Your Vision is Our Focus

New Patient Paperwork

Dear Patient,

Please fill out all of the following pages, and bring them with you to your scheduled appointment time. If you have questions regarding your appointment please call 888-626-2020.

We look forward to sharing in your care!

Our Mission: Preserving the Gift of Sight and Improving Lives ~ One Patient at a Time.

PATIENT:_____ **CHART #:** _____

PATIENT PRIVACY CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- Graystone Eye has a Notice of Privacy Practices and the patient has the opportunity to review this policy.
- Graystone Eye reserves the right to change the notice of Privacy Policies.
- The patient has the right to restrict the uses of their information by Graystone Eye does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- Graystone Eye may refuse treatment without the execution of this Consent.

Signature: _____

Relationship to Patient (if other than patient): _____

Witness Signature:_____ Date: _____
(Practice Representative)

PATIENT:_____ **CHART #:**_____

CONSENT TO RELEASE PROTECTED HEALTH INFORMATION

Due to HIPAA regulations, we no longer are allowed to release any medical information regarding your medical condition, diagnosis, treatment, or prognosis to any person without your consent.

You may designate a person or persons who are allowed to obtain this information, in your absence, by phone or in person.

If you have a Legal Guardian or Power of Attorney, we require that a copy of the legal document by on file with your records at Graystone Eye.

It is important for our office to have on record your designated person/persons to whom we can release medical information. Please list below the appointed person/persons that you will allow to obtain this information.

You may release the following information:

☐ Medical ☐ Financial ☐ Do not release to anyone other than me

Release to:

Name:_____

Relationship to patient: _____

Name:_____

Relationship to patient: _____

Name:_____

Relationship to patient: _____

Patient Signature:_____ Date: _____

Witness Signature:_____ Date: _____
(Practice Representative)

This document will remain effective indefinitely unless otherwise rescinded by written noted.

PATIENT:_____ **CHART #:** _____

MINOR CONSENT FORM

If patient is a minor, please complete the following consent form and provide parent or guardian information.

I / We_____, being the parent(s)/guardian(s) of_____, do hereby request and authorize the physicians of Graystone Eye or person designated by them to perform necessary services for my child. This is including but not limited to dilation of pupils, whether or not I am present at the actual appointment when the treatment is rendered. It is understood that this consent will be effective for one year from the date of the most recent dated signature, as indicated below.

_____ _____
Signature of Parent or Guardian Date

_____ _____
Signature of Parent or Guardian Date

_____ _____
Signature of Parent or Guardian Date

If parent is not available for signature, verbal authorization may be obtained by phone. The following information must be obtained from the parent/guardian giving permission for treatment.

Patient Full Name:_____ Date of Birth: _____

Parent/Guardian:_____ Date: _____

Witness:_____ Date: _____

Witness:_____ Date: _____

Patient Full Name:_____ Date of Birth: _____

Parent/Guardian:_____ Date: _____

Witness:_____ Date: _____

Witness:_____ Date: _____

Patient Questionnaire

updated 2/1/2017

Name: _____ **Date of Birth:** _____

Family Physician: _____ **Referred by:** _____

Email Address: _____

Reason for your visit today_____

Are you experiencing?	Yes	No
Blurred distance vision		
Trouble seeing to drive		
Blurred Near Vision		
Double Vision		
Headaches		
Eye Pain		
Red Eyes		
Floaters		
Dry Eyes		
Flashes		
Tearing		
Itching		

Any other problems_____

3. Current Eye medications:

_____

_____

_____

4. Current Medications (list over the counter and prescriptions)

_____

_____

_____

_____

_____

5. Do you or have you had any of the following disorders?

	Yes	No	**Date/ Type/ Treatment**
Thyroid Disease			
Arthritis			
Diabetes			
Asthma			
Stroke			
Heart Disease			
Cancer			
Trauma			
Previous Surgery			

Eye Conditions:

Cataract			

Glaucoma	_____	_____	_____
Macular Degeneration	_____	_____	_____
Crossed Eyes	_____	_____	_____

6. Have you experienced any of the following in the 5-7 days?

	Yes	No		Yes	No
Fever	_____	_____	Painful Urination	_____	_____
Chest Pain	_____	_____	Insomnia	_____	_____
Excessive Thirst	_____	_____	Bruising	_____	_____
Skin Rash	_____	_____	Environmental Allergies	_____	_____
Sore Throat	_____	_____	Joint Pain	_____	_____
Difficulty Swallowing	_____	_____	Dizziness	_____	_____

7. Do any of your blood relatives have? **If so, who in the family?**

	Yes	No	
Glaucoma	_____	_____	_____
Crossed or Lazy eye	_____	_____	_____
Macular Degeneration	_____	_____	_____
Diabetes	_____	_____	_____

8. Do you use:	Yes	No	How much/how long?
Tobacco products	_____	_____	_____
Alcohol Products	_____	_____	_____

9. List any medical allergies and type of reaction to each: _____

_____

10. Occupation: _____

Have you ever been seen by a Graystone physician in any of our locations? Yes_ _____No_____

If yes, approximately how long ago? _____

Patient Financial Policy

Thank you for choosing Graystone Eye for your eye care needs. Below is our financial policy, which we ask that you read and sign prior to receiving services.

PATIENT CO-PAY IS DUE AT THE TIME OF SERVICE.

Patient Responsibility

As a patient of Graystone Eye, you are financially responsible for any services not covered by your health insurance (which includes co-pays, co-insurance, deductibles). These amounts will be collected the day of your appointment. We accept Cash, Check, Visa, Mastercard, Discover, American Express, Care Credit and all Health Savings Account debit cards.

- *Some insurance plans, including Medicare, do not cover eye refractions (measurement taken to determine the need for glasses or change in prescription).*
- *If you currently wear or wish to start wearing contacts, there is a separate charge for the contact lens fitting fee which must be paid at time of service.*

In order to bill your insurance company, we must have your current insurance card and billing information. We will verify this information at each visit.

If you have a scheduled appointment and have an outstanding balance, you will be expected to pay your balance or establish payment arrangements with our billing department **before** being seen. Non-payment of outstanding balances could result in being discharged from our practice.

Many insurance plans require a referral/authorization for services provided. You will need to obtain this referral/authorization prior to being seen in our office.

Minor Patients

For all services provided to minor patients, the guarantor of the patient is responsible for payment.

I certify that the information given by me in applying for payment under my insurance contract is correct. I authorize insurance benefits to be made on my behalf to Graystone Eye for any services provided. I authorize any holder of medical information about me to be released to my insurance carrier and it's agents to determine benefits payable for related services.

I also authorize Graystone Eye to access my medication history.

Patient Signature Date