Logan Eye Care

for the sincere visual experience

Patient Information (Please Print) **Today's Date: _____/_____/_____**

Miss Mrs. Ms. Mr. Dr. (Please Circle)

Patient's Name: _____ Date of Birth: _____/_____/_____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____ Cell Phone: _____

E-Mail Address: _____ SS Number: _____-_____-_____

Minor Married Single Divorced Widowed (Please Circle)

If patient is a minor: Mother's Name: _____ Father's Name: _____

Employer: _____ Occupation: _____

Student: Yes or No Grade: _____ School: _____

How or by whom were you referred to our office: _____

Primary Physician: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Pharmacy (Name & Address): _____ Phone Number:_____

Primary Insurance Provider: _____ Phone Number: _____

Policy/ID Number: _____ Group Number: _____

Name of Policy Holder: _____ Relationship: _____

Policy Holder SS Number: _____-_____-_____ Policy Holder DOB: _____/_____/_____

Policy Holder Employer: _____

Responsible Party:

Guarantor/Name of person responsible for this account: _____

Relationship of Guarantor to Patient: Self Parent Other (Please Circle)

Authorization:

I certify that I have read and understand the information on the FRONT and BACK of this form, and have answered the questions accurately and to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I understand and agree to be financially responsible of all services rendered on my behalf or my dependents.

X

Signature of patient or parent (if minor) **Date**

Date of last eye exam: _____/_____/_____ Doctor: _____

Do you wear glasses: Yes or No How old are the lenses? _____

Do you wear contact lenses: Yes or No

If yes, what kind? Soft Hard RGP Disposable Daily wear Extended wear

Are you interested in contacts? Yes or No Are you interested in Laser Vision Correction? Yes or No

Medical History Including Present Medications You're Taking:

Do you or have had any of the following medical conditions? If yes, please explain, include date of diagnosis and medications you are CURRENTLY taking:

SELF

		Medical Condition	Medications
Y N	Eye Injuries:		
Y N	Eye Surgery:		
Y N	Loss of Vision:		
Y N	Glaucoma:		
Y N	Macular Degeneration:		
Y N	Cataracts:		
Y N	Retinal Detachment:		
Y N	Diabetic Eye Disease:		
Y N	Amblyopia/ Strabismus:		
Y N	Dry Eyes:		
Y N	Legal Blindness:		
Y N	Any other eye disease:		
Y N	Seasonal allergies:		
Y N	Rheumatoid Arthritis,		
Lupus, other autoimmune disease:			
Y N	Heart disease		
Y N	High Blood Pressure:		
Y N	Diabetes:		
Y N	Thyroid Condition:		
Y N	Cancer:		
Y N	Asthma:		

Social History

Y N Do you have difficulty driving during the day?

Y N Do you have difficulty driving at night?

Y N Do you drink alcohol? How many drinks a day? _____

Y N Do you smoke? How many packs a day? _____

Y N Have you ever had a blood transfusion? Date: _____

Do you… (Please circle Y or N)

Y N Work on a computer? If yes, how many hours a day? _____

Y N Have prescription sun glasses? If yes, how old are the lenses? _____

Y N Participate in recreational sports? If yes, please list: _____

Y N Do you do a lot of reading? If yes, how many hours a day? _____

Y N Want information on Laser Vision Correction?

History reviewed by Dr. Logan with patient:

Signature **Date**

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With recent changes in healthcare laws, as well as our efforts to provide the highest quality of care to our patients, Logan Eye Care has upgraded our computer system to a certified Electronic Health Care Records system.

The new system will allow us to offer more comprehensive care to our patients and will also give patients easy access to their medical records. In order for us to accomplish that goal and meet the HER required guidelines, we ask that you provide us with additional information for your medical records:

*Preferred Language
- O English
- O Spanish

*Race (check one or more that apply)
- O American Indian or Alaska Native
- O Asian
- O Black African American
- O Native Hawaiian or Other Pacific Islander
- O Hispanic
- O White

* Ethnicity
- O Hispanic or Latino
- O Not Hispanic or Latino
- O Native Hawaiian or Other Pacific Islander

* Preferred methods of communication
- O Postal
- O Telephone
- O E-mail _____
- O Text _____

* Do you smoke or have you smoked in the past? _____yes _____no
- O Previous Smoker
  - * How many years has it been since you quit? _____

*Any known prescription drug allergies? _____yes _____no

If yes, please list _____

Thank you for helping us in our efforts to better serve you!

Name (print) _____ Date _____

Signature _____ Date _____

Financial and Insurance Policy

Thank you for choosing Logan Eye Care as your vision care provider. As a part of our services, we request you read and sign the following financial policy prior to services being rendered. Patient or responsible party must complete our information and insurance form before seeing Dr. Carol Logan.

- **Full payment, co-payment, percentages and/or deductibles are due at the time services are rendered.**
  We accept cash, checks, Visa, MasterCard, American Express and Discover. If you are purchasing eyewear or contacts, payment is due prior to any order being processed.
  _____ Initials
- **Office Policy:** Insurance is billed as a courtesy to our patients; however, the patient is the final responsible party. If your insurance has not paid within **60 days** you will be notified. Returns or cancellations are made at the discretion of the office administrator and office credit will be issued in lieu of refunds. Please make your selection carefully.
- **Minor Patients (under the age of 18):** The adult accompanying a minor (patient/guardian) is responsible for full payment at the time of service. For unaccompanied minors, payment arrangements need to be made in ADVANCE and we must have parents or guardians written permission prior to treatment of a minor.
- **Returned Checks:** A $25.00 service charge will be applied to your account for returned checks. No returned checks will be re-deposited. All balances must be paid in cash or by credit card. One attempt will be made to collect this debt from the patient, if not collected within 5 days of the returned check; the account will be turned over to collection agency. We request a copy of your driver's license for our records if you wish to make payments by check.
- **Spectacle Prescription:** Patients have 30 days follow-up care from the date of the fitting to make any changes in the prescription necessary. However, the Optician will be happy to check the prescription of your glasses against your prescription given by Dr. Logan at any time.
- **Eye wear and contact lens prescriptions that are filled elsewhere are not warranted by Logan Eye Care.**
- **Contact Lens Patients:** Additional time and testing is required for the fitting and evaluation for contact lenses. Additional professional fees will be applied, and are generally not covered by your insurance company. Patients have 30 days follow-up care from the date of the fitting to make any changes in the prescription necessary. A contact lens prescription is only valid **one year from the exam date** and cannot be filled once expired. Disposable contacts have been ordered and received by the patient, they cannot be returned.
- **Emergency Visits:** There will be a $50.00 fee charged above and beyond the usual and customary fees if seen outside of office hours.
- Eyeglass and contact lens prescriptions (when requested) are faxed by the end of each business day.
  _____ Initials

Please realize that:

1. **Your insurance is a contract between you, your employer and the insurance company. We are not a party in the contract.**
2. **You are responsible for all charges that are denied/not covered by your insurance company. Not all services are covered under insurances – glasses, contact lenses and/or contact lens fitting or evaluations and some procedures performed by Dr. Logan.**
3. **Although we verify your coverage through your insurance company with each and every patient, verification of benefits is not a guarantee of payment from your insurance company. We request that you present a copy of your insurance card for our records if necessary or any discount plans that are being utilized. Only one insurance / discount plan is accepted, per patient, per year.**

_____ _____

Patient or legally authorized individual signature Date

_____

Printed name if signed on behalf of the patient

Patient Acknowledgement

Notice of Privacy Practices

Our *Notice of Privacy Practices* describes in detail how your health information may be used and disclosed, and how you can access your information.

By signing below, you acknowledge that you have received a copy of the *Notice of Privacy Practices* of Carol Logan, O.D., and Logan Eye Care.

_____ _____

Patient or legally authorized individual signature Date

_____

Printed name if signed on behalf of the patient

Consent of Disclosure

For Health Information For Treatment, Payment, and Health Care Operations

During the course of providing service to you, we create, receive, and store health information that identifies you. As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to safeguard your confidentiality. It is often necessary to use and disclose your health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office. When it is appropriate and necessary, we provide the minimum necessary information to only those in need of your health care information.

When you sign this consent document, you acknowledge and authorize that we may disclose your health information for treatment, payment for our services, and to perform health care operations that includes:

- The use and disclosure of your health information for treatment purposes, not only includes care and services provided here, but also disclosures of your health information, as may be necessary for you to receive follow-up care from us or another health professional.
- The use and disclosure of your health information for the purposes of payment, including, but not limited to, providing this information to your insurance company, third party, billing agent or other vendor for eligibility, determination of benefits, processing claims and receiving payment.
- We may have indirect treatment relationships with other organizations (such as laboratories and vendors) and may have to disclose personal health information for purposes of treatment, payment, or health care operations.
- That support personnel employed by this professional practice or any affiliated agencies, vendors or companies, including the optical personnel will have access to your health information.
- The payment of medical insurance benefits to Carol Logan, O.D., and Logan Eye Care, or other appointed agencies or parties who may accept assignment for services provided.

You have the right to restrict or revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI).

By signing below, you acknowledge that you have read and understand that above information and voluntarily consent to the statements herein.

_____ _____

Patient or legally authorized individual signature Date

_____

Printed name if signed on behalf of the patient

Logan Eye Care

Dilated Eye Exam
Why do we dilate your eye?

Pupil dilation is extremely important, because it allows Dr. Logan to see all the way into the back of the eye. During a normal eye exam, the doctor will use a bright light and a lens to look into the eye, inspecting the health of the cornea, iris, and lens of the eye. However, the bright light causes the pupil to contract, making it difficult to see the back of the eye. The drops are necessary to open the pupils for a broad view of the retina, optic nerve and important blood vessels. The dilation is not only an important tool in diagnosing and documenting a multitude of eye diseases, but it can also reveal general health problems like hypertension (HBP). The dilation is considered part of the eye exam and not billed separately.

_____ I WANT my eyes dilated today, for a more comprehensive component of my eye health records.

_____ I REFUSE my eyes being dilated today.

Refraction for glasses and/or contact lenses

During a refraction, the doctor puts the instrument called a phoroptor in front of your eyes and shows you a series of lens choices. He or she will then ask you which of the two lenses in each choice looks clearer. Based on your answers, your eye doctor will continue to fine-tune the lens power until reaching a final eyeglass prescription. The refraction determines your level of hyperopia (farsightedness), myopia (nearsightedness), astigmatism and presbyopia.

Unfortunately, Medicare considers this a routine test and therefore does not approve it, making it a non-covered service. Since Medicare doesn't cover it, many commercial insurance companies follow suit and also consider it a non-covered service. Vision plans do cover the charge of the refraction.

_____ I WANT a refraction today, for a more comprehensive component of my eye health records.

_____ I REFUSE a refraction today.

Signature of Patient and/or Guardian **Date**

Logan Eye Care

Retinal (Fundus) Photography

"A photograph is worth a thousand words."

During your eye examination, a highly specialized digital camera is used to capture images of the central and peripheral retina, optic disc, and macula. The images captured are used to aid Dr. Logan in monitoring the progression of certain eye conditions/diseases. Fundus photographs are used to document abnormalities associated with diabetic retinopathy, age-related macular degeneration (AMD), glaucoma, cranial nerves, etc.

The photographs become part of your permanent record and will be interpreted and reviewed with you during the exam by Dr. Logan. We will repeat the photographs yearly to document any changes that may occur.

If you have a Vision Benefit Plan, the fee to include photos at your visit is $39.00. If you have medical insurance then the photos may be covered. We will review your coverage with you.

It is Dr. Logan's recommendation that the eyes be photographed for thorough documentation of your eye health.

Please choose one of the following:

_____ I WANT photographs of the eye as a more comprehensive component of my records.

_____ I REFUSE photographs of the eye as a more comprehensive component of my records.

Signature of Patient and/or Guardian **Date**