HOLLY SPRINGS
EYECARE, PLLC

Eric Randle, O.D.
Hunter Edwards, O.D.
Steve Edwards, O.D.

Patient Registration

Please Circle: Male Female / Single Married Widowed / Mr. Mrs. Ms. Miss Dr.

Patient Name: _____
First **MI** **Last**

Nickname: _____Race/Ethnic Group: _____ DOB: _____/_____/_____ Age: _____

Home Address: _____
Street Number/Name / Apt # **City** **State** **Zip**

Home Phone: _____ Cell Phone: (_____)_____

Employer: _____ Work Phone: (_____)_____Ext_____

Social Security #:_____-_____-_____Email Address: _____

Name and phone number of nearest relative(s) and/or friend to contact in case of an emergency:

Name_____ Relation_____ Phone: (____)_____

Is there anyone you would like to add to have access to your information? (Someone we can speak to about your appointments, follow up visits or release your prescriptions to) if so please add them here:

Name_____Relation_____Phone: (_____)_____

Do we have your consent to send texts, emails, leave a voicemail or mail postcards regarding your appointment with us? Please circle: YES / NO

Responsible Party Information (Subscriber of Insurance/person in charge of payment)

Name_____
First MI Last

Home Address: _____

Social Security #:_____-_____-_____ Date of Birth: _____/_____/_____

Employer: _____ Work Phone:(_____)_____

Insurance Information: (Please provide us with information on all medical/vision insurance coverages that you have. We also need a copy of your cards.

Insurance Company Name: _____

Member ID or Policy Number: _____ Group#_____

Phone: (_____)_____ **Do you have vision insurance?** YES / NO

Vision insurance company Name:_____

Vision insurance Member ID: _____

Primary Insured Information (If other than self)

Member Legal Name: _____DOB:____/_____/____
First MI Last

Physical Address: _____

Social Security #: _____Relation: _____

Home Phone: _____ Cell/Alt Phone: (_____)_____

Employer: _____ Work Phone: (_____)_____Ext_____

Signature on File Authorization

Please understand if you do not sign, we are unable able to file your insurance and you will be responsible for your total bill.

I request that payment of authorized insurance payment be made to the Doctor on my behalf for any services provided to me by my physician. I authorize any holder of medical information about me to be released to determine the benefits payable for related services.

Signature of Patient or Responsible Party: _____ Date: _____

I Further understand that I am responsible for the entire bill if declined/or referred to me by my insurance. Insurance is filed as a courtesy to our patients. Balances are due within 30 days of filing date. Insurance co-pays are due at time services are rendered (we are considered specialist, so it will be whatever your specialist co-payment is). Insurances with unmet deductibles must be paid in full at time of service. Payment for non-covered services by private insurance is also due once services are rendered. Any private insurance that is unknown or out of network by our clinic must be paid in full at time of service, once/if we receive payment after filing, we will reimburse according to your insurance payment.

Signature of Patient or Responsible Party: _____ Date: _____

Financial Policy Regarding Vision VS Medical Insurance

It is Important that you be aware of your insurance benefits and how they apply to your visit, so you will know how billing will be handled. Ultimately, it is your responsibility to know what your own insurance plan covers.

If you intend to use your vision insurance benefits for your exam today, please be aware that vision insurance (VSP, Davis, Eyemed, Alwayscare) only cover an exam that is **ROUTINE**. A "routine eye exam" takes place when you come for an eye examination without any medical eye problem. The doctor screens the eyes for disease and will check your vision. If you have a medical condition that drives the exam, the exam **HAS TO BE** billed to your medical insurance and you will be subject to copays and deductibles according to your plan. This includes if your blurred vision is caused by cataracts, complaints related to dry eye, floaters or allergies, or if you need a diabetic exam or follow up for glaucoma or macular degeneration. Even if your exam is medical, we can often still use your vision insurance to help cover the cost of your glasses or contact lenses.

Refraction Fee

You, the patient, are responsible for services not covered by your insurance plan. For example, refraction for glasses is a non-covered service with medical insurance. This is a part of the eye exam in which your prescription is checked. It is considered a routine service. If you do not have vision insurance, you will be expected to pay for the refraction on the day of service, which is $40.00

Your signature below indicates that you understand the differences between routine and medical eye examinations and the potential implications of the differences on the type of exam that gets billed and the potential for fees that may include co-pays, deductibles, and/or co-insurance. You understand that you are responsible for any of these fees as determined by your insurance carrier. If you have any questions, please feel free to ask a member of our staff.

Patient's Name: _____ Date: _____

Patient/Authorized Signature: _____

THIS PAGE FOR CONTACT LENS PATIENTS ONLY

Patient Acknowledgement of Contact Lens Policy

Contact lens patients require monitoring and testing that is beyond what is done for a standard eye exam. This may include:

-Examination of the cornea to ensure health and look for complications from contact lens wear
-Assessment of the contact lens on the eye for appropriate fit
-Contact lens refraction to ensure correct power
-Contact lens trial period
-Follow up appointments to address any issues/answer questions/verify prescriptions

There is an additional $65 fee for this service that is not included in the fee for a standard eye exam. If this fee is not covered by your insurance, payment will be due at the time of service. No trials will be ordered or contact lens prescription released until the contact lens fee has been paid in full. Note that color contact lenses require a specific fit. It is your responsibility to inform the doctor prior to beginning your fit if you are interested.

Often the doctor will recommend a follow up visit to make sure that your contacts fit well and the prescription is correct. Any follow up visits and trial lenses are included with this fee within 90 days. If you wait and return after the 90 day period, another fee will be charged.

Please inform our staff if you are unable to pay this fitting fee today, and we will be happy to reschedule your fit.

The CDC recommends the following for contact lens wearers:

-Schedule a visit with your eye doctor at least once a year
-Take out contacts and call your doctor if you have any eye pain, discomfort, redness or blurry vision
-Understand that eye infections that go untreated can lead to eye damage or even blindness
Symptoms of eye infections include:

- Irritated, red eyes
- Light sensitivity
- Worsening pain in or around the eyes-even after contact lens removal
- Sudden blurry vision
- Unusually watery eyes or discharge

By signing below, you acknowledge that you have read and understand the contact lens fitting policy and a copy of your finalized prescription has been provided to you.

Patient's Name: _____ **Date:** _____

Patient /Guardian Signature: _____

THIS IS YOUR COPY- PLEASE DETACH AND KEEP FOR YOUR RECORDS

Holly Springs Eye Care 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 it carefully.

Here at Holly Springs Eye Care, we are committed to your personal well-being. Protecting the privacy and security of the information you share with us is included in that commitment. While we do not sell, fundraise or trade any information to third parties, we do share information with entities such as your insurance company and quality review organizations as part of our routine and necessary business operations. We do this with the utmost care and sensibility.

This notice is being provided to explain how your personal healthcare information is used, and your rights to review, amend and/or request limitations on the disclosure of this information.

Definitions:
A. Disclosure means the release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.
B. Healthcare means care or service related to the health of an individual. Healthcare includes, but is not limited to, diagnostic, therapeutic, rehabilitative care and the sale or dispensing of a drug, equipment, or other item in accordance with a prescription.
C. Protected Health Information means any individually identifiable health information, whether oral, electronic, or recorded in any form, that is created and relates to the past, present, or future physical or mental health, condition or care of an individual.

Your Rights to Privacy and Disclosure

You have the right to request restriction of uses and disclosures of your Protected Health Information as outlined below. However, there are some instances where Tri Lake Eye Clinic is not required to agree to a requested restriction.

A. At the time you initially receive service at Holly Springs Eye Care; you may request that we restrict the use or disclosure of your Protected Health Information to carry out treatment, payment, or healthcare operations. To request a restriction of your information, Please inform our staff.
B. You can request to receive confidential communications concerning your health information. To receive your information confidentially, contact our Billing Department and direct them to how and where you wish to receive your information.
C. You can inspect and obtain a copy of your protected health information/medical record, unless otherwise protected by law. Contact our Billing Department to make a request.
D. You can obtain a copy of this notice at any time. You will receive one at the time of service if requested.
E. You can amend your protected health information by contacting our Billing Department. We cannot destroy or otherwise remove the original information, but you may add/amend information in your record according to our policy.
F. You can request an accounting of our disclosures of your protected health information, unless protected by law, by contacting our Billing Department.

G. You have the right as the individual to be notified following a breach of unsecured Protected Health Information.
H. You have the right to restrict certain disclosures of Protected Health Information to a health plan where the individual pays out of pocket in full for the health care item or service.
I. Other uses and disclosures not otherwise described in the Notice of Privacy Practices will be made only with authorization from the individual.

Permitted Disclosures:

Holly Springs Eye Care may not use or disclose protected health information, except as permitted or required by law. The following are permitted uses and disclosure under current laws. We can release information to the following unless otherwise restricted by law:
A. To the patient and/or the personal representative of the patient to whom the information pertains
B. To Dr. Edwards', Dr. Randle and staff or other healthcare providers, to carry out treatment, payment, or healthcare operations purposes.
C. To anyone in compliance with an authorization completed by the patient or patient's representative, such as that from a healthcare provider.
D. To others as permitted by and in compliance with some other law or regulation such as those that require us to make certain reports to health oversight agencies.
Individually identifiable health information is frequently shared with the following types of entities for purposes related to the function and operation of a healthcare facility or physician practice:

* Consulting physicians * Health insurance companies
* Managed care organizations * Home Health Care
* Health benefit managers * State/Federal agencies
* Clinical laboratories * Contracted Business Associates

This information is released for the purposes of ensuring continuity of care, billing, to conduct quality assessment and improvement activities, and reviewing the competence or qualifications of healthcare professionals.

We may also use information to contact you and provide appointment reminders and information about treatment alternatives or other health related benefits and services.

The Federal Health Insurance Portability and Accountability Act (HIPAA) established federal guidelines that require Holly Springs Eye Care to maintain the privacy of your protected health information. It also requires Holly Springs Eye Care to provide you with this Notice of our legal duties and privacy practices with respect to your health information. Further, Holly Springs Eye Care is required to abide by the terms of this Notice and to make the new provisions effective for all protected health information that we maintain. In the event we make changes to this Notice, we will make the changes apparent in the new document, post the changes in a prominent place within our facility. We will not individually notify every past patient, but will attempt to abide by the requirements of the Notice in effect at the time of your healthcare.

Should you have any questions about this Notice, please ask our staff.

You may lodge a complaint/grievance relevant to any portion of the Notice provisions. It will be reviewed under the terms and parameters of our grievance process. At no time will you be subject to retaliation for filing a complaint.

This Notice is provided to you on behalf of Holly Springs Eye Care.

PRIVACY PRACTICES ACKNOWLEDGEMENT

HOLLY SPRINGS EYE CARE
640 JM Ash Drive
Holly Springs, MS 38636
(662) 252-3323

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name_____ DOB_____

Signature_____

Date_____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___ Individual refused to sign

___ Communication barriers prohibited obtaining the acknowledgement

___ An Emergency situation prevented us from obtaining the acknowledgement

___ Other (Please Specify

_____
_____
_____