Kent Clinic Welcome Form

We want to welcome you to Kent Eye Clinic. Your new prescription and the doctor's recommendations are based on your eye examination and how you've told us you use your eyes. To optimize your eyesight and eye health, the best lenses and lens treatments are recommended. Our eyes are our most important sense that so many of us take for granted. To ensure continued good eye health, schedule an eye exam annually or as recommended. In between visits, if you have any concerns about your spectacles or eyesight, please call us. With your cooperation, we will continue to work hard to give you the best eye care.

Last Name _____ First Name _____ MI ____ ☐M ☐F Date of Birth ___/___/___
Address _____ City _____ State _____ Zip Code _____
Home Phone (___)_____ Cell Phone (___)_____ Email address _____
Preferred Language _____ Race _____ Ethnicity _____

How did you hear about our office? _____

Vision Insurance Plan Name _____ Group _____
Insured Name _____ Relationship to Patient: ☐ Self ☐ Spouse ☐Child
Insured ID _____ Insured Date of Birth ___/___/___ Insured SS# _____

Medical Insurance Plan Name _____ Group _____
Insured Name _____ Relationship to Patient: ☐ Self ☐ Spouse ☐Child
Insured ID _____ Insured Date of Birth ___/___/___ Insured SS# _____

Payment Collection Policy for Kent Eye Clinic:

- Comprehensive eye examinations will be billed through the patient's vision insurance plan. The patient may be responsible for a co-payment, which is collected on the date of service.
- In the case of an emergency visit or if a medical diagnosis is made, the examination can/will be billed through the patient's medical insurance. The patient may be responsible for a co-payment, which is collected on the date of service. If the deductible is not met, patient will be billed for the co-insurance.
- The patient is responsible for all hardware or services not covered by their health insurance plan.
- In cases where the patient does not carry insurance, the patient is asked to pay immediately after their examination.
- Patients without insurance are given a 20% discount on their examination and glasses order if they are able to pay in full on the same day of service.
- The patient has 60 days after their visit to pay the invoice. If payment cannot be made by the 60th day, a 2.5% fee will be added to the invoice each month until full payment is received.
- A fee of $25 is imposed for any returned checks.

I agree to the payment terms Kent Eye Clinic has listed above.

_____ _____
(Patient/Guardian Signature) (Date)

Health Insurance Portability Accountability Act Acknowledgement

I understand that as part of my health care, Kent Eye Clinic originates and maintains paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnosis, treatment, and any plans for future care of treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually provided

I understand that I have the following rights and privileges per the *Notice of Privacy Practices* (this document is available upon request):

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Kent Eye Clinic is not required to agree to these restrictions requested. I understand that I may revoke this consent in writing, except to the extent, that the origination has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by *Section 164.506 of the Code of Federal Regulations*.

I further understand that Kent Eye Clinic reserves the right to change their notice and practices, and prior to implementations, in accordance with *Section 164.520 of the Code of Federal Regulations*. Should Kent Eye Clinic change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. Mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosures of my health information: -
_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosures for these permitted uses including disclosures via fax.

BY SIGNING BELOW, I ACCEPT THE ABOVE STATEMENT AND TERMS OF THIS CONSENT.

_____ _____
(Patient/Guardian Signature) (Date)

Health Information

Last Eye Exam: _____ years Reason for Visit Today (ie blurry vision, etc.): _____

Primary Care Doctor: _____ Primary Care Dr. Location: _____

Medical Diagnosis (ie Diabetes, Cholesterol, Hypertension, etc.):_____

_____

Medications & Dosage (ie Metformin, Lisinopril, Plaquenil, etc.): _____

_____

_____

Medication Allergy: _____

Previous Eye Surgery, Conditions, Trauma: _____

Smoke: Yes / No / In the past If yes, what type and how much: _____

Drinking: Yes / No If yes, how much: _____

Family Medical History (ie Diabetes, Hypertension): _____

Family Eye History (ie Cataracts, Glaucoma): _____