Section 1: Patient Registration Form

Today's Date: ________________

Patient Name: ____________________________________ Title: Mr. Mrs. Miss Sex: Male Female

Birth Date:____________________________ Social Security Number:________________________________

Home Phone:_______________________________ Cell Phone:____________________________________

Address:_______________________________________City:_______________________________________

State:_______________ Zip:____________________ Email:______________________________________

Preferred Communication Preference: Text Telephone

What encouraged you to come see us today? T.V. Radio Magazine Internet/Website Social Media

FB/Twitter Friend/Family Doctor /Ophthalmologist/Optometrist Referring Dr: ______________________

Primary Care Physician: _________________________________ PCP Phone: __________________________

Pharmacy Name: _________________________City: ________________________Phone: ______________

Employer: ____________________________________ Employer Phone: ____________________________

Address: _____________________________City: ______________________State: ____Zip: ______________

Emergency Contact: _____________________________________ Phone: ___________________________

Reason for Visit: ____

If you are interested in more information about any of the following, please check X box below:

Cosmetic Procedures (Botox, Fillers, Kybella) Ocular Allergy Testing Latisse Dry Eye Treatments Lasik

Section 2: Financially Responsible Person (If under 18 years of age)

Name:_____________________________ Birth Date: _______________ SS#:__________________________

Address: _______________________________ City: _________________________ State: _____ Zip: _______

Phone: _____________________________ Cell: ____________________ Relationship to Patient: __________

Section 3: Insurance Information-Please Provide all Insurance (Health and Vision) Card(s)

Insurance Carrier: _______________________________ Member ID: _____________________________

Subscriber Name: _______________________________ Date of Birth: ___________________________

SECTION 4: PATIENT PRIVACY AND PAYMENT AGREEMENT

1. **MEDICARE and Other INSURANCE:** I request that payment of authorized Medicare/Insurance benefits be made on my behalf to Amedco Kentucky, PLLC dba AbellEyes, for services furnished to me by AbellEyes. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) or other Insurance and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim(s). My signature authorizes releasing the information to the insurer or agency shown. I understand that I am responsible for deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare or Insurance Carrier.
2. **RELEASE OF INFORMATION:** I authorize AbellEyes to disclose all or any part of my medical record and/or financial record for treatment, to receive payment, or for general healthcare operations as covered by HIPAA. This may include information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV. AbellEyes may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. I authorize and request the disclosure of all protected health information for the purpose of review, evaluation and treatment from any/ all other medical facilities or providers to assist Abell Eyes with the continuation of my treatment. This may include records from any other medical provider. A copy of this authorization may be used in place of the original.
3. **OTHER INSURANCE:** I understand that AbellEyes maintains a list of health care service plans with which it contracts. A list of such plans is available should I request it. AbellEyes has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by AbellEyes if I belong to a plan that does not appear on the above mentioned list. **I understand it is my responsibility to verify my insurance coverage and to notify AbellEyes if any services require precertification.** If precertification is required and not obtained prior to a service being rendered, I understand I will be responsible for the bill in full.
4. **NON-COVERED SERVICES:** I understand that AbellEyes contracts with health care service plans (i.e., HMOs, PPOs) related only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered or not medically necessary. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patent and treatment or test not authorized by the health care service plan. The undersigned agrees to cooperate with AbellEyes to obtain necessary health care service plan authorizations.
5. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by AbellEyes, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to AbellEyes for payment within 30 days of receipt of a statement of amounts due by me. **I understand if I do not make payment during this time I could be referred for outside collections through a billing service or collection agency. If my account is transferred to either for failure to pay, I understand that I will be responsible for all collection fees associated with collecting my bill in full and interest at a rate no great than 18% APR. If my account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees in addition to the collection fees and interest.** I understand and agree that if my account is delinquent, I may be charged interest up to 18% APR. Any benefit of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to AbellEyes. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to AbellEyes. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my Bill.
6. **No Show (Less than 24-hour notice): I understand if I fail to cancel/reschedule my appointment 24 hours in advance the following fees will be charged to my account. Office Visits: $10.00 All Surgical/Laser Procedures: $50**
7. **CONSENT TO WIRELESS TELEPHONE CALLS:** If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify AbellEyes to the contrary in writing. In this section, calls and text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by other any form of electronic communication from AbellEyes, affiliates, contractors, servicers, clinical providers, attorneys or its agents including collection agencies.
8. **CONSENT TO EMAIL USAGE:** If at any time I provide my email address at which I may be contacted, unless I notify AbellEyes to the contrary in writing, I consent to receiving communications regarding billing and payment for items and services at that email address from AbellEyes affiliates, contractors, servicers, clinical providers, attorneys or its agents including collection agencies.

Patient/Parent/Guardian Signature: ______________________________ Date: ______________

Medical History Questionnaire

Name: ______________________ D.O.B.: __________ Date: __________

Reason for Today's Visit: ______________________

Approximate Date of Last Eye Exam: ______________________

List all Medications you are currently taking: ______________________

____

List all Major Illnesses or Injuries: ______________________

____

List of all Surgeries you have had: ______________________

____

List of all allergies and reactions: ______________________

____

Do you have any problems in the following areas? If YES, please provide additional information below.	NO	YES
Allergic/ Immunological-sneezing, swelling, redness, itching, hives, etc.		
Blood/ Lymph- bleeding, anemia, etc.		
Cardiovascular-high blood pressure, racing pulse, etc.		
Collagen Vascular-lupus, RA, etc.		
Ears/ Nose/ Throat- hard of hearing, stuffy nose, ear ache, cough, etc.		
Endocrine-diabetes, hypothyroid, etc.		
Eyes- poor vision, eye pain, redness, tearing, etc.		
Females- pregnant, nursing, etc.		
Gastrointestinal- Upset stomach, diarrhea, constipation, ulcer, etc.		
General/ constitutional- fever, tired, weight loss/ gain, etc.		
Genital/ Kidney/ Bladder-impotence, frequent/ painful urination, etc.		
Muscles/ Bones/ Joints-joint pain, stiffness, swelling, cramps, etc.		
Neurological- numbness, headaches, seizures, paralysis, etc.		
Respiratory- congestion, wheezing, short of breath, etc.		
Psychiatric- anxiety, depression, insomnia, etc.		
Skin- pimples, rash, warts, growths, etc.		

Details for any YES answer(s) above: ______________________

____

Family History

Has any members of your family (parent, grandparents, sibling) had any of the following? :

Blindness No Yes Diabetes No Yes Hypertension No Yes

Cancer No Yes Glaucoma No Yes Stroke No Yes

Cataract No Yes Heart Disease No Yes Other No Yes __________

Social History

Have you had a blood transfusion? No Yes

Does your vision limit any of your daily activities? (Driving, Hobbies, Reading, Sports, Work)? No Yes

Do you smoke? No Yes If YES, how much? __________

Do you drink? No Yes If YES, how much? __________

Occupation and Job Duties: ______________________

____

Physician Signature: ______________________ Date: __________

A. **Notifier:**
B. **Patient Name:** **C. Medical Record Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Insurance/Medicare doesn't pay for D. Refraction below, you may have to pay. Insurance/Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect insurance/Medicare may not pay for the D. Refraction below.

D.	E. Reason Insurance/Medicare May Not Pay:	F. Estimated Cost
Refraction	Non-covered Service	$60

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** Refraction listed above.
  Note: If you chose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. Options: Check only one box. We cannot choose a box for you.

OPTION 1. I want the **D.** ~~Refraction~~ listed above. You may ask to be paid now, but I also want Insurance/Medicare billed for an official decision on payment, which is sent to me on an EOB/Medicare Summary Notice (MSN). I understand that if Insurance/Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Insurance/Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

OPTION 2. I want the **D.** ~~Refraction~~ **listed** above, but do not bill Insurance/Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Insurance/Medicare is not billed**.

OPTION 3. I don't want the **D.** ~~Refraction~~ listed above. I understand with this choice I am **not responsible** for payment, and **I cannot appeal to see if Insurance/Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Insurance/Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048) or the phone number listed on your insurance card.

Signing below means that you have received and understand this notice. You may request a copy.

I. Signature:	J. Date:

According to the paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays valid OMB control number. The valid OM control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

HIPAA

Acknowledgment of receiving a copy of the notice of privacy practices

I hereby acknowledge the recipient of Privacy Practices from Amedco Kentucky, PLLC dba AbellEyes on

Date:

____

Signature of the Patient, Guardian or Legal Representative

____

(Printed Name of Patient)

The individual or the individual's legal representative did not provide a written acknowledgment of recipient of the Notice of Privacy Practices. The following explains the good faith efforts to obtain the written acknowledgment and the reasons why the acknowledgment was not obtained:

____

____

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Copies of the HIPAA privacy statement are located at the front desk

ABELLEYES
Refractive Solutions

Patient Name: ____ Account Number:____________________

I ____________________________________ understand that the "Free Evaluation" is to determine if I am a candidate for LASIK, KAMRA, or a Refractive procedure that would not be covered by my insurance.

Should I want glasses, contacts, or are diagnosed with cataracts this exam will be billed to my health or vision insurance and/or I will be responsible for payment. **If insurance is billed I understand I will be responsible for all copays, deductibles or non-covered services.**

*****The Doctor will notify you if a cataract is found and you can choose to stop the evaluation at this point at no charge, or you can choose to continue as a Medical Evaluation which will be billed to your medical insurance or you understand you will be SELF PAY.*****

Signature: ____ Date: __________________________

Witness: ____ Date: __________________________

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. This privacy notice is provided by Abell Eyes Refractive Solutions.

The Health Insurance Portability and Accountability Act (HIPAA) is federal law. We are required by HIPAA to provide you with this notice. This notice describes our privacy practices, legal duties, and your rights concerning your protected information. This notice will remain in effect unless and until we publish and post a new notice.

1. **Our commitment to your privacy:**

As a health care provider, we collect certain information from you. We are committed to protecting the confidential nature of your medical information to the fullest extent of the law. In addition to various laws governing your privacy, we have our own privacy policies and procedures in place. These are designed to protect your information.

2. **Our legal duties:**

We are required by applicable federal and state laws to keep certain information about you private. We treat your medical and demographic information that we collect as part of providing your overage, as "Protected Information". It is our policy to maintain the privacy of protected information in accordance with HIPAA, except to the extent that applicable state law provides greater privacy protections. This Notice of Privacy Practices was drafted to be consistent with the HIPAA privacy regulation. The HIPAA Privacy Regulations generally do not take precedence over state privacy or other applicable laws that that provide individuals greater privacy protections. We reserve the right to change the terms of this notice. Anyone may request a copy of our notice at any time. For more information, please contact our privacy officer.

3. **Our primary uses and disclosure of your protected information:**

We may use and disclose your protected information without your specific authorization for the purposes of treatment, payment and health care operations. When using and disclosing your protected information in our billing and collection and operation activities, we may only request, use, and disclose the minimum amount necessary to complete the activity. We may contract business associated (third parties) to assist us with this process and we will require those parties to agree in writing to our policy.

- Treatment Activities. Activities performed by a health care provider related to the provision, coordination, treatment, or management.
- Payment Activities. These include activities such as determining eligibility or coverage, utilization review, billing, claims, scheduling and collection activities. We may also disclose protected information to health care providers or health plans for their payment or to coordinate benefits.
- Operations Activities. We may use or disclose your protected privacy information to contact/remind you of an appointment. We will also have you sin-in by name and call you by name from the waiting area when you present for an appointment/activity.

4. **Other uses and disclosures of your protected information:**

We must disclose your protected information to you. A written notice is required. You may also give us authorization to use your protected information to anyone. If you give us authorization, you may revoke it at any time. A written revocation is

required. Without your written authorization, we may not use or disclose your protected information for any reason except as described in this notice. The following is a description of other possible ways we may and are permitted by law to use and/or disclose your protected information without our specific authorization. This is not an exhaustive list:

- Family and Friends. If you are unavailable to agree, we may disclose your protected information to a family member/friend/other person when the situation indicates that disclosure would be in your best interest. This includes a medical emergency or disaster relief. If you are available and agree, we may disclose your protected information to the extent necessary to help with your health care or with payment for your health care.
- Public Health and Safety. As permitted by state law and to the extent necessary we may disclose information to avert a serious and imminent threat to your health or safety of others. We may disclose your protected information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or other crimes.
- Legal Process/Proceedings/Law Enforcement/Military/National Security/State or Federal Agencies/Workers Comp. We may use or disclose your information as requires by law. We may disclose your information in response to court order, subpoena, or other lawful process in accord with HIPAA administrative requirements. We may disclose your information as specified by the HIPAA privacy regulation to federal or state agencies to report adverse events, defects et al. or to comply with oversight requests/audits/inspections.

5. **Individual rights:**
    - Access. You have the right to inspect and obtain copies of your protected information or as long as your information is maintained in our record set. You right of access to protected information does not extend to certain information. This includes psychotherapy notes or information compiled unreasonable anticipation of, or for use I a civil, criminal or administrative proceeding. We reserve the right to charge a reasonable fee for copies of protected information that we provide. Any request to access tour protected information must be in writing. You may obtain a form from the front desk or contact the privacy officer. We will respond within 60days of receiving your request. If all or any part of the request is denied, you will receive a detailed response and any appeal rights that you may have.
    - Amendment. You have the right to request that we amend your protected information that we keep in our record set if you believe it is inaccurate. A request for amendment must be submitted in writing will be acknowledged in accord with the same policy as outlined above in the ACCESS section.
    - Disclosure Accounting. You have the right to request and receive disclosures of your protected information. We are not required under the HIPAA privacy regulation to provide you with an accounting of certain types of disclosures: Any prior to April 14, 2003, or disclosures for treatment, payment or operations activities, disclosures to you or related to your authorization, to persons involved in your care, for disaster relief, national security, or intelligence, or ones that are noted as incidental to permitted use/disclosure. To request a copy of disclosure accounting, you must submit a written request and we will respond within 60 days. A reasonable charge will be assessed for this request. Restriction Request- You have the right to request that we restrict use or disclosure of your Protected information. We are not required to agree to such request for a restriction. A written request must be submitted.
6. **Contacting us or the Department of Health and Human Services:**

You may submit a written request or complaint to our privacy officer or you notify the Department of Health and Human Services if you believe your privacy rights have been violated.

Amedco Kentucky, PLLC dba Abell Eyes
Corporate Office
2720 Old Rosebud Road, Suite 110
Lexington, KY 40509