HARMAN
EYE CENTER

Patient Registration

Please review, make necessary changes and supply any missing information.

Patient Name		**Salutation**	Mr. Mrs. Miss Ms.
Date of Birth			
Sex		**SS #**	
Address			
City, State		**Zip code**	

Patient Communication					
Pref. Contact Method			Cell Home Work Email Text US Mail		
Home Phone #		**Work Phone #**		**Extension**	
Cell Phone #		**Email**			

Information			
Marital Status		**Primary Care Provider**	
Occupation		**Employer**	

Account Responsible						
Responsible		**Date of Birth**				
Relationship		**SS #**				
Address						
Home Phone #		**Work Phone #**		**Extension**		
Email						

Primary Insurance			
Carrier Name		**Group Name**	
ID #		**Group #**	
Address			
Phone			
Insured		**Date of Birth**	

Secondary Insurance			
Carrier Name		**Group Name**	
ID #		**Group #**	
Address			
Phone			
Insured		**Date of Birth**	

Emergency Contact					
First		**Middle**		**Last**	
Relationship		**Home#**		**Cell#**	
Work#					

Release Of Medical Information - Status		
Name	**Relationship**	**Release Status**

I authorize and request examination by the physicians and staff of Harman Eye Centers including optometrists and ophthalmic technicians. I authorize the performance of whatever procedures the judgment of the above-named staff may deem necessary during treatment. I also authorize the administration of any anesthetics and analgesics, including eye drops, which the above staff deem advisable. I may request that any procedure not be performed. I authorize payment directly to Harman Eye Center of the insurance benefits otherwise payable to me for their services. I also authorize them to provide information to my insurance company directly pertaining to relevant claims. I understand that I may be charged and I agree to pay a fee for forms completion, medical records, collection agency or attorneys' fees pertaining to my account. By my signature below, I acknowledge that I have received the Harman Eye Center Notice of Privacy Practices.

Patient Signature: _____ DATE: _____

Witness Signature: _____ DATE: _____

Parent/Legal Representative: _____ DATE: _____

Harman Eye Center

MEDICARE FACT SHEET

Dear Patient:

My primary concern as your eye care provider is to provide you with the very best care possible. My office staff and I understand that medical insurance, especially Medicare, can be confusing. If you need any assistance, we are here to help you.

The following information describes Medicare's rules in paying for your services and what you may have to pay out of pocket today. Medicare Part B covers physician's bills for surgery, office visits and diagnostic tests. It is your Part B Medical coverage that pays medical charges.

MEDICARE PARTICIPATION /ACCEPTING ASSIGNMENT:

This office participates with Medicare. This is a real benefit to you because it means that you will receive a savings based on Medicare Guidelines for your services. Here is an example to illustrate what that means to you as a Medicare based on 2019 guidelines:

TYPE OF SERVICE	OUR NORMAL CHARGE	MEDICARE GUIDELINE	YOUR SAVINGS
Comprehensive Exam	$ 160.00	$ 127.41	$ 32.59

MEDICARE PAYMENTS

Medicare will pay 80 % of the guideline amount for covered services. The remaining 20% is your responsibility. Example:

MEDICARE GUIDELINE	MEDICARE PAY 80%	SUPPLEMENTAL (OR) YOUR OUT OF POCKET
$127.41	$ 101.93	$ 25.48

***After all deductibles and/or co-pays are met. *The 2019 deductible is $ 185.00. All doctors in Virginia are REQUIRED by Medicare to collect the co-payment.**

NOT COVERED BY MEDICARE:	YOUR OUT OF POCKET
Refractions	$ 34.00
Eyeglasses	$ Cost varies
Contacts and Contact Lens Fit Fees	$ Cost varies

If you have any questions, please don't hesitate to ask. Our Insurance and Billing department can be reached at 434-385-5600. Thank you for choosing Harman Eye Center for your eye care needs. By signing below you acknowledge that you have received, read and understand the above.

Patient Signature_____ Date: _____

MEDICARE PATIENT CHECKLIST

YOUR NAME:_____

ADDRESS:_____

PHONE: _____ **CELL:** _____

1. ***DO YOU HAVE ANY OF THE FOLLOWING? PLEASE CIRCLE ALL THAT APPLY:***

Problems with Glare	**Change in vision**	**Dry eyes**	**Droopy Eyelids**
Watery eyes	**Glasses don't work as well**	**Red eyes**	**"Crows Feet"**
Glasses don't fit as well	**Problems driving at night**	**Itchy eyes**	**"Laugh Lines"**

2. ***DO YOU HAVE DIFFICULTY, EVEN WITH GLASSES, WITH ANY OF THE FOLLOWING?***

Reading small print, such as labels on medicine bottles, telephone books, or food labels

Reading a newspaper, hymnal or book

Watching television

Recognizing people when they are close to you

Writing checks or filling out forms

Seeing steps, stairs, or curbs

Seeing the golf ball or tennis ball

Reading traffic signs, street signs or store signs

Playing games such as bingo

Doing fine handwork like sewing, knitting, crocheting or carpentry

3. **ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS?**

Plaquenil (Hydroxychloroquine) **Topamax (Topirimate)** **Gilenya (Fingolimod)**

4. ***IF YOU ARE AN ESTABLISHED PATIENT, HAS YOUR INSURANCE CHANGED SINCE YOUR LAST EYE EXAM HERE? (PLEASE CIRCLE)***

YES **NO**

IF YES, PLEASE GIVE ONE OF OUR FRONT OFFICE STAFF YOUR NEW CARD WHEN YOU RETURN THIS FORM.

_____ _____

PATIENT SIGNATURE **DATE**

Harman Eye Center

and its affiliates and/or subsidiaries

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of Harman eye Center Privacy Practices.

_____
(Print Name)

_____
(Signature)

_____
(Date)

This acknowledgement page should be retained in the patient's record. If acknowledgement could not be obtained from patient, the reason(s) must be documented below.

_____
_____
_____
_____

RELEASE OF MEDICAL INFORMATION

By signing below, I authorize Harman Eye Center and affiliates and/or subsidiaries to disclose information regarding my eye care and treatment to the individuals listed below:

_____
Name Phone Number Relationship

_____
Name Phone Number Relationship

_____
Name Phone Number Relationship

_____
(Signature)

_____
(Date)