



West End Eye Care
 4570 Pecan Dr. Suite C
 Paducah, KY 42001-6717
 TEL: (270) 558-4741 • FAX: (270) 558-4742
 westendeye.com • info@eyecarepaducah.com

WELCOME LETTER

Account No.:	
Printed:	

Dear patient:

We welcome you to our practice and ask that you kindly complete or correct all information on this form.

PATIENT INFORMATION																																																																				
PATIENT NAME:	SEX:	SOCIAL SECURITY NUMBER:																																																																		
ADDRESS:	DATE OF BIRTH:	MARITAL STATUS:																																																																		
CITY, STATE & ZIP:	EMAIL:																																																																			
HOME PHONE:	WORK PHONE:	MOBILE PHONE:																																																																		
EMPLOYER:	OCCUPATION:																																																																			
EMPLOYER'S ADDRESS:	PRIMARY CARE PHYSICIAN:																																																																			
EMPLOYER'S CITY, STATE & ZIP:	PRIMARY CARE PHYSICIAN'S PHONE: () -																																																																			
<p>Do you or your family have any history of the following conditions (check all that apply)?:</p> <table border="0"> <tr> <td>Self</td> <td>Family</td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Glaucoma</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Cataracts</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Diabetes</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>High Blood Pressure</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Macular Degeneration</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Heart Problems</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Retinal Degeneration</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Stroke</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Thyroid Condition</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Crossed/Lazy Eyes</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Asthma/ Allergies</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Color Blindness</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Arthritis</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Tuberculosis</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>HIV/Hepatitis</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Cancer</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Neuromuscular</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Blindness</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Other:</td> </tr> <tr> <td></td> <td></td> <td>_____</td> </tr> <tr> <td></td> <td></td> <td>_____</td> </tr> </table>	Self	Family		<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Condition	<input type="checkbox"/>	<input type="checkbox"/>	Crossed/Lazy Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Asthma/ Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Color Blindness	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	HIV/Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Neuromuscular	<input type="checkbox"/>	<input type="checkbox"/>	Blindness	<input type="checkbox"/>	<input type="checkbox"/>	Other:			_____			_____	<p>Do you currently have any of the following symptoms (check all that apply)?:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Blurry distance vision <input type="checkbox"/> Poor night vision <input type="checkbox"/> Eye Strain <input type="checkbox"/> Blurry Near Vision <input type="checkbox"/> Trouble Reading <input type="checkbox"/> Itchy Eyes <input type="checkbox"/> Discharge <input type="checkbox"/> Watering <input type="checkbox"/> Pain in the eye <input type="checkbox"/> Burning eyes <input type="checkbox"/> Sandy/dry eyes <input type="checkbox"/> Red Eyes <input type="checkbox"/> Glare/reflections <input type="checkbox"/> Discomfort in sunlight <input type="checkbox"/> Double vision <input type="checkbox"/> Floaters or spots in vision <input type="checkbox"/> Flashes of light <input type="checkbox"/> Eye injury <input type="checkbox"/> History of wearing an eye patch <input type="checkbox"/> History of eye surgery <input type="checkbox"/> Headaches <input type="checkbox"/> Dental Abscess 	<p>Are you interested in any of the following (check all that apply)?:</p> <ul style="list-style-type: none"> <input type="checkbox"/> New spectacles <input type="checkbox"/> A new prescription <input type="checkbox"/> Light weight glasses <input type="checkbox"/> Anti-reflective lens <input type="checkbox"/> Ortho K <input type="checkbox"/> Colored contact lens <input type="checkbox"/> Sunglasses <input type="checkbox"/> Clip-ons <input type="checkbox"/> Safety glasses <input type="checkbox"/> Lasik <input type="checkbox"/> Contact lenses <input type="checkbox"/> Dry eye therapy <input type="checkbox"/> Myopia control <p>How were you referred to us?</p> <ul style="list-style-type: none"> <input type="checkbox"/> Family doctor <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Insurance company <input type="checkbox"/> Another patient <input type="checkbox"/> _____
Self	Family																																																																			
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<input type="checkbox"/>	<input type="checkbox"/>	Blindness																																																																		
<input type="checkbox"/>	<input type="checkbox"/>	Other:																																																																		

MEDICATIONS:	ALLERGIES:	<p>SOCIAL HISTORY:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Alcohol abuse <input type="checkbox"/> Drug use <input type="checkbox"/> Tobacco use <input type="checkbox"/> Other: <p>_____</p> <p>_____</p> <p>_____</p>																																																																		



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INSURANCE INFORMATION

Patient Name:	
Account No.:	
Printed:	

GUARANTOR		
GUARANTOR NAME:	GENDER:	SOCIAL SECURITY NUMB
ADDRESS:	DATE OF BIRTH:	
CITY, STATE, ZIP:	PATIENT'S RELATIONSHIP TO GUARANTOR:	
HOME PHONE:	WORK PHONE:	

PRIMARY VISION INSURANCE	SECONDARY VISION INSURANCE
COMPANY NAME:	COMPANY NAME:
POLICY ID NO.:	POLICY ID NO.:
POLICY GROUP:	POLICY GROUP:
INSURED PARTY:	

PRIMARY MEDICAL INSURANCE	SECONDARY MEDICAL INSURANCE
COMPANY NAME:	COMPANY NAME:
POLICY ID NO.:	POLICY ID NO.:
POLICY GROUP:	POLICY GROUP:
INSURED PARTY:	INSURED PARTY:

MEDICAL INSURANCE POLICY: As part of our services at this practice we are happy to assist you in determining the benefits of your individual policy and in collecting your reimbursement of insurance benefits for medical services. To avoid any misunderstandings please read the following statements carefully:

The legal obligations of your insurance provider are between yourself and your provider, not between this practice and your provider.

1. When your insurance provider (s) has settled your plan's covered items, you will be notified by a monthly statement if there were any unpaid balances. Unpaid balances can include non-covered items or services, co-pays, deductibles, lapses, ineligibility or termination of coverages. Unpaid balances are the sole responsibility of the patient.
2. To keep the cost of records and collections down any patient portion amounts on your order will be due at the time of service.
3. I authorize the use of this form on all insurance submissions as well as authorizing the release of information to all my insurance companies as well as allowing the doctor to act as my agent to help me in obtaining payment from my insurance companies.
4. I authorize payment to be made directly to the provider and permit a copy of this authorization to be used in place of the original.

REFUND/RETURN POLICIES: No refund can be made on clinical procedures or services, including comprehensive eye examination, refraction, contact lens fitting/evaluation, and medical office visits. Refunds for unopened boxes of contact lenses can only be made within 30 days of receiving the product, provided that the product is returned to the store without damage at the time that the refund is issued. Opened boxes of contact lenses are non-refundable. Prescription and non-prescription eyeglasses, sunglasses, or spectacle lenses cannot be refunded. Patients may have their lenses re-made due to a doctor prescription change, non-adapt, or lab error within 90 days. 90 days after a product is dispensed, no refund, no exchange, no return can be made on any goods purchased at this store.

CONSENT FOR TREATMENT: I hereby authorize West End Eye Care to administer diagnostic and medical procedures as may be necessary for proper health care.

 Signature of patient or authorized representative
 Name of Patient:

 Date

 Authorized representative's name



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HIPAA CONSENT

Patient Name:	
Account No.:	
Printed:	

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Permission to Use and Disclose My Health Information: By signing this form, I give West End Eye Care permission to use and/or disclose my health information to provide treatment, obtain payment, and/or conduct health care operations.

Right to Refuse: I have the right not to sign this consent. If I refuse to sign this consent, West End Eye Care has the right to refuse to treat me. However, treatment required by law –such as emergency care– can be provided to me whether or not I sign this consent.

Right to Review Notice of Privacy Practices: I have been provided with a copy of the Notice of Privacy Practices for West End Eye Care which describes how West End Eye Care may use and disclose my health information. I have the right to review this Notice before signing this consent.

Changes to the Notice of Privacy Practices: West End Eye Care may change the Notice of Privacy Practices as needed. I may obtain a current copy of the Notice of Privacy Practices for West End Eye Care by contacting West End Eye Care.

Right to Request Restrictions on Use/Disclosure: I have the right to request that the usage of my protected health information by West End Eye Care be restricted in how it is used and/or disclosed for the purpose of providing treatment, obtaining payment, and/or conducting health care operations. However, West End Eye Care is not required to agree to any restriction that I request. If West End Eye Care does decide to agree to my request, the use and/or disclosure of my health information by West End Eye Care must be restricted as I requested. If I wish to request restrictions I can contact West End Eye Care. West End Eye Care will notify me on whether my restrictions have been accepted or declined.

Right to Withdraw Consent: I have the right to withdraw this consent at any time. I must do so in writing by contacting West End Eye Care at 4570 Pecan Dr. Suite C, Paducah, KY 42001-6717. My withdrawal of this consent will not be effective for uses and/or disclosures that have already been made based on my prior consent. If I withdraw this consent, then West End Eye Care may refuse to provide to me further treatment or follow-up, other than required emergency services.

Effective Period: This consent is good unless and until I withdraw it in writing.

References to “I” or “me”: References to “I” or “me” in this Consent include the individual for whom the signing party is authorized to sign. If I am signing this consent on behalf of another person, it is because I am that person’s parent, legal guardian, or agent under an active Power of Attorney for Health Care; and I am legally authorized to sign this Consent on behalf of that person.

 Signature of patient or authorized representative
 Name of Patient:

 Date

 Authorized representative’s name

**IWellness Exam
 (Age 18 and Older)**

As part of our Comprehensive Eye Examination, we utilize the IWellness 3D Eye Imaging system to help detect early signs of eye diseases like glaucoma and macular degeneration. The scan will be performed during your workup and will be reviewed by the doctor during your exam. This scan is only recommended for patients age 18 and older.

This test is not covered by vision or medical insurances because it is considered preventative in nature. **The cost of this portion of the exam is \$29 and is the patient’s responsibility at the time of examination.**

IWellness is recommended annually, but you may choose to opt-out of this portion of the exam by intialing below.

I wish to opt-out of the IWellness portion of the examination (Initial): _____