EAGLE RIVER VISION CLINIC

WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions please call: (907) 694-2511

PATIENT INFORMATION

Date_____

Patient_____

Address_____

_____

City State Zip

Home #_____ Cell#_____

E-Mail_____

Sex: M ☐ F ☐ Age_____Birthdate_____

Race _____ Ethnicity _____

Preferred Language _____

Communication Pref : ☐ Phone ☐ email ☐ US Postal Serv

Patient SSN#_____

☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

School_____

Employer_____

Employer Address_____

Employer Phone_____

Occupation_____

Driver's License#_____State_____

Spouse's Name_____

Birthdate_____SS#_____

Occupation_____

Spouse's Work Phone_____

Whom may we thank for referring you?_____

INSURANCE

Who is responsible for this account?_____

Subscriber Name_____

Birthdate_____SS#_____

Relationship to Patient_____

Insurance Co._____

Ins. ID#_____

Group #_____

Is patient covered by additional insurance? Y☐ N☐

Subscriber Name_____

Birthdate_____SS#_____

Relationship to Patient_____

Insurance Co._____

Ins. ID#_____

Group #_____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to **Eagle River Vision Clinic Inc**. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____ _____

Relationship Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **Eagle River Vision Clinic, Inc.**, for any services furnished me by the clinic or doctors associated with the clinic. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the CMS 1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Signature of Beneficiary Date

CURRENT EYE HEALTH

Eye Physician's Name_____

Date of Last Visit_____

Date of last eye exam_____

Do you wear Glasses? Y☐ N☐

☐All the time ☐Occasionally

☐Reading ☐Driving ☐TV

Do you wear contact lenses? Y☐ N☐

Type_____Hours/Day_____

Describe any problems you have with your contact lenses_____

Bloodshot Eyes	Y☐	N☐	Floaters or Spots	Y☐	N☐
Blurred Vision – Distance	Y☐	N☐	Headaches	Y☐	N☐
Blurred Vision – Near	Y☐	N☐	Itching Eyes	Y☐	N☐
Burning Eyes	Y☐	N☐	Light Sensitive	Y☐	N☐
Cataracts	Y☐	N☐	Loss of Vision	Y☐	N☐
Color Vision, Poor	Y☐	N☐	Macular Degeneration	Y☐	N☐
Crossed Eyes	Y☐	N☐	Migraine Headaches	Y☐	N☐
Discharge from Eyes	Y☐	N☐	Night Vision, Poor	Y☐	N☐
Dizzy Spells	Y☐	N☐	Red Eyes	Y☐	N☐
Double Vision	Y☐	N☐	Seeing Halos	Y☐	N☐
Dry Eyes	Y☐	N☐	Seeing Flashes	Y☐	N☐
Eye Infection	Y☐	N☐	Temporary Loss of Vision	Y☐	N☐
Eye Injury	Y☐	N☐	Twitching Eyelid	Y☐	N☐
Eye Strain	Y☐	N☐	Vision Poor	Y☐	N☐
Fainting Spells/Blackouts	Y☐	N☐	Watering Eyes	Y☐	N☐

HEALTH HISTORY (Have you or a family member been diagnosed with:)

Primary Care Physician's Name_____Date of last visit _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following. Also place a mark to indicate if a blood relative has had any of the following problems.

	Yourself		Family Members	
AIDS/HIV	☐ Yes	☐ No	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	☐ Yes	☐ No
Bleeding	☐ Yes	☐ No	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	☐ Yes	☐ No
Drug Sensitivity	☐ Yes	☐ No	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	☐ Yes	☐ No
Hay Fever	☐ Yes	☐ No	☐ Yes	☐ No
Heart Condition	☐ Yes	☐ No	☐ Yes	☐ No
Hepatitis (Type ____)	☐ Yes	☐ No	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No	☐ Yes	☐No
Kidney Disease	☐ Yes	☐ No	☐ Yes	☐ No
Lupus	☐ Yes	☐ No	☐ Yes	☐ No
Migraine Headaches	☐ Yes	☐ No	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No	☐ Yes	☐ No
Shingles	☐ Yes	☐ No	☐ Yes	☐ No

	Yourself		Family Members	
Skin Conditions	☐ Yes	☐ No	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	☐ Yes	☐ No
Thyroid Conditions	☐ Yes	☐ No	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No	☐ Yes	☐ No
Eye Conditions				
Blindness	☐ Yes	☐ No	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	☐ Yes	☐ No
Lazy/Turned Eye	☐ Yes	☐ No	☐ Yes	☐ No
Macular Degeneration	☐ Yes	☐ No	☐ Yes	☐ No
Poor Color Vision	☐ Yes	☐ No	☐ Yes	☐ No
Retinal Disease	☐ Yes	☐ No	☐ Yes	☐ No

Eye Surgeries

Type_____Date_____

Type_____Date_____

Are you pregnant_____Number of children_____

Tobacco use_____Alcohol use_____

MEDICATIONS/VITAMINS/DROPS

List medications you are currently taking, including eye drops:

_____

_____

_____

_____

_____

Pharmacy Name_____

Phone_____

ALLERGIES

List your allergies to medications or other substances:

_____

_____

_____

_____

_____

_____

_____

ERVC Financial Policy

Eagle River Vision Clinic, Inc (ERVC) is committed to providing information and quality services for all of our patients. We encourage our patients to take an active role in their care, interacting with our physicians and staff. As part of our commitment to you, ERVC feels it is important that you understand your financial responsibility. ERVC's policies are listed below. If you have any questions, please ask one of our staff.

PAYMENT AT TIME OF SERVICE/ADDITIONAL CHARGES (charges that may be billed after you leave ERVC) ERVC expects payment at time of service, regardless of insurance status. If you do not have your insurance card at time of service, you may either pay in full or reschedule your appointment. If you have insurance, you will be required to pay your co pay, or percentage, and any unmet deductible amount the day of the visit. The only exceptions to this are patients who have Medicare and a supplemental insurance and patients that have dual coverage and have met all required deductibles.

Please be advised that some charges may not appear on your fee ticket when checking out, and are subject to change upon review. Because some tests may require additional review by physicians, we cannot ensure that all the charges are indicated.

SELF PAY – NO INSURANCE If you do not have insurance, you will be expected to pay for your visit, including the office charges and any testing charges at the time of service.

MEDICAID Any patient receiving Medicaid benefits is required to bring their sticker/Denali Kid Care to each visit. If you do not have your sticker, your appointment may be rescheduled, or payment may be due at time of service as we will not retro bill Medicaid for services provided without a sticker or card. Any services performed that are not covered by Medicaid are your responsibility and due on the day you are seen.

MEDICARE Patients that receive Medicare benefits are required to pay their co pay at each visit. Any service not covered by Medicare is your responsibility. You will be required to pay for your portion at each visit. You will be asked to sign a waiver of liability to ensure you understand your Medicare payment responsibilities. Medicare patients who have secondary insurance are strongly encouraged to contact Medicare enrollment for automatic secondary insurance billing.

PRIVATE INSURANCE ERVC will bill most primary insurances as a courtesy. Payment for co pays or deductible is expected at time of service. If you cannot pay for your portion please ask to speak to the Office Manager for payment arrangements. You will be asked to sign a waiver for non-covered services, which your insurance may deem unnecessary or experimental and these may be your responsibility. If you do not present your insurance card at time of service you will need to pay in full or reschedule your appointment. If ERVC is not given corrected or updated insurance information by you, at the time of service, you will be responsible for any incurred charges. ERVC will bill secondary insurances as a courtesy. ERVC is contracted with Blue Cross/Blue Shield, Aetna, Tricare, VSP, Medicare and Medicaid. ERVC is also a member of the Beechstreet Network. If you do not know your co pay amount, ERVC will expect payment of 30% at time of service. ERVC will assume unknown deductible status has not been met and will expect full payment at time of service. Examples of **insurances we do not bill** are: UHC, HMO's, Avesis, EyeMed, Blue Vision, Davis Vision, Spectra, some out of state insurances that cannot be verified and Fisherman's Fund.

NON COVERED SERVICES Some services are not covered by insurance and are expected to be paid at time of service. Because individual policies vary, it is not possible for our staff to know exactly what your policy will cover. We encourage patients to contact their insurance carrier to inquire about deductibles, co pay amounts and vision benefits prior to their visit. This includes, but is not limited to, services certain insurance companies consider elective, such as, contact lens fittings and optional treatments for eyeglass lenses.

REFUNDS At times refunds or credits are created. IF you receive indication from your insurance company that a possible refund is due, please contact our office. Due to auditing purposes it may take up to 8 weeks to process and receive your refund.

COLLECTIONS Payment for services received at ERVC is the responsibility of the patient, regardless of insurance status. ERVC does not appeal denials for usual and customary, preventative or non covered services. If a patient refuses to remit payment or make financial arrangements, the patient account will be reviewed for possible collection action and considered for dismissal from ERVC. Should your account go to an outside collection agency it will be assigned to **Cornerstone Collections Services** and a 35% **administrative fee** will be assessed by ERVC. You will be responsible for the above mentioned ERVC bill including fees in addition to any collection agency charges.

If you have any questions regarding your financial responsibility to ERVC, please do not hesitate to ask. It is our hope that by providing this information, our patients can be more aware and empowered when receiving care at Eagle River Vision Clinic. Our office number is (907) 694-2511.
I have read and acknowledge the above financial policies.

Signature _____ Date _____

INSURANCE ASSIGNMENT, AUTHORIZATION AND NON COVERED BENEFITS WAIVER
I hereby assign benefits to be paid directly to Eagle River Vision Clinic, Inc and authorize the clinic to furnish information regarding my treatment and services to my insurance carrier. I understand that I am responsible for any amount not paid by the insurance. I understand that certain tests, services or eyeglass options may not be covered benefits within my insurance plan or policy. I know that if I have any questions regarding what is or is not covered under my insurance plan or policy; I should contact my insurance carrier prior to having these services rendered. If I receive services or products that are not a covered benefit within my insurance plan or policy, **I understand I am responsible for payment in full** for the incurred charges. I understand the ERVC will consider this waiver current for today's visit and any future visits.

Patient Signature _____ Date _____

Guardian/Parent Signature _____ Date _____

Printed Name _____ Date of Birth _____

ACKNOWLEDGMENT AND CONSENT

I understand that **Eagle River Vision Clinic, Inc.**
(*Name of physician/physician group*)
(referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

- I understand and agree that This Practice may **use and disclose** my health information in order to:
- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing this form the patient also agrees to allow Eagle River Vision Clinic to leave messages at phone numbers on record for the following:

1. Confirmation of scheduled appointment and/or to remind patient to reschedule missed appointment.
2. Notifying patient of prescriptions that are ready to pick up, (i.e. glasses or contact lenses have arrived), or that medical prescription has been faxed per patient request.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By:_____ Date:_____
(Patient)

-OR-

By:_____ Date:_____
(Patient representative)

Description of Representative's Authority:_____

NOTICE OF PRIVACY PRACTICES
For
Eagle River Vision Clinic

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS
Access: You have the right to look at or get copies of your health information with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will provide you with one copy of your medical records per calendar year. If more copies are requested within that time period there will be a charge of $8.00. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation or your health information for a fee. Contact us using the information listed at the end of this Notice.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Jill Lester

Phone: (907) 694-2511 Fax: (907) 694-3900

E-mail: _____

Address: 16331 Heritage Place #104

Eagle River, AK 99577