HEATON
EYE ASSOCIATES

Come See the Difference

CHILD PATIENT INFORMATION

Child's last name: First: Middle Intital:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Parent's E-Mail Address:	Birth date:	Age:	Sex:
Street address:	Social Security no.:		Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Mother's/Guardian's Name:	Mother's Address and Phone (Home and Cell):	Mother's Employer and Address:
Mother's SSN:		
Father's/Guardian's Name:	Father's Address and Phone (Work and Cell):	Father's Employer and Address:
Father's SSN:		
Contact Person (*Friend or Relative living at a different address, please provide Name and Telephone*):		

Primary Insurance Name and Policyholder:	Secondary Insurance Name and Policyholder:
Policy Number:	
Other Insurance Name and Policyholder:	I declare I have no other insurance than what is listed (date and sign):
Policy Number:	
Preferred Language: ____English _____Other (please list)	Race/Ethnicity: ___Hispanic/Latino ___American Indian/Alaskan __Asian ___Black/African American __White ___Native Hawaiian/Pacific Islander ___Other

Are you here for a Workers' Compensation Injury: Yes No
Date of Injury: _____
Employer's Address: _____
Contact Person at Work/Phone Number:_____

If referred by a Medical Doctor or Optometrist, please list:

PRIMARY CARE PHYSICIAN'S NAME (PCP):

Are you interested in learning more about: _____LASIK _____Getting Out of Glasses _____Cosmetic Botox	PLEASE BRING YOUR INSURANCE CARDS AND DRIVER'S LICENSE TO THE FRONT DESK.

CONSENT FOR TREATMENT

I, by my signature below, grant permission for Heaton Eye Associates to render such care that the physician may deem appropriate in my child's treatment and diagnosis. I agree to my I my child's eyes being dilated if the doctor determines it is necessary.

I have read the NOTICE OF PRIVACY PRACTICES and have had any questions answered by this office. I understand that by signing this form I consent to the following:

a) Sharing information for the purposes of treatment: My health information may be used by Heaton Eye Associates or disclosed to other health care professionals for the purpose of evaluating my health, diagnosing medical conditions, coordinating and providing treatment.

b) Sharing of information for purposes of payment: My health information may be used to seek payment from my health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that I may use to pay for services.

c) Sharing of information for purposes of operations: My health information may be used as necessary for business purposes to support the day-to-day operations of Heaton Eye Associates (including but not limited to the credentialing process, peer review, accreditation and compliance with all federal and state laws).

I hereby assign my health plan benefits or other applicable insurance benefits for medical/surgical treatment for myself/my child to Heaton Eye Associates.

I understand that I am responsible for compliance with the standards and regulations set forth in my/my child's health care plan and further understand that I will be responsible for all deductibles, non-reimbursable fees or fees for service not covered by my/my child's health care plan.

My consent is freely given. I understand that I may revoke this consent at any time if that revocation is in writing. Any use or disclosure that has already occurred prior to the date of my revocation of consent will not be affected.

PATIENT NAME PRINTED

DATE SIGNED

SIGNATURE OF PATIENT/GAURDIAN

RELATIONSHIP TO PATIENT

FINANCIAL POLICY

• **PATIENTS WITH HEALTH INSURANCE COVERAGE:** Heaton Eye Associates is absolutely committed to providingthe highest level of service and quality care. As such, our primary relationship is with you and not your insurance company. While the filing of insurance claims is a courtesy we extend, all charges and payments due for services rendered are the responsibility of each oatient. Please let us know if you have any questions. we are happy to help.

• **PROOF OF INSURANCE COVERAGE IS REQUIRED AT EACH VISIT**. Bring your current insurance card(s) and picture I.D. to each visit. If you are unable to provide proof of insurance coverage at the time of your appointment, we may have to reschedule your appointment. Or you may choose to make a $150 deposit toward your visit prior to seeing the doctor and we will refund/bill you once your insurance has paid for the visit. It is important to provide accurate insurance information, and to notify us of any changes in your health insurance coverage, change of address and/or telephone number(s). Although we participate in most insurance plans, it is important you understand your plan benefits and verify coverage limitations for your personal insurance plan. Let us know if we can help.

• **SOME INSURANCE COMPANIES** (ie; Medicare Advantage Plans, United Healthcare SELECT, Tricare PRIME) REQUIRE PRIOR AUTHORIZATION AND/OR a REFERRAL from a Primary Care Physician (PCP) for an exam with an ophthalmologist. This must be obtained BEFORE your visit. In most situations, we cannot obtain these authorizations/referrals for you. If you need an authorization/referral from your PCP, but have not received one prior to your appointment time, we may need to reschedule your appointment. Or you may choose to make a $150 deposit toward your visit and we will refund/bill you once your insurance has paid for your visit.

• **CO-PAYMENTS, COINSURANCE, DEDUCTIBLES and NON-COVERED CHARGES** are a required part of your contract with your insurance company. Payment will be expected at the time of service, as required by your insurance company. We accept cash, personal checks, MasterCard, VISA, DISCOVER and AMERICAN EXPRESS. If you are unable to pay these required sums on the date of your visit, we will reschedule your appointment.

• **WE FILE INSURANCE CLAIMS** for you with Medicare, Medicaid, and other plans with whom we participate. We will also make every effort to file with your secondary insurance for you as well. After your insurance company has processed your claim, any remaining amount owed by you is due within thirty (30) days. If your insurance company does not respond to our claims, we may ask for your assistance before transferring the financial responsibility to you.

• **VISION PLANS:** We do not participate in any vision plan (YSP, EyeMed, Cole Vision, etc.) except for Block Vision In our Henderson office only. If you have questions, talk to one of our insurance representatives.

• **CHARGES FOR A PATIENT VISIT** can vary greatly based on your medical history, the reason for your visit, and any special testing requested by your doctor. If you have any questions regarding our fees, please call our office.

• **PATIENTS WITHOUT INSURANCE (SELF-PAY): EYE EXAM** - Patients are expected to pay a $150 exam fee (including refraction) prior to seeing the doctor. If any additional testing is required, the balance for the testing is due upon checkout. We offer a 20% cash discount* for full payment of these additional charges with cash, check or credit card. *(excludes: LASIK exams, LASIK Surgery and LIFESTYLE lens).

• **TREATMENT FOR A WORK RELATED INJURY (WORKERS' COMPENSATION)** You must have documentation from your employer (commonly referred to as the "Report of First Injury'') confirming this is a work related injury. Heaton Eye Associates will verify your employer's Workers' Comp coverage. Heaton Eye Associates must receive a copy of the "Report of First Injury" from your employer prior to appointment.

• **A REFRACTION** is a specific test to measure your best possible visual acuity, function and health of your eye. Refraction is a required test for a complete exam and must be performed before any treatment or prescription can be initiated for your vision improvement. Medicare, Medicare Advantage Plans, QMB Medicaid, and most commercial insurance companies consider the refraction a "necessary" but non-covered service that is the patient's responsibility. If you had a refraction performed during your exam, the refraction fee will be collected upon check out.

• **FINANCING:** Heaton Eye Associates offers financing through GE Care Credit for those who qualify, for exams/procedures which exceed $250. If you require financing, please request information and one of our representatives will review your financing options and the application process prior to your appointment.

ADDITIONAL FINANCIAL POLICIES include:

• a $30.00 charge for NSF checks.

• a $25.00 charge for a personal copy of your medical records.

I, _____ (Printed Name of Patient or Guarantor), have read the FINANCIAL POLICY in full. I understand and agree to comply with the FINANCIAL POLICIES of Heaton Eye Associates. I hereby authorize Heaton Eye Associates to release any medical information needed for insurance claims submission and payment. I assign the insurance payment to Heaton Eye Associates for its services. I understand that I am financially responsible for charges not covered by my insurance. (Updated 1/10/14)

SIGNATURE OF PATIENT	**DATE SIGNED**

HIPAA ACCESS FORM FOR PROTECTED HEALTH INFORMATION

I, _____ (Printed Name of Patient or Guarantor), understand that it is the policy of Heaton Eye Associates to restrict Patient name access to my Protected Health Information. My health information may be disclosed to caregiver(s)providing health services, insurance company(ies) for payment of my claim, and basic healthcare operations such as precertification, referrals, etc. I give my permission for the following person(s) to have access (as indicated below) to my Private Health Information.

COMMUNICATLON:

We will leave confidential clinical and/or surgical information on your answering machine, voice mail or cell phone. We will use all means of communication including but not limited to email and texting unless otherwise specified. If you do not consent to the above communication, you must specify how we may contact you:

OTHER COMMUNICATION PREFERENCE

INFORMATION ACCESS PREFERENCES

NAME (PLEASE PRINT)	DATE OF BIRTH	CLINICAL	SURGICAL	FINANCIAL	FINANCIAL
1		ALL	NONE	ALL	NONE
2		ALL	NONE	ALL	NONE
3		ALL	NONE	ALL	NONE
4		ALL	NONE	ALL	NONE
5		ALL	NONE	ALL	NONE

PATIENT SIGNATURE

DATE SIGNED

NEW PATIENT REFERENCES- Please tell us how you found out about Heaton Eye Associates

- FRIEND/FAMILY MEMBER
- PRIMARY CARE PHYSICIAN
- NAME:
- OPTOMETRIST
- NAME:
- TELEVISION
- RADIO
- NEWSPAPER
- YELLOW PAGES
- BILLBOARD
- INTERNET
- OTHER: