

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

1. **Are you currently taking any medications?**  No  Yes, Please List: \_\_\_\_\_

2. **Do you have the following?**  Medication Allergies  Other Allergies (Food, Seasonal, Etc.)  Latex Sensitivity

Please List: \_\_\_\_\_

3. **How many hours per day do you spend on the computer?** \_\_\_\_\_ hours/day

4. **Are you interested in contact lenses today?**  Yes  No (Contact lens evaluations are an additional charge)

5. **Occupation/Hobbies** \_\_\_\_\_

**Are YOU currently being treated for or have any of the following?**

**Constitutional:**  Developmental Disabilities  Cancer  Fatigue Syndrome  Other

**ENT:**  Hearing Loss  Sinusitis  Dry Mouth  Laryngitis  Other

**Neurological:**  Multiple Sclerosis  Epilepsy  Cerebral Palsy  Tumor  Stroke/CVA  Migraine  Autism  Other

**Psychiatric:**  Depression  Attention Deficit  Anxiety Disorder  Bipolar Disorder  Other

**Cardiovascular:**  High Blood Pressure  Stroke/CVA  Heart Disease  Vascular Disease  Congestive Heart Failure  Other

**Respiratory:**  Cigarette Smoker  Asthma  Bronchitis  Emphysema  Chronic Obstruction  Sleep Apnea  Other

**Gastrointestinal:**  Crohn's  Colitis  Ulcer  Acid Reflux  Celiac Disease  Other

**Genitourinary:**  Kidney Disease  Prostate disease/Cancer  STD-Herpetic/Chlamydia  Benign Prostate Hypertrophy  Pregnant  
 Nursing  Herpes  Chlamydia  Other

**Musculoskeletal:**  Osteoarthritis  Arthritis  Fibromyalgia  Muscular Dystrophy  Ankylosing Spondylitis  Osteoporosis  Gout

**Integumentary:**  Eczema  Rosacea  Psoriasis  Herpes Simplex/Cold Sores  Herpes Zoster/Shingles  Other

**Endocrine:**  Type 2 Diabetes Mellitus  Type 1 Diabetes Mellitus  Thyroid Dysfunction  Hormonal Dysfunction  Other

**Hem/Lymph:**  Anemia  Large-volume blood loss  Ulcer  High Cholesterol  Other

**Allergic/Immune:**  Drug Allergies  Environmental Allergies  Rheumatoid Arthritis  Lupus  Sjogren's Syndrome  Other

**Social History**

Do you drink alcohol?  No  Yes Amount: \_\_\_\_\_

Do you use tobacco?  No  Yes Type and Amount \_\_\_\_\_

Are you a  Former Smoker  Never Smoker?

**Family History**

**Please indicate if any of the following conditions are present in your immediate family:**

**Cancer:**  Father  Mother  Brother(s)  Sister(s)  Son(s)  Daughter(s)  Unknown  None

**Diabetes (Type 1):**  Father  Mother  Brother(s)  Sister(s)  Son(s)  Daughter(s)  Unknown  None

**Diabetes (Type 2):**  Father  Mother  Brother(s)  Sister(s)  Son(s)  Daughter(s)  Unknown  None

**Hypertension:**  Father  Mother  Brother(s)  Sister(s)  Son(s)  Daughter(s)  Unknown  None

**Hyperthyroidism:**  Father  Mother  Brother(s)  Sister(s)  Son(s)  Daughter(s)  Unknown  None

**Hypothyroidism:**  Father  Mother  Brother(s)  Sister(s)  Son(s)  Daughter(s)  Unknown  None

**Cataracts:**  Father  Mother  Brother(s)  Sister(s)  Son(s)  Daughter(s)  Unknown  None

**Macular Degeneration:**  Father  Mother  Brother(s)  Sister(s)  Son(s)  Daughter(s)  Unknown  None

**Glaucoma:**  Father  Mother  Brother(s)  Sister(s)  Son(s)  Daughter(s)  Unknown  None

**Other Eye Conditions:**  Father  Mother  Brother(s)  Sister(s)  Son(s)  Daughter(s)  Unknown  None

\*Other pertinent information \_\_\_\_\_

**\*\*Horvath Vision Care Financial Policy\*\***

- Our doctors participate with numerous insurance and managed health care companies and our business office will submit a claim for services rendered. We will not submit insurance claims if insurance is presented after the day of service. You would be given an itemized receipt to send in on your own.
- If a patient has insurance that we *do not participate in*, our office will be happy to provide an itemized receipt; however, *payment in full is expected at the time of service*.
- It is the patient's responsibility to pay any deductible, co-payment, or portion of the charges as specified by the plan at the time of the visit. Any services not covered by an individual's insurance plan are the patient's responsibility and payment in full is due at the time of the visit.
- It is the patient's responsibility that any required referrals for treatment are provided to the practice prior to the visit.
- It is the patient's responsibility to bring their current insurance card and photo identification to each visit.
- The adult accompanying any minor and parents (or guardian) are responsible for payment at the time of service.
- Our staff may help with insurance questions although specific coverage issues can only be addressed by the insurance company.
- An annual eye exam is your yearly eye exam but is only a routine vision exam if no medical symptoms or conditions are found. All yearly eye examinations will be comprehensive.
- If medical conditions are discovered during your routine vision exam, your medical insurance will be billed at that time. You are then responsible for any charges that are not covered by your medical care benefits. In some cases, we will be able to also submit a secondary claim to your vision care plan for additional coverage.
- Often, patients will have both a vision plan and medical insurance. Vision plans such as EyeMed, Humana Vision and VSP will only cover routine vision exams. They do not cover diagnosis, management or treatment of eye diseases. Medical plans such as Aetna, UHC and Medicare must also be used if you have any eye health problem or systemic health problem that has ocular complications. Medical conditions include (but are not limited to) cataracts, glaucoma, diabetes and high blood pressure, as well as redness, eye pain, headaches, watery eyes, allergies, dryness, itching and floaters. Some of these conditions are determined by your case history, however it is not always possible to determine if a medical diagnosis exists that might require medical treatment and/or additional diagnostic testing until your yearly exam is already underway. If you have both types of insurance plans, it may be possible for us to bill some services to one plan and some services to the other. We will use coordination of benefits to do this properly and minimize your out-of-pocket expense. It is certainly your choice if you do not wish us to bill any medical services to your medical plan. However, if your exam does not meet the "vision only" criteria, you may be responsible for our usual and customary fees for a medical eye exam as an out-of-pocket expense payable at the time of service.
- Determining eyeglass prescriptions involves evaluating the overall health of your eyes in a comprehensive exam, therefore Horvath Vision Care never provides a "refraction only" exam.

**By signing below, you agree to the terms of the above financial policies:**

\_\_\_\_\_  
**Patient Signature** (or Guardian)

\_\_\_\_\_  
**Date**

**\*\*Insurance Authorization and Release\*\***

*I hereby authorize the release of any medical or other information necessary to process my insurance claim. I authorize payment of benefits directly to Horvath Vision Care, Inc. I understand that I am responsible for any deductible, copay, share of cost, or service not covered by my insurance.*

\_\_\_\_\_  
**Patient Signature** (or Guardian)

\_\_\_\_\_  
**Subscriber's SS#**

\_\_\_\_\_  
**Date**

**\*\*HIPAA Acknowledgment\*\***

*I am aware that Horvath Vision Care Inc. abides by the HIPAA privacy policy thereby keeping my personal and medical information confidential. Please let a staff member know if you would like a copy of the HIPAA policy.*

\_\_\_\_\_  
**Patient Signature** (or Guardian)

\_\_\_\_\_  
**Date**

**\*\*Notice of Privacy Practices\*\***

We participate in one or more Health Information Exchanges. Your healthcare providers can use this electronic network to securely provide access to your health records for a better picture of your health needs. We, and other healthcare providers, may allow access to your health information through the Health Information Exchange for treatment, payment or other healthcare operations. This is a voluntary agreement. You may opt-out at any time by notifying our front desk staff.