Horizon Eye Care, P.A.
Patient Information Sheet

For your convenience, please print and complete the pre-registration forms before your visit.

Section 1:

Patient's Legal Name: _____
(First, MI, Last)

Parent / Guardian: _____
(If applicable) (First, MI, Last) (Please also complete Section 2)

Address: _____
(house number, street, apt. number)

_____
(City, State, Zip)

Home Phone: _____ Work / Cell: _____

Date of Birth: _____

Email: _____

How did you hear about us: ___ Referral ___ Friend/Family ___ Website
___ Checkers game ___Knights game ___ Yellow pages
___ Other: _____ _____

Employer: _____ Title: _____

Occupation: _____

Preferred Pharmacy: _____
(name, address, phone, zip code)

Section 2: Complete if patient is under 18, a full-time student, or otherwise has a guardian

Address: _____
(If different than above) (house number, street, apt. number)

_____
(City, State, Zip)

Phone: _____
(If different than above)

Section 3: Emergency Contact Information

Contact's full name: _____
(First, MI, Last)

Relationship: _____ Work / Cell : _____

Home Phone: _____

Horizon Eye Care, P.A. ("Horizon")
Patient Agreement and Consent to Treatment

In order for Horizon to provide our patients with quality medical care, we must receive payment for our services. Ensuring that we are appropriately and promptly paid for the services rendered is our patient's responsibility. This document explains the obligations we require from our patients and how our patients meet these obligations. In exchange for services rendered, each patient agrees:

1. To authorize payment of surgical and medical benefits to Horizon, which would otherwise be payable to you. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment and titles V, XVIII, and or XIX of the Social Security Act is correct.

2. To pay for all non-covered charges, co-pays, co-insurance, deductibles, out-of-network charges, and refractions (the measurement of the eye in order to obtain a prescription for contacts or glasses) at the time of service or when otherwise advised. If this is not possible, you agree to contact our Patient Accounts department at (704) 365-0555 BEFORE services are rendered.

3. To provide us with a copy of your most recent insurance card or other proof of insurance at the time of EACH visit. If you do not provide us with valid insurance information at the time of EACH visit and your insurance company subsequently denies our claim, you are personally responsible for any and all charges.

4. To obtain any authorization required by your insurance plan and / or from your Primary Care Physician prior to each appointment. If you do not receive the required authorization, your insurance company may not pay us for our services. In these cases, you are personally responsible for any and all charges.

5. To monitor your insurance company's payment of your account and if unpaid following 30 days from the date of service to contact them regarding their non-payment. You also agree to cooperate with Horizon to resolve the unpaid status of your account.

As a courtesy to our self-pay patients seeking routine eye care, Horizon will provide a reduced charge for payment at the time of service. The entire balance must be paid in full to receive the discount. Once you accept the discount, Horizon will not be responsible to file claims to any insurance company nor will Horizon accept payment on a discounted rate from the insurance company. In the event we receive a payment from an insurance company under this circumstance, we will refund the money back to the insurance company. It is your responsibility to inform us at the point of service if you have insurance coverage for "routine" eye services.

The undersigned, whether as the patient or guarantor of a patient, agrees that in consideration of the services rendered by Horizon, that you are individually obligated to pay for such services in accordance with the regular rates, terms, and conditions of Horizon. In the event we must refer the patient's account to an attorney or collection agency for collection of an amount 90 days or older, the undersigned agrees to pay all actual attorney's fees and collection expenses, including any accrued interest and any bank fees incurred from a returned check.

I voluntarily consent to healthcare treatment from the physicians and staff at Horizon. I am aware that the practice of medicine is not an exact science. No guarantees have been made to me regarding the results of treatments or examinations by my caregivers. I consent to the use and disclosure of protected health information about me for treatment, payment, and operations.

I have read this form and have had the opportunity to ask questions and my questions have been answered. By my signature, I represent that I have voluntarily read, understand and agree to be bound by the above provisions.

Name (Patient or Guarantor) _____ Date _____

Signature _____

Horizon Eye Care, P.A.
Medical History Questionnaire

Mr. Mrs. Miss
Ms. Dr.
(circle one)

_____ Date of Birth: _____
(First, MI, Last)

Referred By: _____ Primary Care Doctor: _____

Allergies (Please list): _____

Current Eye Medicines (Please list): _____

Current Medications (Please list): _____

_____

Have you ever taken oral steroids (i.e. prednisone, etc.) or used steroid eye drops or nasal steroids? Yes _____ No _____

Eye History:

Have you ever had any of the following eye problems? (Please check Yes or No for each)

	No	Yes		No	Yes
Cataracts			Retinal Detachment		
Glaucoma			Macular Degeneration		
Lazy/Crossed Eyes			Diabetic Eye Disease		
Retinitis Pigmentosa			Dry Eyes		
Color Blindness			Eye Trauma		
Iritis					

Medical History:

Have you ever had any of the following? (Please check Yes or No for each)

	No	Yes		No	Yes
Diabetes			Chronic allergies		
High blood pressure			Stroke		
Heart failure			Seizures		
Heart attack			Migraines		
Irregular heartbeat			Ulcers		
Asthma			Intestinal disease		
Emphysema			Lupus		
Hepatitis			Arthritis		
Liver disease			Head trauma		
Kidney disease/stones			Major depression		
Sickle Cell			HIV Positive		
Bleeding disorders			Shock		
Thyroid disease			Cancer		
Sinus problems			Drug or Alcohol abuse		

Other (Please describe): _____

Please list all surgeries: _____

Please turn this form over and complete the other side.

Horizon Eye Care, P.A.
Medical History Questionnaire

Family History:

Has anyone in your family (blood relatives) had any of the following? (Please check Yes or No for each)					
	No	Yes		No	Yes
Diabetes			Migraines		
Glaucoma			Macular degeneration		
Cataracts			Blindness		
Corneal Disease			Retinitis pigmentosa		
Crossed Eyes			Retinal detachment		
Heart disease			Asthma		
High blood pressure			Anesthesia problems		
Blood disorders			Cancer		

Social History:

Marital Status: □ Single □ Married □ Divorced □ Widowed

Occupation: _____ Employer: _____

Hobbies: _____

Do you consume alcohol? _____ No _____ Yes How much? _____

Do you smoke or use tobacco _____ No _____ Yes How much? _____

Review of Systems:

Have you had any of the following problems recently? (Please check yes or no for each)					
	No	Yes		No	Yes
Hearing loss			Environmental/food allergies		
Skin rash			Chest pain/irregular heartbeat		
Dizziness/headache			Fatigue/Fever/Night Sweats		
Blood in urine			Increased thirst/appetite		
Emotional changes			Constipation/diarrhea/vomiting		
Cough and wheezing			Bruising/easy bleeding		
			Joint pain/muscle weakness		

Please explain any "Yes" responses: _____

Please sign and date:

Patient signature (or parent if minor): _____ Date: _____

Doctor Review: _____ Date: _____

Horizon Eye Care, P.A.
Authorization To Release Protected Health Information (PHI)
Authorization To Obtain and Use Prescription History

1. With your permission, we may disclose your PHI to the individuals identified below. I authorize Horizon Eye Care, P.A. to release any personal information relating to my health care.

   To: _____ Relationship To Patient: _____

   To: _____ Relationship To Patient: _____

   To: _____ Relationship To Patient: _____

   To: _____ Relationship To Patient: _____

2. I understand that I have the right to restrict information that may be released and that this restriction must be in writing.

   _____ No Restrictions

   _____ With restrictions (list): _____

3. I agree that Horizon Eye Care, P.A. may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

_____ _____
Printed Name Date

_____
Signature

Horizon Eye Care, P.A.
Authorization for Treatment of Minor

I, being the parent or guardian of _____, a minor (DOB: _____) do hereby request and authorize the physicians and other health care providers of Horizon Eye Care, P.A. (collectively the "Physician") to provide routine eye examinations and medical diagnosis services for my child, which are deemed suggested by the physician, whether or not I am present at the actual appointment.

Below is a list of individuals who have permission to bring my child in for treatment:

Name:	Relationship:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

It is understood that this authorization is given before any specific diagnosis or treatment in order to avoid delay in providing such treatment as is deemed necessary by the Physician in the Physician's professional judgment. Any treatment beyond the scope of this authorization requires express consent from the undersigned parent of guardian.

This authorization to treat will remain in effect until revoked in writing by the undersigned.

_____	_____
Signature of Parent or Guardian	Date
_____	_____
Printed Name of Parent or Guardian	Date
_____	_____
Witness	Date

Horizon Eye Care, P.A.

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____

Address: _____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

_____ An emergency existed & a signature was not possible at the time.

_____ The individual refused to sign.

_____ A copy was mailed with a request for a signature by return mail.

_____ Unable to communicate with the patient for the following reason:

_____

_____ Other: _____

Prepared By: _____

Signature: _____

Date: _____