Hilltop Eye Center

WELCOME TO OUR PRACTICE

Patient Name:_____ Today's Date:____/____/____

Patient Age: _____ Date of Birth: _____ Male ☐ Female ☐

Occupation: _____ Social Security #: _____ Phone: _____

Address: _____

Primary Insured's Name if not "Self": _____ Insured DOB: ____/____/____

Primary Care Doctor/Clinic or Pediatrician if a minor: _____

EYECARE HISTORY

Last Eye Exam: _____ **By whom: _____**

Have you been diagnosed with: (check all that apply)

☐Cataracts ☐Glaucoma ☐Macular Degeneration ☐Strabismus/Turned Eye ☐Amblyopia/Lazy Eye

List prescription eye drops you are currently using: _____

MEDICAL HISTORY

Have you been diagnosed with: (check all that apply)

☐Diabetes* ☐High Blood Pressure ☐High Cholesterol ☐Rheumatoid Arthritis ☐Thyroid Disease

*__If Diabetic__ → **Recent Blood Sugar:_____ Most Recent A1C: _____ How Recent: _____**

Active Medications (prescription or OTC):

_____

DRUG ALLERGIES: LIST ALL KNOWN _____

Are your eyes ever watery, itchy, gritty, or red? Circle all that apply.

Please note any artificial tears you use for relief of these symptoms: _____

Are you interested in new glasses, sunglasses, or contact lenses today? Circle all that apply, turn to back →

FOR OFFICE USE ONLY ☐ **NEW** ☐ **ESTABLISHED**

Vision Plan or Self Pay: _____ Co-Pay: _____ Medical Ins: _____ Co-Pay: _____

Reason for Visit: ☐ Full ☐ Red Eye ☐ Glaucoma FU ☐ Dry Eye ☐ Post-Op ☐ Refraction (Check any/all)

OLD GLRx – OD: _____ **OS**: _____ **ADD**: _____

NEW GLRx – OD: _____ **OS**: _____ **ADD**: _____

☐ PAL ☐ BIF ☐ SV ☐ TRANS ☐ Computer SV or PAL (In Rev) ☐ Hi-Index ☐ SUN

CL FIT COPAY:_____ ☐ I&R Train ☐ Sphere ☐ Toric ☐ MF ☐ MF Toric ☐ RGP (S, T, MF) ☐ PP (S, T, MF) ☐ Med. Necessary

OLD CLRx – OD: _____ **OS**: _____ **Brand**: _____

NEW CLRx – OD: _____ **OS**: _____ **Brand**: _____

***TRIALS ** OD: _____ OS: _____ Brand: _____

TO ORDER ☐ Dispense to Patient ☐ Doctor Eval Needed

Follow-Up: ☐ 1-2w ☐ 3w ☐ 1m ☐ 3m ☐ 6m ☐ 1y ☐ 1-2w Txt Other: _____

Reason: ☐ CL Chk ☐ DFE ☐ Dry Eye ☐ IOP Chk ☐ IPL ☐ OCT Mac/ONH ☐ Refraction ☐ TearCare

POS Items: ☐ MGD Drops (25) ☐ Heat Mask (25) ☐ Hylo Tears (35) ☐ TTO Gel (20) ☐ HypoChlor (20)

Imaging to Pt: ☐ 39 Eidon+OCT ☐ 25 Photo/OCT

Bill Insurance: ☐ Photo/OCT ☐ External Img

☐ Coordinate Benefits ☐ Refraction $30 Payment Type: Amount:

Notice of Privacy Policies & Consent Form

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 our services and to conduct health care operations involving our office.

The Notice of Privacy Practices you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; (4) other aspects of payment described in our Notice of Privacy Policies. Our Notice of Privacy Practices will be updated whenever our privacy practices change. You may obtain an updated copy here at the office (or from our website).

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform health care operations. You also signify that you have received a copy of this Notice of Privacy Practices.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our Notice of Privacy Practices, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for a restriction.

I understand that my prescription results are mine by right, although they make take multiple visits to finalize depending on my ocular health or vision requirements. By signing below, I elect to have these results sent to me electronically by request, and decline having my prescriptions automatically printed for me at the time of finalization.

Payment Policy

It is our responsibility to provide you with the highest quality eyecare. In order to do so we must receive payment for our services in a timely manner. Our policy is to collect payment at the time of service. WE will file medical insurance for you when we are members of the provider panel. If we are not members, you will be required to pay for your services and/or products and then file for any reimbursement. If you have not met your insurance deductible, you will be required to pay for all products and services. We accept cash, personal check, money orders, Visa, MasterCard and Discover. All outstanding balances over 90 days old will begin to accrue interest at a 10% APR. We are available to discuss any questions or concerns that you may have regarding our payment and collection policy. We appreciate you as a patient and thank you for allowing us to continue to provide the highest quality eyecare.

NEW POLICY 2024

For your convenience, we will store in your file credit card information to be used to reconcile your accounts. Payment will be processed to the card on file as services are rendered or ophthalmic supplies purchased. Any balances remaining after billing patient insurance policies will be automatically applied to the card on file no earlier than thirty (30) days after receiving the final determination from your insurance. A notification will be sent via text or email prior to reconciling these balances in case alternative payment needs to be arranged. *Initial here signifies understanding of policy* _____

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment and healthcare operations. I acknowledge that I have received the Notice of Privacy Practices from HILLTOP EYE CENTER.

Acknowledgement of Privacy & Payment Policies and Election for Electronic Prescription Delivery:

_____ _____ _____

Responsible Party Signature Relationship to patient Date

Please print patient name here. _____

ELECTRONIC CONTACT INFO

Our practice strives to correspond in the most efficient and timely manner when it pertains to patient communication. We utilize email and texting to confirm appointments, send reminders and send occasional offers through electronic communication methods. Please maintain updated records to provide these enhanced services.

_____ _____ Texting OK? (circle one)

Email Address Cell Phone Yes No