William B. Hart, M.D.
harteyecenter.com

Patient Information Sheet

Patient Name: ____
First Middle Initial Last

Address: ____

DOB: ________________ Sex: __________ Social Security #: ____________________

Race: ________________ Marital Status (circle): Married Single Divorced Widowed

Cell Phone: ____________________ Email: ____________________________

Alternate Phone: ________________ Preferred Pharmacy: ____________________

Employer: ______________________ Occupation: ____________________

Employer Address: ____

Phone: ________________________ Status (circle): Full-time Part-time

Insured/Responsible Party (if different than above)

Name: ______________________________ Phone: ________________

Address: ____

Relationship to Patient (circle): Spouse Mother Father Guardian

Emergency Contact

Name: __________________________ Phone: ______________________

How did you hear about us?

- ☐ Internet
- ☐ Billboard
- ☐ Word of Mouth
- ☐ TV
- ☐ Phone Book
- ☐ Facebook
- ☐ Referral ______________________

I hereby authorize Hart Eye Center to perform diagnostic and therapeutic procedures, if necessary, for proper eye care.

I request that payment of authorized insurance benefits be made on my behalf to William B. Hart, M.D., for services rendered to me by that physician. I also give consent to be reminded of my appointment or of any new procedures or producdts either by phone, mail, answering machine, email or ***text messaging***.

I understand that Medicare does not pay for routine eye care and that Medicare considers refractions as "routine eye care."

____

Patient Signature Date

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Patient Name: ____________________________________ **Date:** ____________________

Privacy Policy

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for services, and to conduct healthcare operations involving our office. The Privacy Policy describes these uses and disclosures in detail.

I acknowledge that I have been offered and/or received a copy of the Privacy Policy from Hart Eye Center.

____

SIGNATURE DATE

Financial Disclaimers

Eligibility for medical insurance and/or routine vision benefits

We will attempt to verify your plan eligibility for services and/or materials before your appointment. **Verification of eligibility is done as a courtesy only and is not a guarantee of payment**. Please check with your plan administrator if you have any questions regarding your eligibility. It is the responsibility of the patient to tell the receptionist if you want a **routine exam only**. My initials verify I understand the above.

__________ INITIALS

Liability

I understand that account balances and co-payments are due at time of service. If I have medical insurance or routine vision benefits, I authorize my plan carrier to directly pay Hart Eye Center. I also authorize Hart Eye Center to release any information required for payment to be made. **If my plan carrier does not pay, or partially pays, I understand I am responsible for payment in full or the remaining balance.** My initials verify I understand the above.

__________ INITIALS

Notice of Fees

Digital Retinal Imaging Fee

During your comprehensive exam today, we may request “DRI.” This technology involves capturing a high-resolution digital image of the interior portion of your eye, the retina. This technology provides us with a digital retinal fingerprint and serves as a baseline for comparison at future visits. It’s the gold standard for preventive care and disease management. *Typically, insurance plans do not cover this once-a-year, $45.00 fee.* My initials verify I understand the DRI fee and must notify my doctor if I do not want a DRI.

__________ INITIALS

Refraction Fee

The part of your evaluation that determines your prescription is called a refraction. Most insurance plans do not cover the refraction fee, such as Medicare, Medicaid and other Private Pay insurances. Unless known that your insurance does pay, this fee is due at the time of service once a year. The fee is $45.00 once a year. My initials verify that I understand the refraction fee.

__________ INITIALS

I have read and understand the above information.

____

SIGNATURE DATE

Hart Eye Center

See better for the rest of your life.

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Health History Form

Patient Name: ____
First Middle Initial Last

Name of Your Primary Care Physician: ______________________________

Preferred Pharmacy: ____________________ Location: ____________________

Height: ____________ Weight: ______________

YES	NO	
☐	☐	Are you allergic to any medications?
		If so, please list: ______________________
		______________________
☐	☐	Are you a current smoker?
☐	☐	Have you fallen in last 6 months?
☐	☐	Have you had a flu shot this season?
☐	☐	Have you had a pneumonia shot this season?
☐	☐	Are you being treated for high blood pressure?
☐	☐	Are you diagnosed with Glaucoma?
☐	☐	Are you diabetic?
		If so, last: __________ AIC __________ Blood Sugar
☐	☐	Are you diagnosed with Macular Degeneration?
☐	☐	Are you taking Plaquenil?
☐	☐	Do you have watery, dry eyes?
☐	☐	Are you interested in contacts?*
		If "YES":
☐	☐	First time contact lens visit?
☐	☐	Currently being fitted/currently wear contacts

Please be aware, if you are dispensed contact lenses in the exam room, you will be charged a contact lens fitting fee.

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HIPAA Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

THE PATIENT UNDERSTANDS THAT:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- Hart Eye Center has a Notice of Privacy Practices and the patient has the opportunity to review this Notice.
- Hart Eye Center reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but Hart Eye Center does not have to agree to those restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- Hart Eye Center may condition receipt of treatment upon the execution of this consent.

Hart Eye Center employees may leave a message or speak with the following person/persons regarding my medical or financial information if I cannot be reached:

Name: ________________________________ Phone: ________________ Relationship: _________________

Name: ________________________________ Phone: ________________ Relationship: _________________

Print Name: ____
Patient or Representative

Signature: ____ _________________
Date

Witness: ____ _________________
Date