Huffman and Huffman –Eye Care Center, LLC

2580 Bypass Rd, Winchester, KY 40391

PHONE: 859-745-3060 FAX: 859-745-0885

Eye Physicians and Surgeons * Consultative Ophthalmology * Optometry

Dr. James G. Huffman, M.D., Mark D. Huffman, M.D., James M. Huffman, M.D., Justin West, M.D., Rebekah Huffman, D.O., Adrienne Millett, M.D., Lauren Lodholz, O.D, and Emily Workman, O.D.

PATIENT INFORMATION:

Last Name: _____ First: _____ MI: _____

DOB: _____ Social Security #: _____ Sex: M_____ F _____

Mailing Address: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Alternative Phone: _____

Emergency Contact: _____ Phone: _____

Email Address_____

REFERRAL INFORMATION:

Primary Care Provider (Family Doctor): _____ Phone: _____

Pharmacy: _____ City: _____ State: _____

Referring physician/optometrist: _____ City: _____

**** Our practice is not in network with any vision policies. Your visit will be billed under your medical insurance. In the event that your insurance does not cover the visit, you will be held responsible for payment in full for all services rendered.**

_____ Date: _____

Signature of patient

INSURANCE AUTHORIZATION AND PAYMENT POLICY:

All the professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. The patient is responsible for all fees, regardless of insurance coverage. If your insurance does not pay after 90 days, we will bill the patient for the remaining balance.

_____ Date: _____

Signature of patient

MEDICAL AUTHORIZATION INFORMATION:

So that we may submit an insurance claim for services covered under your policy, we must have your authorization to release medical information to your carrier. I hereby authorize release of any and all information necessary to file a claim with my insurance company and assign benefits otherwise payable to me, to the doctor indicated on the claim. I understand that I am financially responsible for the payment of any amount not covered by the insurance carrier. A copy of this signature is valid as the original.

_____ Date: _____

Signature of patient

MEDICARE AUTHORIZATION:

I request that payment of authorized Medicare benefits be made on my behalf to the doctor indicated on the claim for any services furnished by the physician. I authorize any holder of my medical information to release to the Health Care Financing Administration and its agent, including supplemental insurance agents, any information needed to determine these benefits payable to the related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 form is completed, my signature authorizes release of 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, co-insurance, and any non-covered service. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier. I hereby authorize that all physicians at HH-ECC, LLC (dba CKEA) are committed to safeguarding patient privacy and that a full disclosure of their privacy practices is available to me. I hereby authorize Medicare to furnish the above-named doctors with any information regarding my Medicare claims under Title XVII of the Social Security Act.

_____ Date: _____

Signature of patient

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION:

Due to HIPAA, we are not allowed to release any medical and billing information to anyone without the patient's written consent. If for any reason you would like to release your information, you will need to list the names of the people allowed to have access to your medical records and billing information. For instance, if your spouse, child, sibling, grandparent, significant other or power of attorney request your information, WE CANNOT GIVE OUT YOUR RECORDS, PRESCRIPTIONS, APPOINTMENT DATES OR ANY OTHER INFORMATION UNLESS THEY ARE LISTED BELOW. By signing this authorization, you are giving us permission to release your medical and billing information to the following individuals:

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

** You can revoke or change this authorization at any time.

_____ Date: _____

Signature of patient

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you may get access to this information. **Please read it carefully.** Dr. James G. Huffman, Dr. Mark Huffman, Dr. James M. Huffman, Dr. Rebekah Huffman, Dr. Justin West, Dr. Lauren Lodholz, and Dr. Adrienne Millett and all staff are dedicated to protecting your medical information. We are required by law to maintain the privacy of protected health information and to provide you with this notice of our legal duties and privacy practices, with respect to protected health information.

How your medical information will be used and disclosed:

We will use your medical information as a part of rendering patient care. For example, your medical information may be used by the doctor treating you, by the business office to process your payment for services rendered, by our collection agent and by administrative personnel reviewing the quality of care you receive. We may also use and/or disclose your information in accordance with federal and state laws for the following purposes:

- Disclosure of Department of Health and Human Services
- Law enforcement
- Coroners, medical examiners, and funeral directors
- Public Safety
- Business Associates
- School for confirming child was present for an appointment.
- Interpreters
- Persons involved in your care.
- Notifications to a family member or person of your choice
- Appointment reminder calls and letters.
- Any other way required by federal and state laws.

Your rights as a patient:

- Access to your medical records. You are entitled to one (1) free complete copy.
- Restrictions about use and disclosures
- Right to receive an account of disclosures made after 4/14/03
- Request a copy of this notice
- Right to complain to us and/or Department of Health and Human Services

** A more detailed description of your privacy practices is available upon request. If you would like further information regarding your rights, you may contact Cynthia Lewis at 859-623-2020 ext. 207.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I acknowledge that I have received a copy of the Notice of Privacy Practices for this office

_____ Date: _____

Signature of patient

REFRACTION WAIVER

A refraction is the test which we perform to a prescription for glasses. This test is considered a vision service; therefore, **medical insurance will not cover this service.** The out-of-pocket cost for this service is **$25 each time you receive the test** and cannot be billed. You are entitled to opt out of this service if you choose to do so. **This office does not file claims on vision coverage. We only file claims on medical coverage.**

_____ YES, I elect to receive this service and receive a new glasses prescription today. I understand the above statement. I also understand that the charge of $25 is to be paid at the time the service is rendered.

_____ NO, I defer this service and understand I will not be able to receive a glasses prescription today.

DISCALIMER: If you are requesting a new contact lens prescription today, you will be charged a contact lens fitting fee of $60. This charge is separate from the refraction fee. If you choose to receive a glasses and contact lens prescription, you will be responsible for both the $25 refraction fee and the $60 contact lens fitting fee on top of any co-pays or other fees.

I acknowledge that I have read and understand the refraction waiver for this office.

_____ Date: _____

Signature of patient

Patient Name: _____DOB: _____Pharmacy: _____

PATIENT MEDICAL HISTORY

Height: _____ Weight: _____

Do you use Tobacco or tobacco products? Yes _____ No_____

If Diabetic: LFBS (Last fasting blood sugar) & Date: _____ Last A1C & Date: _____

Do you have any food/drug allergies? Yes _____ No _____ If answering yes, explain:

_____

List all major surgeries and/or injuries (if list available please turn in at check in). _____

_____

_____

List any eye conditions/diseases you have previously had (ex. Lazy eye, drooping eyelids, glaucoma, cataracts, retinal disease, eye infections, injuries to the eye). _____

_____

Do you wear glasses or contacts? Yes _____ No_____

If you wear contact, what type are they? Rigid _____ Soft _____ Extended Wear _____

- Are they comfortable? Yes ____ No_____
- How old are they? _____

Do you drive? Yes _____ No_____

PATIENT FAMILY MEDICAL HISTORY

Please check any family history of the following diseases and conditions. This includes parents, grandparents, uncles, and aunts that are living or deceased. If adopted, write N/A.

Blindness: Yes _____ No _____ Relation to you: _____

Cataracts: Yes _____ No _____ Relation to you: _____

Crossed Eyes: Yes _____ No _____ Relation to you: _____

Glaucoma: Yes _____ No _____ Relation to you: _____

Retina/Macula: Yes _____ No _____ Relation to you: _____

Cancer: Yes _____ No _____ Relation to you: _____

Diabetes: Yes _____ No _____ Relation to you: _____

Heart Disease: Yes _____ No _____ Relation to you: _____

Kidney Disease: Yes _____ No _____ Relation to you: _____

Lupus: Yes _____ No _____ Relation to you: _____

Thyroid Disease: Yes _____ No _____ Relation to you: _____

High Blood Pressure: Yes _____ No _____ Relation to you: _____