Vision Care Optometry of Hanford

Tracey H. Nguyen O.D.

Jeffrey W. White O.D.

Patient Information

Date: _____ SSN#: _____ Birth date: _____

Name: _____ Sex: Male☐ Female☐ Other_____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____E-mail: _____

Preferred Language: _____

Employer/School: _____ Phone: _____

Business Address: _____Occupation: _____

Emergency Contact: _____ Phone: _____

Payment Information

Adult Responsible for account: Name_____

Social Security#: _____ Birth date: _____ Relationship: _____

Address: _____

Phone: _____ E-mail: _____

Vision Insurance: **Primary**

Insured Name: _____

Birth date: _____ Relationship: _____

SSN#:_____ INS Name: _____

Employer Name: _____

Secondary

Insured Name: _____

Birth date: _____ Relationship: _____

SSN#:_____ INS Name: _____

Employer Name: _____

Medical Insurance **Primary**

Insured Name: _____

Birth date: _____ Relationship: _____

SSN#:_____ INS Name: _____

Employer Name: _____

Secondary

Insured Name: _____

Birth date: _____ Relationship: _____

SSN#:_____ INS Name: _____

Employer Name: _____

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Ocular Health

Date of Last Vision Exam: _____ Name of Previous Dr: _____

Eye Disease History: ☐ No ☐ Yes, Please explain: _____

_____

Eye Injury History: ☐ No ☐ Yes, Please explain: _____

_____

Family Eye Disease History ☐ No ☐ Yes, Please explain: _____

_____

Allergies: ☐ None ☐ Yes, Please explain: _____

Do you currently wear glasses: ☐ No ☐ Yes, if so how old is your current pair _____

Are they for: ☐ Reading ☐ Distance ☐ Both

Do you currently wear contacts: ☐ No ☐ Yes, if so how old is your current pair _____

What is the brand of contacts you are currently wearing? _____

Please check all that apply:

Hypertension:	☐ Self	☐ Family Member	Relation to patient_____
High Blood Pressure:	☐ Self	☐ Family Member	Relation to patient_____
Diabetes:	☐ Self	☐ Family Member	Relation to patient_____
High Cholesterol:	☐ Self	☐ Family Member	Relation to patient_____
Glaucoma:	☐ Self	☐ Family Member	Relation to patient_____
Cancer:	☐ Self	☐ Family Member	Relation to patient_____
Thyroid:	☐ Self	☐ Family Member	Relation to patient_____
Asthma:	☐ Self	☐ Family Member	Relation to patient_____
Other:	☐ Self	☐ Family Member	Relation to patient_____

Primary Care

Physician Name: _____

City & State_____ Phone#: _____

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FINANCIAL POLICY

If your health care expenses are in part paid for by an insurance company, this office requires that you pay any **deductibles** or **co-payments** at the time services are rendered. We will bill your insurance plan for the portion of the fees that are covered by your insurance. However, if we are not contracted or a participating provider with your insurance, our policy dictates that payment it to be made in **full** at the time services are rendered. Dr. Nguyen and Dr. White are participating provider's with Medicare and various other insurance plans. Our patient care coordinators will be happy to discuss those plans with you.

A copy of your insurance care is required at the time of your first appointment and anytime your insurance changes for any reason. This information will be kept in your medical file. Our office will bill your insurance plan directly as a service to you, but not in substitute of your primary responsibility for payment. Any fee's which are not paid by your insurance, are the **patient's responsibility.** You will receive a statement when there is a balance due. All patient balances are expected to be paid within thirty (30) days of services. A $2.50 statement fee will be added to all statements not paid within thirty (30) days in addition to 1.5% service charge per month. There will be a $30.00 service charge for all returned checks, and any broken or cancelled appointments the day of.

Out office requires half (50%) deposit to order glasses or contacts. Upon receipt of your deposit your order will be processed. At anytime the patient decides to cancel the order once it's at the lab, the patient will be responsible for the lab cost. There will be a $20 charge for refractions that are not covered by your insurance.

Please remember that medical services are rendered to each patient at the requests of the patient; therefore, each patient is responsible to us for payment. Request for alternative methods of payment will be reviewed on an individual basis. In an effort to insure that our patients receive the necessary care they need, every financial option will be considered prior to services being rendered to them.

Should you have any questions or concerns about your insurance or your account, please call our office (559) 584-1630. We will be happy to help you in any way.

I have read the above policy and agree to comply with its provisions. I understand that if I am covered by an insurance plan, your office will bill them directly as a convince to me, but that I will remain personally responsible for all charges for services rendered until they are paid in full.

Patient Name: _____

Patient Signature: _____ Date:__/__/__

Effective 10/13/2017

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____