

LODESTAR

FAMILY EYE CARE, PC

JACOB FRANK, OD | KARA REYNOLDS, OD

GUIDING YOU TO BETTER VISION

Youth Patient Form

Patient Name: _____ Date: _____

Parent/Guardian Name(s): _____

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

Parent/Guardian Cell Phone: _____ Parent/Guardian Home Phone: _____

Parent/Guardian Email: _____

Preferred Method of Contact: Cell Phone Home Phone Email

Patient's Date of Birth: _____ Grade in School: _____

Sex ___M___F

Name of Person Responsible for Account: _____

Responsible Party's Date of Birth: _____ Responsible Party's Social Security Number: _____

Occupation: _____ Name of Employer: _____

Please list any family members of your household who come to our office.

Emergency Contact Information

Name: _____ Phone: _____ Relationship: _____

Who referred you to our office?

Insurance Listing Family Member Physician/Eye Doctor Website Facebook Passed by Office

Previous Patient of Dr. Frank Dr. Reynolds Friend/Family Member – Name: _____

Other: _____

Please list any eye problems, medical problems or learning/developmental problems this patient has.

Any difficulties at school? _____

Patient's Primary Care Doctor? _____ Date of last exam/visit: _____

Please list current medications and/or supplements:

Is the patient allergic to any medications? Yes No Please List: _____

Previous Eye Doctor: _____ Last Eye Exam: _____

Have any bloodline relatives had glaucoma, macular degeneration or other loss of sight? Yes No

Does the patient presently wear glasses? Yes No If yes, how old are the glasses? _____

When do they wear them? _____

Does the patient presently wear contact lenses? Yes No

What type? Soft Disposable Hard Gas Permeable Other

If yes, how old are the contacts? _____ If no, have they ever worn contact lenses? Yes No

INSURANCE INFORMATION

Primary Policy Holder Name: _____

Primary Policy Holder Date of Birth: _____ Primary Policy Holder Last 4 Social Security Number: _____

Do you have vision care benefits? Yes No

If yes, what company and ID number: _____

Do you have medical health insurance? Yes No

If yes, what company name and ID number: _____

Parent or Guardian Signature: _____

Print Name: _____ Relationship: _____

Financial Policy

Patient name (please print): _____

Our goal is to provide the very best and most complete care available. To provide this service in the most efficient manner, please be aware of the following office policies:

- ❖ Payment is expected at the time of service for treatment performed that day unless prior arrangements have been made. For your convenience, we accept cash, checks, major credit cards, and CareCredit.
- ❖ We will file an insurance claim on your behalf as a courtesy to you; however, you must supply, prior to the appointment, all the necessary information for filing.
- ❖ Any deductible as well as any estimated percentages your insurance does not cover, are to be paid on the date of treatment.
- ❖ It is the patient's responsibility to know the details of the insurance coverage, including percentages payable, waiting periods, deductibles, yearly maximums, services not covered under the plan, and any other related information.
- ❖ Not all services are a covered benefit. Some insurance companies arbitrarily select certain services they will not cover. While the filing of insurance claims is a courtesy that we extend to patients, all charges are your responsibility from the date the services are rendered.
- ❖ Balances left unpaid may result in being sent to collections, and/or termination from care at Lodestar Family Eye Care, PC.
- ❖ Services rendered in optical are highly customized and are **Non-Refundable**, and cannot be cancelled once we have placed your order. **We take no responsibility and assume no liability for glasses and contacts ordered online.**
- ❖ We require a 50% deposit for ordering frames, lenses and contact lenses.
- ❖ If you cannot keep your appointment, a 24-hour notice for rescheduling or cancelling appointments is required. A \$75 fee may be applied for any missed appointment that is not cancelled in advance.

By my signature below, I acknowledge that I have read and that I understand the above statements and am willing to accept responsibility to pay for services rendered. This authorization is not limited in time.

Signature: _____ Date: _____

Agreement to Receive Electronic Communications

- ❖ I agree that Lodestar Family Eye Care PC may communicate with me electronically at the contact information I have provided.
- ❖ I am aware that there is some level of risk that third parties might be able to read unencrypted emails.
- ❖ I am responsible for providing Lodestar Family Eye Care updates to my contact information.
- ❖ I may withdraw my consent to electronic communications at any time by calling 907.745.2273.
- ❖

Signature: _____ Date: _____

If you are signing as a personal representative of the patient, please describe your relationship to the patient and the source of authority to sign this form.

Print Name: _____ Relationship: _____ Source of Authority: _____

Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA)

I acknowledge that I have received the *Notice of Privacy Practices* from Lodestar Family Eye Care, PC. 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.

Date: _____

Patient Name: _____ Signature _____

If you are signing as a personal representative of the patient, please describe your relationship to the patient and the source of authority to sign this form.

Print Name: _____ Relationship: _____

Source of Authority: _____

Receipt of Notice of Privacy Practices

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. This information 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 the 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 to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our **Notice of Privacy Practices**. Our policy will be updated whenever our privacy practices change. You can get an updated copy here at the office. When you sign this consent document, you signify 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 healthcare operations. You also signify that you have received a copy of our **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.

Authorization for Disclosure of Information

I, _____, authorize Lodestar Family Eye Care PC to disclose information regarding my health, medical records, testing, and procedures to the following individuals:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgements
- Other (Please specify)

