FAMILY EYECARE CENTER
Drs. Holland and Baker
629 Broad St. P. O. Box 188
Elizabethton, TN 37643
423-543-7376
familyeyecare1@embarqmail.com

Welcome To Our Office!

Enclosed is a packet of new patient papers to fill out and bring with you on the day of your appointment. Having this information filled out in advance will decrease the amount of time that you may have spend in our office. You will also need to bring any insurance cards (both medical and vision) so that we may file your claim.

Any co-payments or co-insurance will be expected on the day services are provided, unless other arrangements have been made in advance. We currently accept cash, check or credit card.

Please bring a list of any and all medications and/or eye drops that you may be using, including over the counter or non-prescription medications and eye drops. Many of these can affect your eyes and visual system, and we need this information in order to better determine your prescription and over-all health of your eyes.

If you have any type of glasses, including half-eyes or readers, please bring them with you, even if they are old, broken, or you are not currently wearing them. This way we can determine how much or how fast your eyes may be changing.

If you wear contact lenses, please have them on when you come in for your appointment, unless there is an obvious problem such as discomfort, an eye infection, or a lost or damaged lens. We will be able to better evaluate how your present lenses are fitting in order to determine what changes, if any, need to be made.

We look forward to *"seeing"* you!

John F. Holland, O.D. **Ashley C. Baker, O.D.**

Welcome To Our Office

FAMILY EYECARE CENTER

Dr. John F. Holland
Dr. Ashley C. Baker
629 Broad Street
Elizabethton, TN 37643
423-543-7376
www.drshollandandbaker.com

NAME ______________________________ _______ ______________________________________ DATE________________________
First MI Last

STREET ADDRESS ____ HOME PHONE ____________________________

MAILING ADDRESS ____ WORK PHONE ___________________________

CITY, STATE, ZIP____CELL PHONE ___________________________

BIRTHDATE ______________________ AGE ____________ SEX: [ ] MALE [ ] FEMALE E-MAIL __________________________________

OCCUPATION _______________________________________ EMPLOYER ____

SOC. SEC. # ___________________________________ PARENTS / SPOUSE ____

SPOUSE'S EMPLOYER ____SPOUSE'S SOC. SEC # ____________________________

EMERGENCY CONTACT (OTHER THAN HOME NUMBER)____ PHONE __________________

IS THIS EXAMINATION FOR?

_____ GLASSES _____ MEDICAL EYE PROBLEM _____ OTHER
_____ CONTACT LENSES _____ LASER VISION CORRECTION

HAVE YOU EVER WORN GLASSES? YES _____ NO _____ DO YOU WEAR THEM NOW? YES _____ NO _____

HAVE YOU EVER WORN CONTACT LENSES? YES _____ NO _____ DO YOU WEAR THEM NOW? YES _____ NO _____
WOULD YOU BE INTERESTED IN TINTED CONTACT LENSES? YES _____ NO _____

DO YOU HAVE A PAIR OF SUNGLASSES IN YOUR CURRENT PRESCRIPTION? YES _____ NO _____
ARE THEY POLARIZED OR HAVE UV (ULTRAVIOLET) PROTECTION? YES _____ NO _____ NOT SURE _____

IF YOU CURRENTLY WEAR EYEGLASSES, ARE THERE CERTAIN TIMES WHEN YOU WOULD RATHER NOT?
(FOR EXAMPLE - SPORTS, BUSINESS PRESENTATIONS, SOCIAL OCCASIONS, ETC.) YES _____ NO _____

IF YOU CURRENTLY WEAR CONTACT LENSES, DO YOUR BACK-UP EYEGLASSES HAVE YOUR CURRENT
PRESCRIPTION? YES _____ NO _____ NOT SURE _____

WOULD YOU LIKE INFORMATION ON LASER VISION CORRECTION AND REFRACTIVE EYE SURGERY? YES _____ NO _____

WOULD YOU LIKE INFORMATION ON CONTACT LENSES? YES _____ NO _____

WHEN WAS YOUR LAST EYE EXAM? ___________________________________

WHO MAY WE THANK FOR REFERRING YOU? ____

PERSON RESPONSIBLE FOR PAYMENT (GUARANTOR)____ GUARANTOR'S D.O.B.______________

HOME PHONE ____________________ WORK PHONE ____________________ CELL PHONE ____________________ SS # __________________

RELATIONSHIP TO PATIENT_________________________________EMPLOYER ____

ADDRESS (IF DIFFERENT FROM PATIENTS) ____

PLEASE INDICATE METHOD OF PAYMENT:

_____ CASH / CHECK _____ VISION CARE INSURANCE _____ OTHER
_____ CREDIT CARD _____ MAJOR MEDICAL INSURANCE
_____ MEDICARE _____ TENN CARE

PAYMENT IN FULL IS DUE AT THE TIME SERVICES ARE RENDERED

MEDICAL HISTORY

OCULAR HISTORY: DO YOU HAVE NOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING EYE CONDITIONS?

yes	no		yes	no	
[ ]	[ ]	EYE DISEASE	[ ]	[ ]	CATARACTS
[ ]	[ ]	EYE INJURY	[ ]	[ ]	GLAUCOMA
[ ]	[ ]	EYE OPERATION	[ ]	[ ]	RETINAL DISEASE, TEARS OR DETACHMENTS
[ ]	[ ]	BLINDNESS	[ ]	[ ]	MACULAR DEGENERATION
[ ]	[ ]	DRY EYES	[ ]	[ ]	FREQUENT EYE INFECTIONS
[ ]	[ ]	CROSSED EYES	[ ]	[ ]	TEARING OR DISCHARGE
[ ]	[ ]	LAZY EYE / AMBLYOPIA	[ ]	[ ]	SENSITIVITY TO EYE MEDICATIONS
[ ]	[ ]	FLASHES / FLOATERS	[ ]	[ ]	OTHER

REVIEW OF SYSTEMS: DO YOU HAVE NOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS?

yes	no		yes	no	
[ ]	[ ]	SKIN PROBLEMS	[ ]	[ ]	STOMACH / INTESTINAL PROBLEMS
[ ]	[ ]	HEADACHES	[ ]	[ ]	ARTHRITIS
[ ]	[ ]	SEIZURES	[ ]	[ ]	ANEMIA
[ ]	[ ]	ALLERGIES	[ ]	[ ]	BLOOD DISORDERS
[ ]	[ ]	SINUS	[ ]	[ ]	ENDOCRINE (THYROID OR OTHER GLANDS)
[ ]	[ ]	ASTHMA / BRONCHITIS	[ ]	[ ]	NEUROLOGICAL PROBLEMS
[ ]	[ ]	EMPHYSEMA / COPD	[ ]	[ ]	PSYCHOLOGICAL PROBLEMS
[ ]	[ ]	HIGH BLOOD PRESSURE	[ ]	[ ]	CANCER – WHAT TYPE? ______________________
[ ]	[ ]	HEART DISEASE	[ ]	[ ]	MAJOR OPERATIONS OR SURGERIES
[ ]	[ ]	DIABETES	[ ]	[ ]	OTHER
[ ]	[ ]	KIDNEY DISEASE			

PLEASE LIST ANY MEDICATIONS OR TREATMENTS OF ANY KIND THAT YOU ARE CURRENTLY TAKING:

PLEASE LIST ANY KNOWN ALLERGIES OR SENSITIVITIES TO ANY MEDICATIONS:

IS THERE ANY FAMILY HISTORY OF THE FOLLOWING?

yes	no		yes	no	
[ ]	[ ]	BLINDNESS	[ ]	[ ]	CROSSED EYES
[ ]	[ ]	CATARACTS	[ ]	[ ]	LAZY EYE / AMBLYOPIA
[ ]	[ ]	GLAUCOMA	[ ]	[ ]	HIGH BLOOD PRESSURE
[ ]	[ ]	MACULAR DEGENERATION	[ ]	[ ]	DIABETES
[ ]	[ ]	RETINAL DISEASE	[ ]	[ ]	OTHER

SOCIAL HISTORY (*This information is kept strictly confidential*):

DO YOU HAVE ANY VISUAL DIFFICULTY WHEN DRIVING? [ ] YES [ ] NO IF YES, PLEASE DESCRIBE:

DO YOU SMOKE OR USE TOBACCO PRODUCTS? [ ] YES [ ] NO DO YOU DRINK ALCOHOL? [ ] YES [ ] NO

DO YOU USE ANY KIND OF ILLEGAL DRUGS? [ ] YES [ ] NO

HAVE YOU EVER BEEN EXPOSED TO OR INFECTED WITH ANY SEXUALLY TRANSMITTED DISEASE? [ ] YES [ ] NO

HAVE YOU EVER BEEN EXPOSED TO OR INFECTED WITH HIV / AIDS? [ ] YES [ ] NO

ACKNOWLEDGEMENT OF PRIVACY POLICY AND CONSENT TO TREATMENT

Patient: ____________________________________

In keeping with our commitment to insure your privacy, and in accordance with *HIPAA Regulations*, our office has established a *Privacy Policy* and guidelines for *Privacy Practices*. Please read the following and acknowledge your acceptance. If you have any questions or need further information, please let myself or the office staff know and we will be happy to explain anything you don't understand. We will be glad to provide you with a copy of our ***PRIVACY POLICY AND PRACTICES*** upon request.

1. I consent to treatment for myself and/or on behalf of the patient mentioned above, and give permission for *Family EyeCare Center* – Drs. Holland and Baker and/or associate(s) to examine, diagnose and initiate treatment as deemed appropriate.

2. I authorize *Family EyeCare Center* - Drs. Holland and Baker and/or associate(s) to explain my treatment and care to other family members, friends or caregivers on my behalf who are helping me with my health care.

3. I authorize *Family EyeCare Center* - Drs. Holland and Baker and/or associate(s) to send medical or other information to other health care providers regarding treatment of my health condition and to also request records from any prior providers. (Includes office notes, test results, and medical reports).

4. I authorize the release of any medical or other information necessary for payment purposes or to process insurance claims (government and/or commercial) to the insurance carrier I am participating with. I also request payment of benefits to the party who accepts assignment. I understand I will be financially responsible for non-covered services and charges.

5. I authorize the release of any health information needed in order to carry out any health care operations, such as administrative and managerial functions, that we have to do in order to run our office.

6. I authorize *Family EyeCare Center* - Drs. Holland and Baker and/or associate(s) and/or any staff members to contact me regarding appointments and/or tests. If I am unavailable, messages may be left on my answering machine or with other family members. Appointment cards and/or information concerning treatment alternatives and/or any other health related information may be sent to my mailing address.

I have read, understand, and accept the above. I authorize the disclosure of my health information for treatment, payment, and health care operations. I acknowledge that I have been offered or provided a copy of *Family EyeCare's* ***"Notice of Privacy Practices."*** I understand that this is an on-going agreement and will remain in effect until revoked by me in writing.

Signed: ____ **Date** ________________

IF PATIENT IS A MINOR OR HAS NEED OF A GUARDIAN:

I attest that I am the Parent, Legal Guardian, Care Taker or other Personal Representative of the above patient and have the authority to authorize care and treatment for said patient. I also have the authority to make any necessary financial arrangements for said patient.

Parent/Guardian/Representative (please print) ____

Signed: ____ **Date** ________________

INSURANCE ASSIGNMENT AND RELEASE

MEDICARE

I request payment of authorized Medicare benefits be made either to me or on my behalf to *Family EyeCare Center* - Drs. Holland and Baker and/or associate(s) for any covered services furnished to me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

I understand Medicare will not cover any services determined as routine or screening. I understand I will be financially responsible for these charges. These services include refraction, routine eye exams, glasses and contact lenses (with the exception of after cataract surgery or for aphakic patients), non-medically necessary tints, coatings, other additional patient options for glasses, contact lens cleaners and solutions. Other non-covered services by the Medicare program include low vision exams and low vision aids.

MEDIGAP OR OTHER INSURANCE BENEFITS

I request that payment of authorized Medigap or other insurance benefits be made either to me or on my behalf to *Family EyeCare Center* - Drs. Holland and Baker and/or associates(s) for any services furnished to me. I authorize any holder of medical information about me to release to

____

Name of Medigap or Other Insurer

any information needed to determine these benefits of the benefits payable for related services.

These assignments will remain in effect until revoked by me in writing. A photocopy of these assignments are to be considered as valid as the original.

Signed: ____ **Date:** ______________

(Patient or Guarantor)

FINANCIAL POLICY AND INSURANCE

I hereby authorize payment directly to *Family EyeCare Center* – Drs. Holland and Baker and/or associate(s) for all insurance benefits for any services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance company. I authorize *Family EyeCare Center* – Drs. Holland and Baker and/or associate(s) to release any information required to secure payment of benefits. I authorize the use of this signature on all insurance claims submitted.

All co-pays and deductibles are due at the time of service. Please be aware that your insurance carrier may not consider some of the services provided reasonable and necessary. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary fees.

In the event that this or any claim is not paid in full by my insurance, I agree to pay in full the entire balance for any and all services rendered. We reserve the right to charge interest in the amount of 18% as provided by state law and/or a monthly re-billing charge of $5.00 minimum. I also understand and agree that if I fail to pay my balance in full, my account will be turned over to a collection agency. If this action becomes necessary, I will be obligated to pay all costs of collection, including collection agency fees, court costs, and attorney's fees in addition to the balance owed on my account.

Signed: ____ **Date**: ____________________

(Patient or Guarantor)

Thank You For Allowing Us To Provide Your Vision And Eye Care!

EARLY DETECTION OF GLAUCOMA

GDx VCC NERVE FIBER ANALYSIS SCREENING

We are excited to announce that we have incorporated into our practice the **GDx VCC** Nerve Fiber Analyzer, a highly sophisticated, computerized instrument that provides **early detection of glaucoma**.

Glaucoma is a leading cause of legal blindness and is the single most common cause of irreversible blindness among African Americans in the United States. An estimated 120,000 Americans are legally blind due to glaucoma. At least 2 to 3 million people in the U.S. have glaucoma, although **estimates indicate about half are not aware of it**. Another 5 to 10 million people have elevated intraocular pressure (IOP), a risk factor for developing glaucoma.

Left untreated, glaucoma can lead to blindness. Because it often has no symptoms and causes no pain, many people are unaware that they have the disease until they experience loss of vision. Dr. Holland and Dr. Baker feel it is vital to screen for this disease as part of a quality eye health exam.

The GDx VCC Screening Exam:

The GDx VCC, when used as part of a comprehensive eye examination, detects glaucoma up to six years earlier than any other available technology by evaluating the actual site where the damage occurs.

The exam takes about two minutes, is non-contact, requires no pupil dilation, and causes no discomfort. In just a few minutes, we can learn more about the health of your eyes!

We strongly recommend that all of our patients receive the GDx VCC screening exam. It is especially important if any one of the following apply:

1) Have Glaucoma
2) Have a family history of Glaucoma
3) Have Diabetes
4) A strong eyeglasses prescription
5) Over age 40
6) African American or Latino ancestry
7) High intraocular pressure (IOP)

This state of the art procedure just takes a few minutes of your time. The additional charge is only $20.00.

Please check the appropriate line below and sign at the bottom.

__________ I **DO** want the GDx VCC nerve fiber screening exam.
__________ I **DO NOT** want the GDx VCC nerve fiber screening exam.

Patient's Signature: ______________________________________ Date: __________________

Please Note: While this test is **"optional"** for some patients as it represents preventive health care, for others, the GDx VCC is **"required"** because of certain eye conditions that may be present or need to be "ruled out." In this latter case, you may be able to submit your bill for the exam to your major medical insurance company for reimbursement.