Policy Number: _____
Insurance Authorization and Release/Acknowledgement of Receipt of Notice of Privacy Policies: I request that payment of authorized insurance benefits for any services furnished to me be made on my behalf to Dr. Ballard, Dr. Hinkle, or Dr. Frazier. I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services. I acknowledge that I have been given a copy of this office's notice of privacy policies.

Signature: _____ Date: _____

WELCOME TO RIVERTON VISION CENTER, P.C.

Patient Health History

First Name _____ Last Name_____ Height____ Weight____
Preferred Language_____ Race/Ethnicity_____
Do you use tobacco products? Yes/No Packs per day? _____ How many years? _____
Do you drink alcohol? Yes/No How often? _____

Please circle Yes Or No if you have ever been diagnosed or treated for a disease of the following systems. If yes, please list the specific condition(s).

Yes/No Eye Conditions (Cataract,Glaucoma,Trauma,etc.) _____
Yes/No Cardiovascular (High blood pressure, Heart disease, etc.) _____
Yes/No Endocrine (Diabetes, Thyroid, etc.) _____
Yes/No Genitourinary (Kidneys, Ovaries, etc.) _____
Yes/No Ears/Nose/Throat _____
Yes/No Blood (HIV, Sickle Cell, etc.) _____
Yes/No Gastrointestinal (Ulcers, Crohn's, etc.) _____
Yes/No Skin (Rash, eczema, etc.)_____
Yes/No Muscle/Bone (Arthritis, fibromyalgia, etc.) _____
Yes/No Neurological (Parkinson's, Seizures, etc.)_____
Yes/No Psychiatric (Depression, ADHD, etc.) _____
Yes/No Lungs (Asthma, COPD, etc.) _____
Yes/No Any Hayfever, Food or Seasonal Allergies?_____
Are you currently pregnant or nursing? Yes/No _____
Other _____

Please List:

Medications	Reason	Dosage

Please List Eye Drops or Eye Vitamins _____
Allergies to Medications? Yes/No if yes, please list _____
Have you had any surgeries? Yes/No if yes, please list _____

Other Past Medical History_____

Is there a family history of the following? (parents, siblings, grandparents) If yes please list.

Yes/No Diabetes _____ Yes/No Glaucoma _____
Yes/No Heart Disease_____ Yes/No Cataracts_____
Yes/No Cancer _____ Yes/No Macular Degeneration_____

Reviewed by Doctor: _____ Date:_____

OptoMap Screening Retinal Exam

Doctors Ballard, Hinkle, and Frazier believe that the **Optomap Screening Retinal Exam** is an essential part of your comprehensive eye exam and recommend it for all patients once per year.

Diseases such as macular degeneration, glaucoma, retinal tears or detachments, as well as other health problems such as diabetes and high blood pressure can be detected with a thorough exam of the retina.

An Optomap Retinal Exam provides:

A scan to confirm a healthy eye or, to detect the presence of disease.
An overview or map of the retina, giving your doctor a more detailed view than can be achieved by other means.
A permanent record for your medical file, enabling your doctor to make important comparisons if potential problems show themselves at a future examination.

The Optomap Screening Retinal Exam is fast, easy, and comfortable.

PLEASE NOTE: The Optomap Screening Retinal Exam is a non-covered service with your health plan, meaning that you would be responsible for the charges. Our fee for the Optomap Screening Retinal Exam is $ 39.00

_____ Yes - I want to take advantage of this advanced technology.

_____ No - I decline the Optomap screening against medical advice.

Patient Signature: _____ Date: _____

Riverton Vision Center Financial Policy

Payment

Full payment is due at the time of service. We accept cash, check, Visa, MasterCard or Discover.

Insurance

Are you aware of what your insurance covers? We cannot bill your insurance company unless you provide us with your insurance information and a copy of your card. Your insurance policy is a contract between you and your insurance company; we are not a party to that contract.

Some or all services and material provided to you may not be covered as "reasonable and necessary" under Medicaid, Medicare, and/or other medical insurances. The balance is your responsibility whether your insurance company pays or not. If your insurance company has not paid your account in full within 90 days, the balance will automatically be transferred to you. Billed charges are due upon receipt. Regarding insurance plans where we are a participating provider, all co-pays and deductibles are due the day of service. In the event that your insurance coverage changes to a plan where we are not participating providers, you are responsible for the all charges.

Discounts applied to services and material cannot be combined with billing an insurance plan.

Minor Patients (under 18 years old)

The parent or guardian accompanying a minor is responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit card or insurance plan or payment for services and any co-pays is made by cash or check. The parent or guardian should call ahead and authorize treatment, such as Optos imaging and/or dilation.

Patient Satisfaction Guarantee

All prescription optical materials are customized and fabricated specifically for each individual patient. Fees for these materials are non-refundable. Once ordered, these products are the financial responsibility of the patient. Full payment is needed prior to ordering. With prior approval, occasionally we can place the order with at least a 50% deposit. Full payment is required before dispensing any materials and all custom orders must be picked up within 30 days.

If you are not satisfied with your glasses for whatever reason, you can exchange them within 30 days of receiving them. Just return them in their original condition within 30 days. If you exchange them for a pair at a higher price, you'll only pay the price difference. If you exchange them for a pair at a lower price, you will not receive the price difference as a refund. This guarantee does not apply to glasses purchased through Vision Service Plan.

All materials not picked up after 90 days become the property of Riverton Vision Center.

If you are not satisfied with your contact lenses for whatever reason, you can exchange or return unopened, unexpired boxes of contact lenses within 30 days of receiving them. If you purchase contact lenses and remove the UPC from the boxes to send in for a rebate, these boxes cannot be returned for credit or exchanged. This guarantee does not apply to colored contact lenses or those purchased through Vision Service Plan. All sales of colored contact lenses are final; they cannot be returned for credit or exchanged as they are a special order product.

Delinquent Accounts

There will be a 1.5% monthly service charge on accounts 30 days past due. Accounts not paid in full within 120 days may be sent to an outside collection agency.

There will a $35 service fee charged for any returned check. Cash, credit card or money order will then be required for payment.

By signing below, I acknowledge that I have received and understand the policy above.

Patient Signature:_____ Date:_____

Patient Name:_____

RIVERTON VISION CENTER, P.C. PATIENT ACCESS TO RECORDS REQUEST

Your Right to Request Access

As a patient, you have the right to request access to, inspect, or copy protected health information about yourself that was created by or is maintained in Riverton Vision Center, P.C. records. Your rights include receiving an answer to the request within 30 days. If there are delays in acting on your request, you will be told in writing. Your request and the answer will be kept in your patient file.

Patient Records Access Request

Name: _____ Date of Birth: _____

Type of record: _____ Date of request: _____

If you are asking to access, look at, or obtain a copy of your protected health information (PHI) created by Riverton Vision Center, P.C. please consider the following:

- Riverton Vision Center, P.C. cannot give you access to psychotherapy notes.
- Riverton Vision Center, P.C. may deny you access to your PHI if it was given to Riverton Vision Center, P.C. by someone other than a healthcare provider, under the promise of confidentiality.
- Other Federal or State laws and regulations may prohibit Riverton Vision Center, P.C. from providing you with access to some or all of your records.
- Your request may be denied if professionals involved in your case believe that access to your information could be harmful to you or others.
- You may be charged a reasonable, cost-based fee.

This request is to ☐ **view** and/or to ☐ **receive a copy of** the following PHI (be as specific as possible):

This request is to view records from ___/_____/____ to ____/_____/_____ and requests that the records be delivered via ☐ paper mailed copy ☐ email: _____

or ☐ other: _____

_____ _____

Signature of patient *Date*

_____ _____

Signature of personal/legal guardian or representative *Date*

Relationship to patient (if applicable): _____

For more information on your right of access to PHI and medical records, refer to Riverton Vision Center, P.C.'s Patient Consent Form and Notice of Privacy Practices.