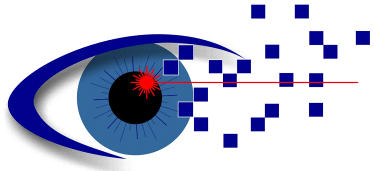


OMNI EYE CENTERS

of Kansas City

Legacy Ridge Medical Plaza
301 N.E. Mulberry St. Suite 101
Lee's Summit, MO 64086
(816) 525-EYES (3937)

As a new patient to our practice, we would like to offer a warm welcome and our thanks for choosing us to provide your eye health care. In order for us to establish your file and provide the most beneficial use of your time with us, the doctor has asked you to complete the following tasks and bring them to your appointment. The doctor needs this information in order to give you the best care possible.

- **Photo Identification**

- **Complete Patient Information Form:** This information includes personal demographics needed to establish your file and billing/insurance indicating who will be financially responsible for your visit.

- **Complete Medical and Eye Health History:** Since many general health conditions may be associated with visual symptoms and/or eye health problems, this important record will allow us to care for you as a "whole person" rather just a pair of eyes. This form includes a complete list of prescription and non-prescription medications.

- **Complete Agreement of Responsibility:** This form details the understanding that the patient is ultimately responsible for all charges incurred, allows Omni Eye Centers of Kansas City to bill your insurance and gives Omni Eye Centers of Kansas City consent to treat.

- **Complete HIPAA Patient Notice:** This form describes how Omni Eye Centers of Kansas City will use your medical information.

- **Insurance cards:** For all medical insurance you have coverage with.

- **Eyeglasses:** Please bring ALL pairs of eyeglasses you currently use, including prescription or non-prescription reading glasses, sunglasses, etc. We have instruments to compare the optical power of your old lenses with your new exam findings, thus enabling us to determine and explain how your vision has changed over time.

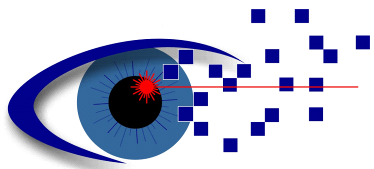
- **Eye drops, ointments, etc.:** Please place any eye drops or ointments that you use in a small bag and bring it along with you. Your doctor will review whether these are still appropriate, and whether there may be better options that are now available.

- **Dilation Explained:** The doctor may use drops to dilate your eyes in order to fully evaluate their internal health. This has the effect of temporarily increasing sensitivity to light and causing "fuzzy" vision at near (reading) distance for a period of up to 2-3 hours. Please make the necessary arrangements so that you are prepared to have your eyes dilated during the exam.

- **Time Expectations:** A complete dilated eye exam will take 1 to 2 hours to complete from start to finish. This time may be less or more depending on the circumstances of your eye health. If your appointment is for a pre-operative visit please allow additional time for scheduling and counseling if you may be having surgery.

Completing the task list for the items that apply to you will assure you of receiving the most thorough and professional care possible and in a very efficient manner.

We look forward to your visit!



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PATIENT INFORMATION

NAME Last First MI			DATE
Street Address			Social Security #
City		Age	Birthdate
State	Zip Code	Sex M F	Marital Status Married Single Widowed Divorced
Home Phone ( )	Cell Phone ( )	Work Phone ( )	
Employers Name/Address			
Spouse			
Emergency Contact			Emergency Phone # ( )

Billing

Guarantor (person financially responsible)		Relationship to Patient
Address (if different from patient)		Phone # ( )
Primary Insurance	Policy Holder	Policy Holders Date of Birth
Secondary Insurance	Policy Holder	Policy Holders Date of Birth

Referral

Whom may we thank for telling you about our practice? Name:	FRIEND/FAMILY INSURANCE COMPANY NEWSPAPER PATIENT YELLOW PAGES OPTOMETRIST
I give permission for OMNI EYE CENTERS OF KC to send a Thank you letter for my referral Signature:	
Primary Care Physician	Family Optometrist

HEALTH HISTORY

Name_________________________________ **Date**___________________________

PLEASE CIRCLE ANY CONDITION THAT APPLIES TO YOU

Fatigue/Sleeplessness	Kidney disease	Cancer
Heart Disease	Bladder Problems	Blood Disorder
Sinus/Allergies	Uterine/Prostate problems	Head or Spinal Injuries
Shortness of Breath	Diarrhea/Constipation	Depression/Anxiety
High Cholesterol	Hernia	Nervousness
High Blood Pressure	Hemorrhoids	Forgetfulness
Asthma	Migraines/Stroke	Dentures
COPD/Emphysema	Seizures, Convulsions, or Fainting	Hearing Aides
Tuberculosis	Diabetes Type I or Type II	Other ____________
GERD	Arthritis/Muscle/myalgia/osteo	_________________
Ulcer		

Do you smoke YES/NO   Do you drink YES/NO   Do you use drugs YES/NO

Please List all medications you are currently taking:

_________________ _________________ _________________ _________________

_________________ _________________ _________________ _________________

_________________ _________________ _________________ _________________

Please list ALL medications you are ALLERGIC to:

_________________ _________________ _________________ _________________

Your OCULAR HISTORY (Have you been diagnosed with any of the following in the past?)

	YES	NO		YES	NO
Glaucoma	○	○	Cataracts	○	○
Macular Degeneration	○	○	Retina Disease	○	○
Iritis	○	○	Cornea Disease	○	○

Other__________________________

Cataract surgery (date of surgery) Right eye__________ Left eye ________ Do you have a lens implant? Yes No
Other EYE surgery________________________ Date of surgery______________________________

SURGICAL HISTORY (Please include date and type)

____

____

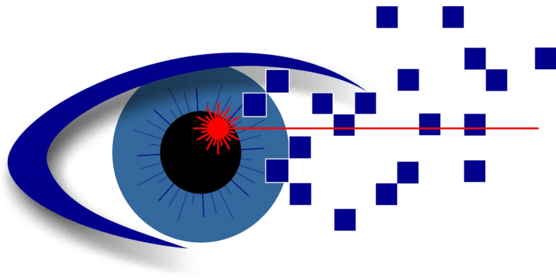
____ _____

HOBBIES: ____

FAMILY HISTORY: Has anyone in your family (blood relatives) had any of the following?
Please note relationship to patient: F=father M=mother S=sister B=brother GF=grandfather GM=grandmother U=uncle A=aunt

	YES	NO		YES	NO
Glaucoma	○	○	Cataracts	○	○
Macular Degeneration	○	○	Retina Disease	○	○
Cornea Disease	○	○	Diabetes	○	○
Heart problems	○	○	Breathing Problems	○	○

Other general health problems__________________



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HIPAA PATIENT NOTICE

HIPAA is an acronym for the Health Insurance Portability & Accountability Act of 1996 (a federal law). Of significant concern to healthcare organizations is the Administrative Simplification section of the Act, which requires healthcare organizations to comply with specific rules regarding:

*Unique Identifiers for health plans, providers, individuals, employers
*Healthcare Transaction & Code Sets for transmitting data electronically
*Privacy regulations over disclosure and use of health information
*Security regulations over protections of electronic health information

It is our policy to not release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cell phone and /or pager. Whenever returning phone calls and the answering machine picks up, we do not leave a message if the name or the telephone number is not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone. If you would like information released to someone other than yourself please complete the following:

I authorize Onmi Eye Centers of KC to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever the information changes.

Home telephone	____ yes	____ no
Answering machine	____ yes	____ no
Work telephone	____ yes	____ no
Voice mail	____ yes	____ no
Cell phone	____ yes	____ no

Please list names of people we can discuss your medical care with:

Spouse:____ ____ yes ____ no

Parent:____ ____ yes ____ no

Other:____ ____ yes ____ no
Please give name and relationship

____
Signature Patient/Guardian   Date

RECIEPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEGEMENT FORM

I, _____________________________________, have received a copy of Omni Eye Center Notice of Privacy Practices.
Patient Name

I, _____________________________________, refuse to accept a copy of Omni eye Center Notice of Privacy Practices.
Patient Name

____
Signature of patient   **Date**

Agreement of Responsibility

I understand that professional services are rendered to the patient and the patient is responsible for charges incurred for these services. Payment for annual deductibles and co-insurance may be collected at the time of service. I understand that I am financially responsible for charges not covered by my insurance company.

Consent to Treat

I voluntarily consent to such care and treatment as prescribed by the physician as is necessary in his/her judgment.

Release of Information/Assignment of Benefits

I authorize use of this form on all my insurance submissions and authorize release of information needed to process a claim to all of my insurance companies. I permit a copy of this to be used in place of the original. I authorize the provider to act as my agent in helping me obtain payment from my insurance companies. I understand the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement on disputed claims. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand I will receive a monthly statement for any balance due by me.

Medicare Authorization

I request payment of authorized Medicare benefits be made on my behalf to Omni Eye Centers of Kansas City, for any services furnished to me by that physician. I authorize the holder of medical information, about me, to release to Medicare and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the release of the information to the insurer/agency shown. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and the uncovered services. Co –insurance and the deductible are based upon the charge determination of the Medicare carrier.

Medigap Authorization

The following is to be filled out if you have a Medigap insurance policy for which you wish to assign benefits. A Medigap or Medicare Supplemental policy is a health insurance policy or other health plan, offered by a private company, to those entitled to Medicare benefits. It is designed to pay certain costs that Medicare does not pay. By law, this excludes a policy or plan offered by an employer to employees or former employees, as well as a policy or plan offered by a labor organization to members or former members.

This agreement is in effect until revoked in writing by the patient.

SIGNATURE: ____ DATE:______________________________

NAME (print): ____