HUFFMAN &HUFFMAN,P.S.C.

Eye Physicians and Surgeons • Consultative Ophthalmology • Low Vision Services

James G. Huffman, M.D
Mark D Huffman, M.D.
James M. Huffman, M.D.
Bruce H. Koffler, M.D.
Douglas G. Owen, M.D.
Sarah E. Huffman-Stanifer, O.D.
Hannah C. Huffman, O.D.
Amy D. Henson, O.D.
H. Matt Magee, O.D.
Todd M. McGeorge, O.D.

PATIENT INFORMATION

NAME: (LAST) _____ (FIRST) _____(MI)_____

DATE OF BIRTH: _____ SOCIAL SECURITY # _____SEX: M( ) F ( )

CONTACT INFORMATION

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

CELL PHONE: _____ ALTERNATIVE: _____ WORK: _____

EMAIL ADDRESS: _____

EMERGENCY CONTACT: _____ PHONE: _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

PHARMACY NAME: _____ PHONE: _____

REFERRAL INFORMATION

(If you were referred to us by another physician and/or optometrist)

DOCTOR'S NAME: _____ PHONE: _____

PARENT OR GUARDIAN INFORMATION

NAME: (FIRST) _____ (LAST) _____(MI)___ DOB: _____

VISION INSURANCE INFORMATION

VISION INSURANCE: _____ INSURANCE ID#: _____

POLICY HOLDER: _____ POLICY HOLDER SSN#: _____

POLICY HOLDER DATE OF BIRTH: _____ RELATIONSHIP TO PATIENT: _____

INSURANCE AUTHORIZATION / PAYMENT POLICY

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. The patient is responsible for all fees, regardless of insurance coverage. If your insurances do not pay after 90 days, we will bill the patient for the remaining balance.

PATIENT SIGNATURE: _____

MEDICAL AUTHORIZATION INFORMATION

So that we may submit an insurance claim for services covered under your policy, we must have your authorization to release medical information to your carrier:

COMMERCIAL INSURANCE:

I hereby authorize release of any and all information necessary to file a claim with my insurance company and assign benefits otherwise payable to me, to the doctor indicated on the claim. I understand that I am financially responsible for the payment of any amount not covered by my insurance carrier. A copy of this signature is as valid as the original.

PATIENT SIGNATURE: _____

MEDICARE:

I request that payment of authorized Medicare benefits to be made on my behalf to the doctor indicated on the claim for any services furnished by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, including supplemental insurance agents, any information needed to determine these benefits of benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 form is completed, my signature authorized release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and any non-covered service. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

I understand that an eye refraction is a non-covered Medicare charge, and therefore I am responsible for the payment of this charge.

I understand that all physicians at Huffman & Huffman, P.S.C. are committed to safeguarding patient privacy and that a full disclosure of their privacy practices is available to me.

I hereby authorize Medicare to furnish to the above named doctors any information regarding my Medicare claims under Title XVIII of the Social Security Act.

PATIENT SIGNATURE: _____

Name:_____ Date of Birth: _____ Pharmacy: _____

PATIENT MEDICAL HISTORY

Do you have any food and / or drug allergies? Y ( ) N ( )
If you answered yes, please explain:

_____
_____

List any medications you take, this includes oral contraceptives, aspirin, or over the counter meds:
(If you have a printed list, we will copy it)

_____
_____
_____
_____

List all major injuries and/ or surgeries up have had: (If you have a printed list, we will copy it)

_____
_____
_____

List any eye conditions and/ or disease you have previously had such as, crossed eyes, lazy eye, drooping eyelids, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury:

_____
_____

Are you pregnant and /or nursing? Y ( ) N ( )
Do you wear glasses and / or contacts? Y ( ) N ( )
If you wear contacts, how old are they? _____
If you wear contacts, what type are they? Rigid ( ) Soft ( ) Extended Wear ( ) Other (
Are you current contacts comfortable? Y ( ) N ( )
Do you drive? Y ( ) N ( ) Do you use tobacco? Y ( ) N ( ) Do you drink alcohol? Y ( ) N ( )

PATIENT'S FAMILY MEDICAL HISTORY

Please note any family history, this includes parents, children, grandparents, aunts, or uncles (living or deceased) for the following conditions:

Disease / Condition	No	Yes	Relation to You
Blindness			
Cataracts			
Crossed Eyes			
Glaucoma			
Retina / Macula			
Cancer			
Diabetes			
Heart Disease			
High Blood Pressure			
Kidney Disease			
Lupus			
Thyroid Disease			

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor; if you prefer:

Have you been having any of the following problems with the problems with your eyes?

___ Loss of Vision/Side Vision
___ Blurred Vision
___ Distorted Vision/Halos
___ Double Vision
___ Dryness
___ Mucous Discharge
___ Redness
___ Itching
___ Burning
___ Foreign Body Sensation
___ Excessive Tearing/Watering
___ Glare/Light Sensitivity
___ Eye Pain or Soreness
___ Bumps on Lids
___ Flashes/Floaters in Vision
___ Tired Eyes

Are you being treated for any of the following health problems?

___ High Blood Pressure
___ Heart Disease
___ Thyroid Disease
___ Graves Disease
___ High Cholesterol
___ Diabetes
___ Arthritis

Review of Systems

Do you currently have any of the following problems?

Cardiovascular
___ Chest Pain
___ Irregular Heartbeat
___ Shortness of Breath

Ear, Nose & Throat
___ Dizziness
___ Hearing Loss
___ Hoarseness
___ Ringing in Ears
___ Sore Throat

Musculoskeletal
___ Back Pain
___ Joint Pain
___ Muscle Aches
___ Stiffness
___ Swelling

Respiratory
___ Cough
___ Trouble Breathing
___ Wheezing

Constitutional
___ Fatigue
___ Fever
___ Night Sweats
___ Weakness
___ Weight Loss

Hematologic
___ Bleeding
___ Bruising
___ Tender Nodes

Neurological
___ Balance Problems
___ Headache
___ Numbness
___ Tingling

Skin
___ Hair Loss
___ Rash
___ Skin Lesions

Genitourinary
___ Genital Discharge
___ Genital Lesions
___ Painful Urination
___ Urgency

Metabolic
___ Cold Intolerance
___ Excess Hunger
___ Excessive Thirst
___ Frequent Urination
___ Heat Intolerance

Psychiatric
___ Anxiety
___ Depression
___ Insomnia
___ Irritability
___ Nervousness

Allergy
___ Itching
___ Hives
___ Runny Nose
___ Seasonal

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If you are here for a vision exam and the doctor diagnoses you with a medical problem, we will have to bill your medical insurance and you will have to reschedule for a routine eye exam when the medical problem is resolved.

Examples are as follows:
*If you are being seen for a routine exam and the doctor finds that you have cataracts, that visit will/can be billed medically.
*If you are being seen for a routine vision exam and the doctor finds that you have a foreign body, the doctor will remove it and that visit will be billed medically.
*If you are being seen for a routine vision exam and the doctor finds that you have some type of allergy, that visit will be billed medically.
*If you are being seen for a routine vision exam and you are a diabetic, we can bill your exam through your vision insurance (if there are no complications due to the diabetes), and if you come back for your 6 month recommended check-up, we can bill that visit medically, (We can rotate what insurance is billed every 6 months in cases such as this)>

I hereby acknowledge that I, the patient, am responsible for providing the Check In Staff with my correct insurance as well as notifying the Check Out Staff which insurance I would like to be billed. However, I understand that if it is found that I have a medical diagnosis and/or a medical problem that needs to be evaluated at the time of my visit then my medical insurance must be billed. If I choose to bill my vision insurance, I will need to schedule a routine eye exam at a later date.

Huffman and Huffman, P.S.C. CANNOT bill a vision and medical insurance for the same visit.

Signature: _____

Date: _____

REFRACTION WAIVER NOTICE

A **refraction** is the test which we perform to get a prescription for glasses and/ or contacts. This test is considered a vision service. If you only have a medical insurance, {Medicare, Anthem BlueCross BlueShield, United Health Care, etc.} this service will not be covered. The out of pocket cost for this service is $25.00. (If you get a new prescription for glasses at each visit, the cost is $25.00 each time.) However, if you have a separate vision insurance such as, Eye Med, Davis, Spectera, VSP, etc., this service will be covered by your vision insurance.

Disclaimer: If you visit is billed medically and you receive a glasses and/ or contact prescription, you will be charged for the refraction because we cannot bill both your medical and vision insurance in one visit.

Please check one of the followings:

( ) YES, I elect to receive this service. I understand the above statement. I also understand that the charge of this service is to be paid for at the time of the visit.

( ) NO, I defer this service and understand I will not be able to receive a glasses prescription.

_____ _____

Patient Signature Date

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you may get access to this information. ***PLEASE READ IT CAREFULLY.***

Dr James Huffman, Dr Mark Huffman, Dr Sarah Huffman, Dr Amy Henson, Dr Hannah Huffman, Dr Matt Magee and Dr Holly Pendel are dedicated to protecting your medical information. We are required by law to maintain the privacy of protected health information and to provide you with this notice of our legal duties and privacy practices with respect to protected health information.

How your medical information will be used and disclosed:

We will use your medical information as part of rendering patient care. For example, your medical information may be used by the doctor treating you, by the business office to process your payment for the services rendered, by our collection agent, and by administrative personnel reviewing the quality of care you receive. We may also use and/or disclose your information in accordance with federal and state laws for the follow purposes:

- Disclosure to Department of Health and Human Services
- Law Enforcement
- Coroners, Medical Examiners and Funeral Directors
- Public Safety
- Business Associates
- School for confirming child was present for a visit
- Interpreters
- Persons involved in your care
- Notification to a family member or person of your choice
- Appointment recall cards and letters
- As required by law

Patient Rights:

- Access to your medical record
- Restrictions about uses and disclosures
- Right to receive an accounting of disclosures made after 04/14/2003
- Request a copy of this notice
- Right to complain to us and/or the Department of Health and Human Services

A more detailed description of our privacy practices is available upon request. If you would like further information regarding your rights, you may contact Loretta Huffman at (606)877-1877 or Jan Schantz at (606)679-7461.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Notice of Privacy Practices for this office

PATIENT SIGNATURE: _____ DATE: _____

Name:_____ Date of Birth: _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Due to HIPPA, we are not allowed to release any medical and/or billing information to anyone without your (the patient's) consent. If for any reason you would like to release your information you will need to list the name(S) of the person(S) allowed to have your medical and/or billing information. For instance, if your spouse, child, sibling, grandparent, significant other, or POA comes in the office to request your information **we cannot give out your records to them if their name is not listed below.**

By signing this authorization, you are giving us permission to release your medical information to the following individual(S):

1:Name:_____

Relation:_____

2:Name:_____

Relation:_____

3:Name:_____

Relation:_____

You can revoke or change this authorization at any time.

Signature:_____ Date:_____

DISCLAIMER:

THE WAIT IS OFTEN LONG, ONCE YOU'RE CALLED BACK IT'S POSSIBLE YOU COULD BE HERE FOR A FEW HOURS **DEPENDING ON THE SEVERITY OF YOUR (OR OTHER'S) CASE.**

WE SINCERELY APOLOGIZE, HOWEVER, PLEASE REMEMBER EVERY PATIENT IS DIFFERENT AND ONE MAY REQUIRE MORE ATTENTION THAN ANOTHER. WE PROMISE TO GET TO YOU AS SOON AS WE CAN AND YOU WILL BE TREATED WITH OUR UTMOST CARE!

WE THANK YOU FOR YOUR BUSINESS,

HUFFMAN AND HUFFMAN, P.S.C