Welcome to Hecker Eye Care Associates. We look forward to a healthy and educational relationship while providing your eye care needs. Please review the enclosed information and forms. It is essential to complete the items listed below before your appointment. We realize your time is very important. Completing this information prior to your appointment will help expedite the check in process at our office. Your eyes are dilated for all cataract evaluations, comprehensive and diabetic eye exams, glaucoma evaluations and occasionally for other types of appointments. Your eyes remain dilated for approximately 3-6 hours after your exam. Please plan for your appointment to last approximately 2½ hours for all dilated exams and up to 3 hours for cataract evaluations.

****For ALL of your appointments, please bring a photo ID and ALL active medical insurance cards, otherwise we will need to reschedule your appointment.**

****Established Patients** who have filled out these forms in the past: We do need you to again please sign or initial the designated areas on these forms once a year. In addition to that, please update any information that has changed since the last time you were seen.

Patients under the age of 18 must be accompanied by a parent or legal guardian.

Any patient who is not able to answer questions regarding their health and/or is not physically able to move around without assistance must have a family member or caregiver with them during the exam.

PATIENT INFORMATION

PERSONAL INFORMATION:

Patient Name:____

Date of Birth:____

Social Security Number:____

Sex: ___ Male ___ Female

Address:____

City, State, Zip:____

Email:____

Home Phone Number:____

Cell Phone Number:____

Other Phone Number:____

Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed

Employer Name:____

Employer Address:____

City, State, Zip:____

Do you wear eyeglasses? ___ YES ___ NO

Do you wear contact lenses? ___ YES ___ NO

Primary Care Doctor/General Practitioner Name:_______________________________

Phone Number:____

Address:____

City, State, Zip:____

How did you hear about our practice? ___ Referred by Physician ___Referred by Friend/Family/Neighbor/Other _____Other

Their Name?____

Do you have an Endocrinology Doctor? ___ YES ___ NO

IF YES: Their Name:____

City, State:_____________________________ Phone Number:___________________________

Do you have a Rheumatology Doctor? ___ YES ___ NO

IF YES: Their Name:____

City, State:_____________________________ Phone Number:___________________________

Do you have an Optometry Doctor? ___ YES ___ NO

IF YES: Their Name:____

City, State:_______________________________ Phone Number:_____________________________

Do you have a Retina Doctor? ___ YES ___ NO

IF YES: Their Name:____

City, State:_______________________________ Phone Number:_____________________________

Pharmacy Information

Preferred Pharmacy Name:____

Pharmacy Phone Number:____

Pharmacy Address:____

City, State, Zip:____

INSURANCE INFORMATION

Primary Insurance Carrier Name:____

Name of Policy Holder:____

Policy Holder Date of Birth:____

Policy Holder Social Security Number:____

Relationship to Patient:____

Please bring all ACTIVE Insurance Cards with you to your appointment, and a photo ID!

Do you have secondary insurance? ___YES ___NO

Secondary Insurance Carrier Name:____

Name of Policy Holder:____

Policy Holder Date of Birth:____

Policy Holder Social Security Number:____

Relationship to Patient:____

Who should we notify in case of an emergency?

Name:____

Relationship:____

Phone Number:____

Address:____

City, State, Zip:____

Do you have a “Power of Attorney” (POA)? ___Yes ___No

If yes, please provide POA Name______________________Phone Number___________________

and Relationship to you:_______________________

Hecker Eye Care Associates HIPAA Compliance Patient Consent Form / AUTHORIZATION TO RECEIVE/RELEASE HEALTH INFORMATION

Our **Notice of Privacy Practices** provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature, you have reviewed our notice before signing this consent.

The terms of the notice may change and, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations.
- Hecker Eye Care Associates reserves the right to change the privacy policy as allowed by law.
- The patient has the right to restrict the use of the information, but Hecker Eye Care Associates does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- Hecker Eye Care Associates may condition receipt of treatment upon execution of this consent.

Please keep in mind that communications via the internet or text are not secure or encrypted. Although it is unlikely, there is a possibility that information you include in any email or text can be intercepted and read by other parties besides the person to whom it is addressed. Please do not include personal identifying information such as your birthdate or personal medical information in any emails or text messages you send to us. We cannot diagnose or treat your condition via the internet or text message; you must come into the office for an appointment.

May we phone, email or send a text to you to confirm your appointment?
___YES ___NO

May we leave a message on your answering machine at home or on your cell phone?
___YES ___NO

Disclosures we make unless you object: Unless you instruct us otherwise, we may disclose your information to a member of your family, relative, friend or other person who is involved in your healthcare or payment of your healthcare. We will limit the disclosure to information relevant to that person's involvement in your healthcare or payment.

In addition, do you have any particular person or family members that you authorize to receive and discuss information regarding your personal health information (general information, surgical and billing)?

__ Yes __No If yes, please provide:

1) Name: ______________________________ Relationship: ____________________

Phone Number: ____________________________ Alternate Number:____________________________
Is this person your Power of Attorney for medical purposes? __Yes __No

2) Name: ____ Relationship:__________________________

Phone Number: __________________________________ Alternate Number______________________

I hereby authorize Hecker Eye Care Associates to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, laboratories, radiology facilities or other institutions. **This authorization remains in effect until revoked.**

I have reviewed the aforementioned information and provide my consent regarding any and all the issues as stated above.

I have reviewed Hecker Eye Care Associates' **Notice of HIPAA Privacy Policy.** A copy of this policy will be provided to me upon request.

Patient Signature: ______________________________________ **Date:** ________________________

Printed Name____

MEDICATIONS: PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING.

	Medication Name	Dosage	Frequency	Reason (Example-High Blood Pressure)
1.				
2.				
3.				

4.				
5.				
6.				
7.				
8.				
9.				
10.				

Are you allergic to any medications? ___YES ___NO

If YES, please list the name(s) of the medications you are allergic to:

____

____

____

____

Ethnicity (Select one) ___ Hispanic or Latino ___ Not Hispanic or Latino

Race (Select one) ___American Indian/Alaska Native ___Asian ___White
___ Black/African American ___Native Hawaiian or Other Pacific Islander ___Other Race

FAMILY HISTORY

Do any of your blood relatives have any of the following?
If "**YES**" please list M = Mother F = Father S = Sibling GP = Grandparent

Condition	**YES**	**NO**	**Relationship**	**Explanation of Problem**
Blindness				
Macular Degeneration				
Glaucoma				
Cancer				
Diabetes				
Heart Disease or High Blood Pressure				
Stroke				
Other				

SOCIAL HISTORY

Current Occupation:____

Do you drive? ___YES ___NO

Do you drink alcohol? ___YES ___NO

If yes, ___Occasional ___More than 4 days a week

Have you ever smoked? ___YES ___NO

Do you currently smoke? ___YES ___NO

If so, how many packs per day? ____

MEDICAL HISTORY

For the following conditions you have had in the past, ***please answer yes or no*** *as to how they apply to you.* ***If YES***, **please identify and explain condition.**

General / Constitution (fever, heat stroke, weight loss/gain, unusually tired, HIV, etc.)

____
____
____

Ears, Nose, Throat (hard of hearing, stuffy nose, earache, dry mouth, sinus, etc.)

____
____
____

Cardiovascular (high blood pressure, racing pulse, heart attack, chest pain, congestive heart failure, high cholesterol, etc.)

____
____
____

Respiratory (congestion, wheezing, shortness of breath, asthma, COPD, emphysema, sleep apnea, etc.)

____
____
____

Gastrointestinal (upset stomach, diarrhea, constipation, hernia, ulcers, GERD, etc.)

____
____
____

Genital, Kidney, Bladder (Painful / Frequent urination, impotence, yellow jaundice, etc.)

____
____
____

Females (Are you pregnant or nursing?)

____

Muscles, Bones, Joints (joint pain, stiffness, swelling, cramps, fibromyalgia, rheumatoid arthritis, lupus, etc.)

____
____
____

Skin (warts, growths, rash shingles, etc.)

____
____

Neurological (numbness, headache, seizures, paralysis, stroke, dementia, memory loss, etc.)

____
____
____

Psychiatric (anxiety, depression, insomnia, etc.)

____
____
____

Endocrine (Diabetes, hypothyroid, hormone, etc.)

____
____
____

Blood/Lymph (bleeding, high cholesterol, anemia, problems related to blood transfusions, etc.)

____
____
____

Allergic/Immunologic (sinus, sneezing, swelling, redness, itching, hive, lupus, rheumatoid arthritis, autoimmune conditions, etc.)

____
____
____

Cancer (breast, prostate, lung, skin, colon or other)

____
____
____

Eyes (cataract, glaucoma, detached retina, blindness, lazy eye, eye injury, corneal problems, Corrective Surgery Including Lasik, etc.)

____
____
____

SURGICAL HISTORY

Type of Surgery/Hospitalization	Date	Doctor

PATIENT EXPECTATION CONSENTS

Release of Information and Assignment of Benefits:

*I hereby authorize Hecker Eye Care Associates to release information to my medical providers listed on the patient registration form or authorization form, as well as any of my insurance companies when necessary to complete my claims, and also to the Ambulatory Surgical Center if I am having surgery there. I request payment of authorized health insurance benefits (Medicare, all commercial insurance, Medicaid, etc.) be made to either me or on my behalf to Hecker Eye Care Associates for any services furnished by that institution. I accept responsibility for all charges not covered by my insurance or other third party payers and all costs incurred in or related to the collection of such charges, including but not limited to reasonable collection agency charges, not to exceed 50% of the principal attorney's fees and cost of suit. **I am**

responsible for my co-pay that is listed on my insurance card or insurance deductibles at the time of appointment. INITIALS REQUIRED*: ______

Financial Policy

We are dedicated to providing our patients with the highest quality ophthalmic care and to running our clinic efficiently. Please assist us in achieving these goals by complying with our financial policy. Co-pays and deductibles are payable upon check-in. It is your responsibility to verify insurance and determine the status of coverage (copay and deductible) prior to your visit. **Photo identification with current address and current original insurance card(s) are required at check-in**.

Our office participates with most major medical insurance plans. **We do not accept "Vision Plans".** We provide **MEDICAL and SURGICAL** ophthalmologic care to our patients. **If you have a managed care plan that requires a referral to see a specialist, you must obtain a referral in order for your visit in our office to be covered under your medical insurance.** If you do not have a valid referral and still wish to be seen, you will be asked to pay for the visit prior to your examination.

We appreciate prompt payment in full for any outstanding balance. If you are unable to pay a balance in full, please notify our billing department immediately and we will try to work out a payment plan with you. If your account is turned over to our collection agency, you agree to pay any fees imposed by the collection agency in order to collect the overdue amount in addition to a **$50.00** administrative fee. Any check payments that do not clear the bank will be subject to a **$25.00** returned check fee.

Filling out forms for patients; The fee for DMV form is: $10.00. Fees for other forms (FMLA, Insurance, Dictated Letters, Etc.): will vary, at a range of $25.00 to $50.00, depending on the complexity of the forms. Fees are collected at the time the form is dropped off in the office.

*There will be a $50.00 charge if you fail to show for any scheduled appointments or cancel the same day as your appointment. **INITIALS REQUIRED*:** ______

Leaving Messages:

*I give permission for detailed appointment, medical care, test results, and billing information to be left on my preferred contact, which is listed below. **INITIALS REQUIRED*:** ______

Preferred method of contact:____

Medication Repository:

*Any pharmacy that participates with a central repository will have an updated list of your medications. In order to provide you with the best possible care, the providers would like your permission to access this repository. **INITIALS REQUIRED*:** ______

Consent for Refraction:

What is a refraction? This is a procedure for which we obtain measurements that determine the best corrected visual acuity for each eye. The measurements are used to determine many things about your eyes and vision, and also to dispense to you a prescription for glasses. Even if you don't wear glasses or don't have any concerns about your vision, or don't want a glasses prescription, a refraction is necessary in order for your provider to determine the overall health and status of your eyes. That is why the refraction is an essential part of an eye exam. However, Medicare and most insurance companies consider the refraction to be a "non-covered" service, so do not cover the cost of a refraction.

If the refraction is not covered by your insurance, our fee is $35.00, payable at the time the service is rendered. If the refraction is covered by your insurance we are happy to file that claim for you. **The refraction fee is separate from and in addition to your copay and deductible.**

*ACKNOWLEDGEMENT: I have read the above information and understand that if the refraction is a non-covered service, I accept full financial responsibility for the cost of this service. **INITIALS REQUIRED*:** ______

Consent to Dilate:

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the eye doctor to get a better view of the inside of your eye. Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. While dilated you may experience glare and difficulty focusing. **It is not possible for your eye doctor to predict how much your vision will be affected nor for how long. Operating a motorized vehicle may be difficult after an examination. It is best if you make arrangements not to drive yourself.** Adverse reactions occur rarely, however dilating drops can provoke acute angle-closure glaucoma, allergic reactions, increased blood pressure, irregular heart rate, and dizziness. This is extremely rare and treatable with immediate medical attention. Additionally, we recommend sunglasses which we can provide to you.

*I hereby authorize Hecker Eye Care Associates physicians and/or such assistants as may be designated by him/her to administer dilating eye drops. I understand the eye drops are necessary to diagnose my condition. **INITIALS REQUIRED*:** ______

Declined Dilation:

*I also understand that if I decline dilation that there is potential for partial or total loss of vision which may exist and without dilation may go undetected. **INITIALS REQUIRED*:** ______

Time in Office:

*Please plan to be at our office for at least two to three hours. Time frames vary due to testing needed. We make every effort to keep your appointment as efficient as possible, but also want you to be prepared for the time needed to make that happen.   Temperatures in the office vary by location, so please be prepared and bring a jacket or sweater if you get cold easily.   **INITIALS REQUIRED*:** ______

Signature of Patient/Authorized Representative____

Printed name of above signature:____

Date signed:____

This last form is only for patients considering cataract surgery- all others may skip this part.

Quality of Vision Checklist

At Hecker Eye Care Associates, we strive to provide the best quality of care and customized vision solutions for our patients. This checklist will assist us in providing the treatment best suited for your visual needs and lifestyle. Please fill this form out completely. If you have any questions, please let us know and we will be happy to assist you.

What are your favorite hobbies?

____

____

If you work, what are some of your work related tasks?

____

____

How much time per day do you spend on the computer?__________________________________

Do you find yourself switching between different pairs of glasses throughout the day?_______

Does your work or livelihood require night time driving? ___YES ___NO

Would you like to be less dependent on glasses? ___YES ___NO

How would you describe your personality?
___Easy going ___Perfectionist ___In between

Have you stopped doing an activity that you really loved to do? ___YES ___NO

If yes, please explain:

____

____

Please rate on a scale of 1-10 how much you dislike wearing glasses with 1 being NOT BOTHERED and 10 being VERY BOTHERED. ____

What activities do you generally wear glasses for?____________________________________

What activities do you generally not wear glasses for?_________________________________

Have you tried Mono-Vision contact lenses? ___YES ___NO

Have you ever tried Bi-focal contact lenses? ___YES ___NO

Is there anything you would like us to know?____________________________________

____

____

Information on Cataract Surgery and Intraocular Lens Implants

If you choose to proceed with cataract surgery, your eye surgeon will review in detail your options and recommend a surgical plan based on your individual needs. The information below will provide some information about some of your options. You may also visit our website for more information: www.heckereye.com

Basic Monofocal Lens

If you choose the basic monofocal lens implant, Medicare and most private insurance carriers will pay 80%, but we recommend you research your coverage with your insurance company. With the basic lens implants, there is a very high likelihood that you will need glasses for near vision activities after surgery, even if you do not wear near vision glasses before surgery. Near activities include reading, applying makeup, shaving, sewing, reading your watch and cell phone and baiting fish hooks.

Presbyopia Correcting Lens (Multifocal Lens)

Some advanced technology implants are designed to provide a full range of vision near and far, and others for far and mid- range vision. If you are considering these options, your eye surgeon will counsel you at the time of your visit There is an additional cost for this technology. Medicare and private insurance provide basic coverage and allow you to pay for the upgrade, if you choose to do so. We will review the costs with you at the time of your visit. The goal with these lens implants is to significantly decrease your dependence on glasses.

Astigmatism Correcting Lens (Toric Lens)

The Astigmatic correcting lens implant is specially designed to treat those who have astigmatism. In years past, cataract surgery removed the cataract, but a patient with astigmatism still required glasses for near and distance vision. The design of the Toric lens makes it possible to reduce or eliminate astigmatism. Whether you choose a monofocal or multifocal lens implant, there is an additional cost for this upgrade. Your surgeon will let you know if you are a candidate for a toric lens implant.

___YES, I would like to hear about more freedom from glasses after cataract surgery.

___NO, I just want my basic coverage.