Hughes Quality Eyecare

Emergency Contact Form

Patient Information:

_____ _____

Patient Name Date of Birth

In case of emergency, contact:

_____

Name

_____

Address

_____

Phone Number

_____ _____

Patient/Guardian Signature Today's Date

Hughes Quality Eyecare
2682 Kull Road
Lancaster, Ohio 43130

Payment Policy

Payment for services rendered are due at the time of the visit. Our office accepts cash, check, credit card, and CareCredit. This is NON-refundable.

I. Self-Pay Patients

I acknowledge that I do **NOT** have vision and/or medical insurance at the time of my visit. I agree to pay all charges out-of-pocket and in full on the day of my appointment and before materials are ordered. Hughes Quality Eyecare does not offer payment plans. It is my responsibility to determine if I am covered by any insurance entity. If I learn of coverage after my appointment and payment, I understand that Hughes Quality Eyecare cannot back-bill the insurance company and will not provide a refund.

_____ _____

Patient Signature Date

II. Insurance Holder

I will present my insurance card for vision and/or medical coverage at the time of my appointment. I understand that it is my responsibility to be aware of the amount of my copay, which is due at the time of the visit, and the amount of my deductible (if applicable), which will be billed at a later date. If my insurance carrier changes, it is my responsibility to notify the office at the time of my visit. I agree to pay my copay today.

_____ _____

Patient Signature Date

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Dilation Information and Consent

In order to provide a thorough eye examination, Dr. Hughes performs a dilated eye examination on patients at no additional cost. Dilation provides a more detailed examination of the retina and internal structures of the eye, which is done to detect potentially blinding conditions as early as possible.

Dr. Hughes can look into the eyes without dilation, but only about one third of the retina is visible (depending on the size of your pupil). The retina in the inner lining of the back of the eye, which is responsible for vision.

Dr. Hughes recommends patients have their eyes dilated at least once per year, more often in some cases, to rule out diabetic damage, retinal tears, detachments, tumors, and other eye and systemic diseases. Any of these can occur without symptoms and may not be seen without dilating your eyes.

The dilating drops may cause some temporary blurred near vision and light sensitivity. The effect of the eye drops could last up to four hours or more, but typically last less than three hours.

Modern technology has helped to advance eyecare. Hughes Quality Eyecare offers a photograph option. This does not replace the value of dilation, but it is better than no dilation at all. Photos help to provide a wider view of the retina while documenting ocular health. This cannot be billed to your insurance and has an out-of-pocket cost.

☐ I would like to have a dilated eye exam today.

☐ I REFUSE to have a dilated eye exam or photos taken today. I understand the risk to my vision by not having a dilated exam.

☐ I REFUSE to have a dilated eye exam, but I would like photos taken. I understand this service cannot be billed to insurance and will cost $50. I understand that it does not replace the value of dilation.

_____ _____

Signature Date

Name: _____

Hughes Quality Eyecare
2682 Kull Road
Lancaster, Ohio 43130

Diabetic Screening Form

1. Are you diabetic? (please circle) Yes

   No

2. Are you prediabetic? (please circle) Yes

   No

3. If you are diabetic or prediabetic:

   Last HbA1C: _____

   Last blood sugar reading: _____

If you have answered **yes** to either of the above questions, please read and acknowledge below.

If you answered **no**, this form is complete.

A diabetic examination is more extensive than a routine, yearly check-up. Dr. Hughes is looking for diabetic retinopathy. This includes hemorrhaging (bleeding), cotton wool spots (areas not receiving enough oxygen), and edema (swelling) in the eyes. After your appointment, Dr. Hughes will write a personal letter to your primary care physician and/or endocrinologist (specialist) to relay the findings. This is important for two reasons. First, this ensures that your eyes are healthy. Second, your health care provider is required to have documentation of at least yearly eye exam for insurance purposes, which is why they ask you the date of your last eye examination.

Vision insurance plans, such as VSP, Eyemed, Spectera, Superior Vision, Avesis, etc do **not** cover this type of examination. Your diabetic visit will be billed to your medical insurance. It is your responsibility to be aware of the amount of your copay, which is due at the time of the visit, and the amount of your deductible (if applicable), which will be billed at a later date.

Medical insurance companies often will not cover the cost of a refraction. A refraction is the test that Dr. Hughes performs to determine glasses and contact lens prescriptions ("which is better one or two?"). If insurance does not cover this test, a bill will be sent later with the cost of $40. If you do not want to have a possible refraction bill, we can always reschedule a second appointment to perform a routine examination coved by your vision plan.

I would like to return for a second appointment for my refraction. This will be billed to my vision insurance.
_____ (initial)

I would like my refraction performed at today's appointment. I understand that I may receive a bill for $40 + any deductible not met. _____ (initial)

_____ _____
Name Date

Hughes Quality Eyecare
2682 Kull Road
Lancaster, OH 43130

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how Hughes Quality Eyecare may use and disclose your protected health information and when we need your written authorization to do so. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Name of Patient (print): _____

Date of Birth: _____

The above party may disclose my health information to the following recipient:

Name/Organization: _____

Phone: _____

Fax: _____

My Rights: I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party. I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards. I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization. I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _____ Date: _____

If the patient is a minor or unable to sign please complete the following:
❑ Patient is a minor: _____ years of age ❑ Patient is unable to sign because:
_____

Hughes Quality Eyecare Authorized Representative Signature:
_____ Date: _____

Turn Over →

Print Name of Representative: _____

Authority of representative to sign on behalf of patient:
Parent ❑ Legal ❑ Guardian ❑ Court Order ❑ Other: ❑

Notices of Privacy Practices (HIPAA)

The signature below indicates that I have been provided with a copy of the Notice of Privacy Practices for the authorized party listed above and have read and understood its content.
Signature of Patient or Authorized Representative:

_____ _____
Signature Date