HEATON
EYE ASSOCIATES

CHILD PATIENT INFORMATION

Child's Last Name:		Child's First Name:		Middle Initial:
DOB:	Age:	○ Male ☐ Female		SS#:
Address:		City:	State:	Zip:
Mother/Guardian:		Home Phone:		Cell Phone:
Address:		City:	State:	Zip:
DOB:	SS#:	Marital Status (circle one): Single / Mar / Div / Sep / Wid		
Email:		Home Phone:		Cell Phone:
Employer:	Employer Address:			
Father/Guardian:		Home Phone:		Cell Phone:
Address:		City:	State:	Zip:
DOB:	SS#:	Marital Status (circle one): Single / Mar / Div / Sep / Wid		
Email:		Home Phone:		Cell Phone:
Employer:	Employer Address:			
Emergency Contact & Phone (friend/relative living at different address):				
Primary Insurance:				
Policy Holder:		Policy Number:		
Other Insurance:				
Policy Holder:		Policy Number:		
Here for a worker's compensation injury? ☐ No ☐ Yes		Date of Injury:		
Employer's Address:		Contact Person at Work & Phone:		
I declare I have no other insurance than what is listed (sign & date)				
Race/Ethnicity: ☐ Hispanic/Latino ☐ American Indian/Alaskan ☐ Asian ☐ Black/African American ○ White ☐ Native Hawaiian/Pacific Islander ☐ Other (please list):				
Preferred Language: ☐ English ☐ Other (please list):				
Referring Optometrist:		Primary Care Physician (PCP):		
I am interested in learning more about: ☐ LASIK ☐ Getting Out of Glasses ☐ Cosmetic Procedures and/or BOTOX				

PLEASE BRING YOUR INSURANCE CARDS AND DRIVER'S LICENSE TO THE FRONT DESK.

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FINANCIAL POLICY

- **PATIENTS WITH INSURANCE** should understand that Heaton Eye Associates is absolutely committed to providing you with the 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 to our patients, all charges are your final responsibility regardless of your insurance coverage.

- **PROOF OF INSURANCE COVERAGE IS REQUIRED AT EACH VISIT.** Bring your current insurance card(s) to each visit. If you are not able to provide proof of your insurance coverage at the time of your appointment, we may have to reschedule your appointment, or you may choose to make a $200 deposit toward your visit prior to seeing the doctor and we will refund/bill you once your insurance has paid for your visit. It is your responsibility to provide our office with accurate insurance information, and to notify us of any changes in your health insurance coverage. Also, please tell us of any address and/or telephone number(s) changes. Although we participate in most insurance plans, we expect our patients to know/ verify the coverage of their personal insurance plan.

- **SELF PAY** We offer a 20% discount to patients who wish to pay in full by cash, check or credit card when insurance is not filed (excluding LASIK, Premium Lens and Cosmetic Procedures.)

- **SOME INSURANCE COMPANIES (i.e., Medicare Advantage Plans, Blue Cross 38000) REQUIRE PRIOR AUTHORIZATION AND/OR A REFERRAL** from a primary care physician for ophthalmology visits. You must obtain this BEFORE your visit. We can normally get this information for you, but there may be instances where we will need your assistance in contacting your PCP or insurance company if we cannot get a response. If you need an authorization/referral but have not obtained one by your appointment, we may need to reschedule your appointment, or you may choose to make a $200 deposit toward your visit prior to seeing the doctor and we will refund/bill you once your insurance has paid for your visit. You should always ask if your referral / authorization has been received prior to your appointment.

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

- **WE FILE INSURANCE CLAIMS** for you with Medicare, Medicaid, and insurance carriers with whom we participate. We will also make every effort to file with your second and third carriers for you. 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.

- **Coordination Of Benefits** is the insurance payment process when you have more than one insurance plan that potentially covers the services provided. You will receive an explanation of the benefit statements from your insurance payer when payment is made or if the claim is denied for some reason.

- **WE ONLY PARTICIPATE IN THE FOLLOWING VISION PLANS:** Superior Vision, March Vision, and Envolve. If you have vision insurance through another carrier, we will provide you with an itemized statement for you to use for reimbursement. You will be billed in full for your routine eye exam. We do not file claims to other vision plans.

- **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 and will be included in your charges.

- **TREATMENT FOR A WORK-RELATED INJURY (WORKERS' COMPENSATION)** The patient must have prior authorization from your employer and a copy of the Report of First Injury from the insurance company providing your employer's Workers' Comp coverage. BEFORE being seen.

- **A REFRACTION** is a test to measure your best possible vision. A refraction is a required test for a complete exam and must be performed before any treatment/prescription can be initiated for your vision improvement. Medicare, Medicare Advantage Plans, QMB Medicaid, and most commercial insurance companies consider a refraction a necessary but non-covered charge. If your exam includes a refraction, our $45 refraction fee will be collected at the time of your visit.

- **FINANCING** is available to qualified patients through Care Credit for exams/procedures. If you require financing, please request a representative to explain your financing options and the application process prior to your appointment.

- **CREDITS** In the event that your HEA account has a credit and a balance owed to Heaton Laser and Surgery Center, we reserve the right to transfer HEA credits to the outstanding HL&SC balances prior to issuing a refund.

ADDITIONAL FINANCIAL POLICIES include:

- a $32.00 charge for NSF checks

- a $25.00 charge for a copy of your medical records (for personal copies only)

I, _____
(Printed Name of Patient or Guarantor), have read the above FINANCIAL POLICY in full. I understand and agree to comply with the FINANCIAL POLICIES of Heaton Eye Associates. I authorize Heaton Eye Associates to release any medical information needed for insurance claims submission. I understand that I am financially responsible for charges not covered by insurance.

Signature Date

HEATON
EYE ASSOCIATES

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/my child's treatment and diagnosis. I agree to my/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 I had answered by this office. I understand that by signing this form I consent to the following:

- **Sharing information for the purposes of treatment: My/my child's health information may be used by Heaton Eye Associates or disclosed to other health care professionals for the purpose of evaluating my/my child's health, diagnosing medical conditions, coordinating, and providing treatment.**
- **Sharing of information for purposes of payment: My/my child's 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.**
- **Sharing of information for purposes of operations: My/my child's 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 (print please)

Signature of Patient/Guardian **Relationship to Patient** **Date**

HIPAA ACCESS FORM FOR PROTECTED HEALTH INFORMATION

Print PATIENT NAME: _____, Date of Birth _____ understand that it is the policy of Heaton Eye Associates to restrict 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 pre-certification, referrals, etc. I give my permission for the following person(s) to have access as indicated below, to my Private Health Information.

COMMUNICATION

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

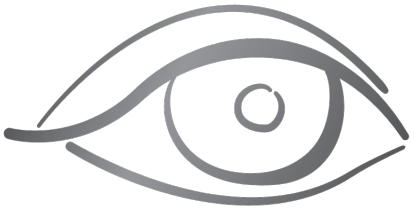
We cannot release information to anyone not listed.

NAME *(please print)*	DOB	CLINICAL	SURGICAL	FINANCIAL
1.		All / None	All / None	All / None
2.		All / None	All / None	All / None
3.		All / None	All / None	All / None
4.		All / None	All / None	All / None
5.		All / None	All / None	All / None

Signature of Patient or Guardian **Date**

Please tell us how you found out about Heaton Eye Associates:

⬭	Friend/Family Member		⬭	Television		⬭	Internet
⬭	Primary Care Physician		⬭	Radio		⬭	UTH Physician
	Name: _____		⬭	Newspaper		⬭	Other: _____
⬭	Optometrist:		⬭	Yellow Pages			
	Name: _____		⬭	Billboards			



HEATON
EYE ASSOCIATES

FTC EYEGLASS MODALITY CONSENT

I would like to receive my glasses prescription via:

_____ Paper

_____ Patient Portal

_____ Email *preferred email address:* _____

I REALIZE THIS PERMISSION REMAINS EFFECTIVE UNTIL I REVOKE IT IN WRITING.

_____ _____

Patient Signature Date

_____ _____

Patient Name DOB