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 ***Do you have a living will?** [] Yes [] No

What encouraged you to come see us today? [] T.V. [] Radio [] Magazine/Newspaper [] Internet/Website

[] Social Media FB/Twitter []Friend/Family [] Dr. /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 the 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: ______________________________

Patient Name:_______________________________________ DOB:______________________

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 patient 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 up to 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. **The Bad Check NSF Fee is $100.**
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-$150***
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: ______________

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 healthcare 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	$35

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 copays 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 a 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

Patient Name:____ DOB:__________________________

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

____ **Date:** ______________________

Signature of the Patient, Guardian or Legal Representative

The individual or the individual's legal representative did not provide a written acknowledgment of the 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:

____

____

____

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

MEDICAL HISTORY QUESTIONNAIRE

Name: ____ **Date of Birth:** ____/____/______

Referring Doctor:________________________________ **Primary Care Physician:**______________________________

Pharmacy Name and Location (street, city):____

Race: □ American Indian or Alaska Native □ Asian □ Black or African American
□ Native Hawaiian or Other Pacific Islander □ White

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino

Preferred Language: □ English □ French □ Spanish □ Russian □ Italian □ Other____________________

Allergies:	**Reaction**	**Severity**
___________________________	________________________________	mild / moderate / severe
___________________________	________________________________	mild / moderate / severe
___________________________	________________________________	mild / moderate / severe

Past Ocular History: (Please mark all that apply) □ No history of eye problems

□ Amblyopia (Lazy Eye)
□ Astigmatism
□ Cataracts
□ Corneal Disorder
□ Diabetic Retinopathy
□ Dry Eye Syndrome
□ Glaucoma
□ Hyperopia (Farsighted)
□ Iritis/Uveitis
□ Macular Degeneration
□ Myopia (Nearsighted)
□ Retinal Detachment

Other____

Ocular Surgeries: (Please mark all that apply) □ No prior ocular surgery

R - L	**R - L**	**R - L**
□ □ Blepharoplasty (Lid Surgery)	□ □ Glaucoma Surgery	□ □ Strabismus (eye muscle surgery)
□ □ Cataract Surgery	□ □ Laser Retinal Surgery	□ □ Vitrectomy
□ □ Corneal Transplant	□ □ LASIK	□ □ YAG Laser Capsulotomy

Other____

Current Eye Medications: (Please list)

_______________________________ _______________________________ _______________________________
_______________________________ _______________________________ _______________________________

Other Medical History: □ No history of illnesses

□ Anemia
□ Arthritis
□ Arrhythmia
□ Asthma
□ Cancer
□ Congestive Heart Failure
□ COPD
□ Diabetes (circle: Type 1 or Type 2)
□ Fibromyalgia
□ Headache
□ Hearing Loss
□ Heart Attack
□ Hepatitis
□ Herpes
□ High Blood Pressure
□ High Cholesterol
□ HIV/AIDS
□ Kidney Disease
□ Liver Disease
□ Lupus
□ Migraine
□ Multiple Sclerosis
□ Polymyalgia Rheumatica
□ Psychiatric Disorder
□ Rheumatoid Arthritis
□ Stroke
□ Thyroid Disease

Other____

General Surgeries/Procedures: (Please list)

_______________________________ _______________________________ _______________________________
_______________________________ _______________________________ _______________________________

All Other Medications: (Please list)

_______________________________ _______________________________ _______________________________
_______________________________ _______________________________ _______________________________

Please continue on the back side of this page →

Family History: (Please indicate relationship) □ No history of illnesses □ History unknown

□ Blindness
□ Cancer
□ Cataracts
□ Diabetes
□ Glaucoma
□ Heart Disease
□ High Blood Pressure
□ Lazy Eye
□ Macular Degeneration
□ Retinal Disease
□ Stroke
□ Other___________________________

Social History: (Please mark all that apply)

Smoking: □ current every day smoker □ current some day smoker □ former smoker □ never smoked

Alcohol Use: □ No □ Yes If yes, how much and how often?____

Drug Use: □ No □ Yes If yes, which and how long?____

Review of Systems: (Please mark all that apply)

Eyes
- □ Previous Surgery
- □ Contact Lens
- □ Pain
- □ Double Vision
- □ Glaucoma
- □ Cataracts
- □ Macular Degeneration
- □ Dry Eyes
- □ Flashes
- □ Floaters

Ear, Nose, and Throat
- □ Hard of Hearing
- □ Ringing in Ears
- □ Vertigo

Cardiovascular
- □ Chest Pain
- □ Dizziness
- □ Fainting Spells
- □ Shortness of Breath
- □ Irregular Heart Beat
- □ Difficulty Lying Flat

Constitutional
- □ Fatigue / Weakness
- □ Fever
- □ Weight Gain / Loss

Respiratory
- □ Cough
- □ Congestion
- □ Wheezing
- □ Asthma

Gastrointestinal
- □ Heartburn
- □ Nausea / Vomiting
- □ Jaundice / Hepatitus

Genitourinary
- □ Pain / Difficulty
- □ Blood in Urine
- □ History of Kidney Stones
- □ History of STD's

Psychiatric
- □ Anxiety / Depression
- □ Mood Swings
- □ Difficulty Sleeping

Endocrine
- □ Increased Thirst
- □ Increased Hunger
- □ Increased Urination
- □ Increased Sweating
- □ Fingernail Changes

Blood/Lymph Nodes
- □ Easy Bruising
- □ Gums Bleed Easy
- □ Prolonged Bleeding
- □ Heavy Aspirin Use

Musculoskeletal
- □ Stiffness
- □ Arthritis
- □ Joint Pain / Swelling

Skin
- □ Rash / Sores
- □ Lesions
- □ Hives / Eczema

Neurological
- □ Seizures
- □ Weakness / Paralysis
- □ Numbness
- □ Tremors

Immunologic
- □ Hives
- □ Itching
- □ Runny Nose
- □ Sinus Pressure

Patient Signature: ____ Date:______________________________

Amedco Kentucky, PLLC dba Abell Eyes Refractive Solutions

CONSENT TO PARTICIPATE IN TELEMEDICINE CONSULTATION DURING COVID-19

(Please note there may be longer than normal wait time during your visit.)

Name: ____ Chart Number:______________________

DOB______________________ Date:________________________

1. PURPOSE. The purpose of this form is to obtain your consent for a telemedicine consultation with a physician (MD or OD). The purpose of this consultation is to assist in the consultation, diagnosis, treatment or annual exam for Ophthalmology, and Optometry. **This consent is valid for 1 calendar year**.
2. NATURE OF TELEMEDICINE CONSULTATION. Telemedicine involves the use of audio, video, text or other electronic communications to interact with you, consult with your healthcare provider and/or review your medical information for the purpose of diagnosis, therapy, follow-up and/or education. During your telemedicine consultation, details of your medical history and personal health information may be discussed with other health professionals through the use of interactive video, audio, text and telecommunications technology. Additionally, a physical examination of you and diagnostic testing will take place in either our Lexington or Campbellsville location and be performed by a graduate of medical school in Optometry under the supervision of Thomas G. Abell, M.D. or a technician.
3. RISKS, BENEFITS AND ALTERNATIVES. The benefits of telemedicine include having access to medical specialists and additional medical information and education without having to travel outside of your local health care community. A potential risk of telemedicine is that because of your specific medical condition, or due to technical problems, a face-to-face consultation still may be necessary after the telemedicine appointment. Additionally, in rare circumstances, security protocols could fail causing a breach of patient privacy. The alternative to telemedicine consultation is a face-to-face visit with a physician.
4. MEDICAL INFORMATION AND RECORDS. All laws federal and state concerning patient access to medical records and copies of medical records apply to telemedicine. Dissemination of any patient identifiable images or information from the telemedicine consultation to researchers or other entities shall not occur without your consent.
5. CONFIDENTIALITY. All existing confidentiality protections under federal and Kentucky law apply to information used or disclosed during your telemedicine consultation.
6. RIGHTS. You may withhold or withdraw your consent to a telemedicine consultation at any time by notifying us in writing with your signature without affecting your right to future care or treatment.

My health care provider has discussed with me the information provided above. I have had an opportunity to ask questions about this information and all of my questions have been answered. I have read and agree to telemedicine visits and/or consultation.

Signature of Patient or Patient's Representative______________________________________Date:________

Relationship of Representative to Patient____

Signature of Witness (required if patient unable to sign) ____

2720 Old Rosebud Road •Suite 110 • Lexington, Kentucky 40509

1800 Old Lebanon Road Campbellsville, KY 42718