VOLD VISION

YOUR SIGHT IS OUR VISION

2783 N. Shiloh Drive,
Fayetteville, AR 72704

Phone: (479) 442-8653
Fax: (479) 442-2678

PATIENT REGISTRATION INFORMATION

Date: ____/____/____

Last Name:_____First Name:_____ MI:_____

Sex: _____ DOB: ____/____/____ SSN:____-____-____

Address:_____

City: _____State:_____ Zip Code:_____

Phone #: (____) ____-____ Work Phone: (____) ____-____

Contact Preference: _____ Consent to call: ☐ Yes ☐ No Consent to email ☐ Yes ☐ No

Patient Email: _____ Marital Status: _____

Employer: _____Occupation: _____

Language: _____ Race: _____ Ethnicity: _____

SPOUSE OR RESPONSIBLE PARTY (IF PATIENT IS A MINOR)

Last Name: _____ First Name:_____MI: _____

Relationship: _____ Phone #: (____) ____-____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____ Phone #: (____) ____-____

REFERRAL INFORMATION

How did you hear about Vold Vision? _____

If your doctor referred you, please list Doctor: _____ **Clinic:** _____

U of A Razorback Athletes: Please list sport(s) _____

We are proud to be the Official Eye Care Provider of the Arkansas Razorbacks

3919 Mall Ave., Fayetteville, AR 72703
1517 Gene George Blvd., Springdale, AR 72762
1102 NW Lowes Ave., Bentonville, AR 72712

INSURANCE INFORMATION

Name: _____ DOB: ____/____/____

PRIMARY INSURANCE

Policy holder name: _____

DOB: ____/____/____ SSN: ____-____-____

Insurance Name: _____

Policy #: _____ Group #: _____

Relationship to policy holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

Employer's Name: _____

Address: _____ City: _____

State: _____ Zip Code: _____

SECONDARY INSURANCE

(OR VISION INSURANCE)

Policy holder name: _____

DOB: ____/____/____ SSN: ____-____-____

Insurance Name: _____

Policy #: _____ Group #: _____

Relationship to policy holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

Employer's Name: _____

Address: _____ City: _____

State: _____ Zip Code: _____

DISCLOSURE OF HEALTH INFORMATION

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatments. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operation and that the organization is not reqired to agree to the restriction requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance theron.

I grant permission to speak with the following people regarding my health information: _____

_____

_____

Signature of Patient or Legal Representative/Witness Date, Notice Effective Date or Version

CONSENT TO CALL

I consent to receive ☐ calls ☐ texts from Vold Vision for my protected healthcare and other services.

Patient Signature: _____ Date: ____/____/____

NOTICE OF NONCOVERED REFRACTION SERVICES TO PATIENTS

Definition of REFRACTION: The refraction test is an eye examination that measures a person's ability to see an object at a specific distance.

Medicare and most commercial insurance plans do not cover refractions. If it is determined that you need to have this test and your insurance does not pay for it, you will be held responsible for paying that portion of the exam fees at the time of service along with your co-pay and deductible if not met yet.

By signing, I understand that the refraction may not be a covered service under my insurance plan. If I want a glasses prescription update/renewal or other eye services performed today, I agree to pay any fees related to this non-covered service along with my co pay and deductible.

Patient Signature: _____ Date: ____/____/____

MEDICAL HISTORY

Name: _____ DOB: ____/____/____

Last Eye Exam: ____/____/____

Have you ever had surgery on your eye(s): ❑ No ❑ Yes If yes, please list surgery: _____

_____

Do you have any allergies to medication? ❑ No ❑ Yes If yes, please list medication name and explain reaction(s): _____

Do you have any allergies to latex? ❑ No ❑ Yes If yes, explain reaction: _____

_____

Do you have any allergies to Betadine or Iodine? ❑ No ❑ Yes If yes, explain reaction: _____

_____

Do you take any medications? ❑ No ❑ Yes If yes, list the name of medication, milligram dosage and how often you take it (including oral contraceptives, aspirin, over-the-counter medications, and home remedies) _____

_____

_____

_____

_____

List all major injuries, surgeries, and/or hospitalizations you have had: _____

_____

_____

_____

_____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, cataracts, retinal disease, eye infections or injury: _____

_____

_____

Are you pregnant and/or nursing? ❑ No ❑ Yes If yes, what trimester? _____

Do you wear glasses? ❑ No ❑ Yes If yes, how old is your present pair of lenses? _____

Do you wear contact lens? ❑ No ❑ Yes If yes, how old is your present pair of lenses? _____

Type of current contact lenses: ❑ Rigid ❑Soft _❑ Daily ❑ Bi-Weekly ❑Monthly ❑ Extended Wear

❑Mono Vision ❑Multi-Focal ❑Other _____

Are they comfortable? ❑ No ❑ Yes

SOCIAL HISTORY

Name: _____ DOB: ____/____/____

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

❑ Yes, I prefer to discuss my Social History information directly with the doctor.

❑ No, I will discuss my social history with a technician

Do you drive? ❑ Yes ❑ No If yes, do you have visual difficulty when driving? ❑ No ❑ Yes If yes, please describe here: _____

Do you use Tobacco products? ❑ No ❑ Yes ❑ Current ❑ Past If past, when did you stop? _____

If Yes, ❑ cigarettes ❑ chew ❑ cigar ❑ smokeless tobacco How much do you use/how long? _____

Do you drink alcohol? ❑ No ❑ Yes If yes ❑ Beer ❑ Wine ❑ Liquor

Do you drink daily? ❑ No ❑ Yes

Do you use illegal drugs? ❑ No ❑ Yes If yes, type/amount/how long: _____

Have you ever been exposed to or infected with: ❑ Gonorrhea ❑ Hepatitis ❑HIV ❑Syphilis

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children, living or deceased) for the following conditions:

Disease/Condition	No	Yes	?	Relationship
Blindness	❑	❑	❑	
Cataract	❑	❑	❑	
Crossed Eyes	❑	❑	❑	
Glaucoma	❑	❑	❑	
Macular Degeneration	❑	❑	❑	
Retinal Detachment/Disease	❑	❑	❑	
Arthritis	❑	❑	❑	
Cancer	❑	❑	❑	
Diabetes	❑	❑	❑	
Heart Disease	❑	❑	❑	
High Blood Pressure	❑	❑	❑	
Kidney Disease	❑	❑	❑	
Lupus	❑	❑	❑	
Thyroid Disease	❑	❑	❑	

Other: _____

REVIEW OF SYSTEMS

Name: _____ DOB: ____/____/____

Do you currently, or have you ever had, any problems in the following areas? Circle All that Apply:

Constitutional	Ear, Nose, Mouth, Throat	Lymphatic/Hematologic
Fever, Weight Loss/Gain, Fatigue,	Seasonal Allergies	Anemia
Night Sweats, Weakness	Itching	Bleeding Problems
Integumentary	Hives	Bruising
Skin, Hair Loss, Rash, Skin Lesions	Sinus Congestion	Tender Nodes
Neurological	Runny Nose	Hepatitis
Headaches	Post-Nasal Drip	Cirrhosis
Migraines	Chronic Cough	Allergic/Immunologic
Seizers	Dry Throat/Mouth	Psychiatric
Stroke	Respiratory	Anxiety
Numbness	Asthma	Depression
Tingling	Chronic Bronchitis	Insomnia
Balance Problems	Emphysema	Irritability
Eyes	Cough	Nervousness
Loss of Vision	Trouble Breathing	Endocrine
Blurred Vision	Wheezing	Thyroid/Other Glands
Distorted Vision/Halos	Shortness of Breath	High Blood Pressure:
Loss of Side Vision	COPD	Well Controlled
Double Vision	Pneumonia	Borderline Control
Dryness Mucous	Use Oxygen	Poor Control
Discharge	Vascular/Cardiovascular	Unknown BP Control
Redness	Heart/Chest Pain	Diabetic
Sandy or Gritty Feeling	Vascular Disease	Well Controlled
Itching	Heart Attack	Borderline Control
Burning	Rheumatic Fever	Poor Control
Foreign Body Sensation	Heart Failure	Unknown Diabetic Control
Excess Tearing/Watering	Irregular Heartbeat	Metabolic
Glare/Light Sensitivity	High Cholesterol	Cold Intolerance
Eye Pain or Soreness	Gastrointestinal	Excess Hunger
Chronic Eye/Lid Infection	Chronic Diarrhea	Excessive Thirst
Sties or Chalazion	Chronic Constipation	Frequent Urination
Flashes/Floaters in Vision	HEENT	Heat Intolerance
Tired Eyes	Dizziness	Heart Burn/GERD
Genitourinary	Hearing Loss	Assistive Devices
Genital Discharge	Hoarseness	Dentures
Genital Lesions	Ringing in Ears	Hearing Aides
Painful Urination	Sore Throat	Cane
Urgency	Bones/Joints/Muscles	Walker
Frequent Urinary Tract Infection	Rheumatoid Arthritis	Wheelchair
Have you ever been on dialysis?	Muscle Pain	
Cancer	Joint Pain	
Thyroid Problems	Back Pain	
	Stiffness or Swelling	

If you answered yes, or have a condition not listed, please explain and list medications: _____

Doctor Signature: _____ Date: ____/____/____

HIPAA ACKNOWLEDGEMENT

I hereby acknowledge that I have been made aware that Vold Vision has a privacy policy in place in accordance with the Health Insurance Portability Act of 1996 (HIPAA). As a patient, I acknowledge that Vold Vision has a privacy policy in effect and has made this policy available to me. I am entitled to an additional copy of the privacy policy if I desire. I authorize the release of any previous results or images in the event Vold Vision is in need of them to help with the diagnosis of my procedure today. I permit a copy of this authorization to be used in place of the original. I understand and acknowledge that I am personally responsible for the services rendered at this facility. Vold Vision will bill my insurance carrier as a courtesy. In the event of non-payment I understand I will be responsible for any outstanding balances.

Patient Signature: _____ Date: ____/____/____

MEDICAID WAIVER

Medicaid will only pay for services that they deem "necessary" and that are filed in a timely manner. If for any reason Medicaid does not pay your charges due to your lack of benefit knowledge or the correct procedures are not followed, you as the patient are responsible for all charges. Your signature is required to ensure that you are aware of your responsibilities. This is an agreement that you are willing to pay any charges that Medicaid denies. If for any reason you do not present to the office with your Medicaid card before your scheduled appointment with the physician you will be asked to reschedule or you will be considered self-pay for the duration of care.

Patient Signature: _____ Date: ____/____/____

Witness Signature: _____ Date: ____/____/____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Vold Vision any services furnished me by that physician. 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 as well as obtaining a copy of my credit report in order to conduct daily operations if needed. 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 on this form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing 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. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature of Insured or Beneficiary: _____ Date: ____/____/____

FINANCIAL POLICY

PAYMENT & FEES Payment for your care is due at the time provided. The only exception to this policy is if we are contracted with your health insurance plan (see instructions below). The fee for an office visit will range from $90.00 to $300.00. Cash, check, MasterCard, Visa, and Discover are acceptable payment methods.

INSURANCE You are required to present your insurance identification card at the time of your appointment. We will file a claim for your services if we are contracted with your health insurance plan. Please, verify in advance that the physician you have chosen to see is contracted with your plan. Any co-payment, co-insurance, and/or deductible is due at the time of service. Please be prepared to pay this amount. A co-payment is normally a fixed dollar amount per office visit, identified on your insurance card. Co-insurance is the percentage of the bill that is the patient's responsibility. A deductible is a fixed dollar amount that must be paid before the insurance will begin to pay. Again, if you do not have your current insurance identification card or other acceptable proof of insurance, your visit will be considered private pay and you will be responsible for full payment at the time of service.

It is, at all times, your responsibility to follow up on all requests from your insurance company regarding claims and to question any unpaid insurance claims. If you do not receive an explanation of benefits from your insurance within 60 days of your visit, please call them. After insurance has processed your claim, you will be billed for any remaining balance or non-covered services. This amount is due upon receiving your statement. Your insurance makes the final determination regarding payment at the time the claim is processed.

REFERRAL If your insurance plan requires a referral, it is your responsibility to request the referral from your primary care physician to be sent to our office. Failure to obtain a referral when required can result in reduced benefits or non-payment by your insurance company, making you responsible for payment of the visit.

I, the undersigned, have read and understand the financial policy as described above and agree to pay for any and all medical services including, portions not covered or denied by my insurance. Failure to pay in a timely manner will result in my account being turned over to an outside collection agency.

Patient Signature: _____ Date: ____/____/____

Witness Signature: _____ Date: ____/____/____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____ And assign directly to Vold Vision all medical 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 payment of benefits to include obtaining a copy of my credit report as needed. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian: _____ Date: ____/____/____

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. You have the right to obtain a paper copy of this notice upon request.

Patient Health Information

Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How we use your patient Health Information

We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission

Examples of Treatment, Payment, and Health Care Operations

Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacist who are filling your prescriptions, and to family members who are helping with your care.

Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan. Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it. Special Uses We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. Other Uses and Disclosures We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes: Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events. Research: We may use or disclose information for approved medical research.

Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.

Health oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activates.

Judicial and administrative proceedings: We may disclose information in response to an appropriate subpoena or court order. Law enforcement purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.

Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.

Workers Compensations: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights

You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.

Request Restrictions: you may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions. Also, if you have paid for your healthcare treatment out-of-pocket and in full, and if you request that we limit disclosure of your information to a health plan for purposes of payment or healthcare operations, we will abide by your request.

Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.

Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for copies.

Amend Information: if you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty

We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect

Changes in Privacy Practices

We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person

If you have any questions, request, or complaints, please contact:

Vold Vision
2783 N. Shiloh Drive Fayetteville, AR 72704
479-442-8653

Effective Date: _____

I, _____ Hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed: _____

If not signed, reason why acknowledgement was not obtained: _____

_____

Staff Witness seeking acknowledgement:

_____