HILL VISION SERVICES - PATIENT INFORMATION RECORD Today's Date_____

Name: (Last)_____ (First)_____ (MI)_____

Date of Birth: _____ Age: _____ Social Security No. _____

Address: (Street) _____ (City) _____ (State) _____ (Zip Code) _____

Home Phone: (____) _____ Daytime Phone: (____) _____

Cell Phone: (____) _____ Email Address: _____

Patient's Sex: Male_____ Female_____ ~ Marital Status: Single_____ Married_____ Widow_____ Divorced_____

Patient's Occupation: _____ Employer: _____

Patient's Employment Status: Full Time_____ Part Time_____ Retired_____ Not Employed_____

PREFERRED COMMUNICATION: ☐ Telephone ☐ Mail ☐ Email

Do we have permission to leave a message on your voicemail: Yes_____ / No_____

Do you wish to opt out of text / SMS messages? Yes_____ / No_____ (used for appointment reminders; NOT used for marketing purposes or sold to 3rd parties).

PREFERRED OFFICE: ☐ Creve Coeur ☐ Lake St. Louis ☐ Glen Carbon

PHARMACY: _____ Location _____ Phone: _____

HOW DID YOU HEAR ABOUT OUR PRACTICE: _____

SPOUSE INFORMATION: Name: _____ Date of Birth: _____

Social Security Number: _____ Employer: _____

IN CASE OF EMERGENCY NOTIFY: _____ Daytime Phone: (____)_____

WHO IS YOUR PRIMARY CARE PHYSICIAN: _____

GUARANTOR INFORMATION (Person responsible for account):

Name: (Last) _____ (First) _____ Birth Date: _____

Address: (Street)_____ (City) _____ (State) _____ (Zip Code) _____

Phone: (____) _____ Employer_____ SSN No. _____

MEDICAL INSURANCE INFORMATION:

Primary Insurance Co. _____ Secondary Insurance Co. _____

Do you have a vision plan? Name of plan: _____ Name of policy holder: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION: I hereby authorize release of information necessary to file a claim with Medicare and/or my insurance company and assign benefits otherwise payable to me to the doctor or group indicated on the claims. In addition to foregoing, I authorize the release of my medical information by or between any of my treating physicians and the Centers of Medicare & Medicaid Services (if applicable), my insurer and/or any other entity involved in the administration of my health benefits. I understand I am financially responsible for payment of this account regardless of insurance or other third-party involvement. If the account is sent to an attorney or collection agency, I will be responsible for any collection fees and/or court costs. A copy of this signature is as valid as the original.

Signature_____ Date_____

Hill Vision Services – NEW PATIENT Medical History

Patient Name: _____ Date: _____

Ocular History – Please circle all that apply (Circle which eye, if known)

- ☐ Allergies/Allergic Conjunctivitis
- ☐ Blepharitis
- ☐ Cataract (R / L / Both)
- ☐ Corneal Dystrophy
- ☐ Crossed Eye/Lazy Eye (R / L / Both)
- ☐ Diabetic Retinopathy (R / L / Both)
- ☐ Dry Eye
- ☐ Eye Injury (R / L / Both)
- ☐ Epiretinal Membrane/Macular Pucker (R / L / Both)
- ☐ Floaters (R / L / Both)
- ☐ Glaucoma (R / L /Both)
- ☐ Macular Degeneration (R / L /Both)
- ☐ Retinal Detachment (R / L / Both)
- ☐ Red Eyes (R / L / Both)
- ☐ Other: _____

Ocular Surgeries – Please circle all that apply

- ☐ Cataract Surgery Right Eye ~ Left Eye
- ☐ Yag Capsulotomy Right Eye ~ Left Eye
- ☐ Corneal Transplant Right Eye ~ Left Eye
- ☐ Glaucoma Surgery Right Eye ~ Left Eye
- ☐ Eyelid Surgery – Right Eye ~ Left Eye
- ☐ Retinal Detachment Repair - Right Eye ~ Left Eye
- ☐ Lasik
- ☐ Other **Eye** Surgeries: _____

_____

EYE DROPS (INCLUDING ARTIFICIAL TEARS)

_____ _____ _____

_____ _____ _____

Medical History / Review of Systems

Please circle all that apply

- ☐ Anxiety/Depression
- ☐ Asthma
- ☐ Atrial Fibrillation/ Arrhythmia
- ☐ BPH
- ☐ Cancer (list type_____ _____
- ☐ Coronary Artery Disease
- ☐ COPD
- ☐ Diabetes Type I/Type II
- ☐ Dialysis/Kidney Disease
- ☐ Gerd
- ☐ Heart Attack
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia/Lymphoma
- ☐ Lupus
- ☐ Migraine/Headache
- ☐ Radiation Treatment
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Sjogrens Syndrome
- ☐ Stroke
- ☐ Other_____

Past Surgeries – Please circle all that apply

- ☐ Heart Surgery
- ☐ Organ Transplantation
- ☐ Hip Replacement
- ☐ Skin Cancer Removal
- ☐ Brain Surgery / Neurosurgery
- ☐ Hysterectomy
- ☐ Knee Replacement
- ☐ Other major surgeries: _____

Medications (**Names ONLY – dosage and frequency NOT NEEDED** -including over-the-counter and supplements – **OR** – provide list)

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Medication Allergies: No _____ Yes (Please list): _____

Social History

Tobacco use: **By selection an option below, I am acknowledging that HVS recommends non-smoking or discontinuation of smoking to prevent macular degeneration, cataracts, dry eye, and other eye diseases.**

Tobacco Use: ____ Never Smoker ~ _____Former Smoker (Date quit:_____) ~ _____Current Smoker (_____pack(s) per day)

Alcohol Use: _____Never drink ~ _____ Occasional drink ~ _____1 drink per day ~ _____3 or more drinks per day

Recreational Drug Use: _____No ~ Yes (If yes, please specify) _____

Family History – Please circle all that apply, if known

Glaucoma: (Father/Mother/Siblings/Children)
Retina Detachment: (Father/Mother/Siblings/Children)
Corneal Dystrophy: (Father/Mother/Siblings/Children)
Crossed Eye/Lazy Eye: (Father/Mother/Siblings/Children)
Macular Degeneration: (Father/Mother/Siblings/Children)
High Blood Pressure: (Father/Mother/Siblings/Children)
Diabetes: (Father/Mother/Siblings/Children)

Physician Signature: _____ Date : _____

Hill Vision Services, LLC

Patient Financial Policy

Thank you for choosing our practice. We are committed to the success of your medical care. Please understand that payment of your bill is part of this care. To help avoid misunderstandings, we ask our patients to read and acknowledge the following financial policy.

All payment is expected at the time of service.

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable co-insurance and co-payments for participating insurance companies. Hill Vision Services, LLC accepts cash, personal checks (in-state and Illinois only), VISA, MasterCard and Discover.

Patients with an outstanding balance of 60 days overdue must make arrangements for payment prior to scheduling appointments.

INSURANCE/SERVICES: We bill participating insurance companies as a courtesy to you. You are expected to pay your co-payment at the time of service. If we have not received payment from your insurance company within 45 days of the date of service, you will be expected to pay the balance in full. For worker's compensation, if your visit is deemed not work related, your medical insurance will be billed (or self pay if you have no insurance).

INSURANCE/OPTICAL MATERIALS: We participate with VSP, VBA, Eyemed, Davis, and Spectera vision plans and we will bill these insurance companies as a courtesy to you. You are responsible for your co-payment at the time of purchase. You are responsible for knowing your optical benefits. If you have vision benefits with a different vision carrier other than VSP, VBA, Eyemed, Davis, or Spectera but still choose to purchase your eyewear from Hill Optical, we assume that you are waiving your right to use your other vision benefits. Payment is expected at the time orders are placed. You are responsible for all charges.

REFUNDS: Overpayments will be refunded upon written request to the responsible party within 30 days.

MANAGED CARE: If you are enrolled in a managed care insurance plan that requires an **insurance referral** to see our doctors, you must bring the **referral** with you or make arrangements to have it sent to our office prior to your appointment. **NO RETROACTIVE REFFERALS ARE ALLOWED.**

MISSED APPOINTMENTS/LATE CANCELLATIONS: Broken appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. Cancellations are requested 48 hours (two business days) prior to the appointment. There may be a $50.00 charge for canceled or missed appointments not canceled 48 hours (two business days) prior to the scheduled appointment time. Excessive abuse of scheduled appointments may result in discharge from the practice.

ACKNOWLEDGMENT

I have read, understand and agree to the above Financial Policy. I understand that charges not covered by my insurance, as well as applicable co-pays and deductibles, are my responsibility. I authorize insurance benefits be paid directly to Hill Vision Services, LLC, and I authorize them to release any pertinent medical information to facilitate payment of a claim. I have been offered a copy of this policy.

_____	_____	_____
Date	**Signature of Responsible Party**	**Printed Name**

HILL VISION SERVICES, LLC
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 CAREFULLY

USES AND DISCLOSURES:

TREATMENT: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

PAYMENT: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided and the medical condition being treated.

HEALTH CARE OPERATIONS: Your health information may be used when necessary to support day-to-day activities and management of Hill Vision Services, LLC. For example, information on the services you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality.

LAW ENFORCEMENT: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations and to comply with government mandated reporting.

PUBLIC HEALTH REPORTING: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

OTHER USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us or your decision to revoke your authorization.

ADDITIONAL USES OF INFORMATION: Your health information will be used by our staff to call or send you appointment reminders.

No mobile information will be shared with 3rd parties/affiliates for marketing/promotional purposes. All other categories exclude text messaging originator opt-in data and consent this information will not be shared with any 3rd parties.

HILL VISION SERVICES, LLC
NOTICE OF PRIVACY PRACTICES

INDIVIDUAL RIGHTS: You have certain rights under the federal privacy standards.
These include:

- The right to request restrictions in the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive and accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

HILL VISION SERVICES, LLC DUTIES: We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

RIGHT TO REVISE PRIVACY PRACTICES: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in your policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

REQUEST TO INSPECT PROTECTED HEALTH INFORMATION: You may general inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the receptionist(s) or the Privacy Official. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

COMPLAINTS: If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Attn: Privacy Official
Hill Vision Services, LLC
12601 Olive Blvd
Creve Coeur, MO 63141

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Effective Date: This notice is effective on or after July 4, 2007.

Hill Vision Services, LLC

Acknowledgment of Receipt of Notice of Privacy Practices & Authorization to Release Information to Specified Family Members and Close Friends

PATIENT NAME: _____ D.O.B.: _____

ACKNOWLEDGMENT OF RECEIPT

Hill Vision Services, LLC reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the Notice of Privacy Practices for Hill Vision Services, LLC.

_____ _____

Signature of patient/parent/guardian *Date*

_____

Relationship of Patient Representative to Patient

INABILITY TO OBTAIN ACKNOWLEDGMENT OF RECEIPT

An attempt was made to obtain an acknowledgment of receipt of the Notice of Privacy Practices on ____/____/____. The acknowledgment was not obtained because:

____ The patient/parent/guardian declined to sign the acknowledgment

____Other:_____

_____ _____

Signature/printed name of staff member *Date*

AUTHORIZATION TO RELEASE HEALTH INFORMATION TO FAMILY MEMBERS & CLOSE FRIENDS

I authorize Hill Vision Services, LLC to disclose health information to the following family members and/or close friends to the extent necessary to help with your healthcare.

NAME	D.O.B. OR SSN	NAME	D.O.B. OR SSN

_____ _____

Signature of patient/parent/guardian *Date*

_____

Relationship of Patient Representative to Patient

Reviewed (by patient): _____	**Date: _____**	**Reviewed (by patient): _____**	**Date: _____**
Reviewed (by patient): _____	**Date: _____**	**Reviewed (by patient): _____**	**Date: _____**