

# MASON FAMILY VISION

## PATIENT INFORMATION

**Patient Name** \_\_\_\_\_ **Gender**  Male  Female  
Last First Middle

**Preferred First Name** \_\_\_\_\_ **Marital Status**  Minor  Single  Married  Widowed

**Patient Home Address** \_\_\_\_\_  
Street Apt City State Zip

**Phone** Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

**Texting OK**  Yes  No

**Email** \_\_\_\_\_

**Patient DOB** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Age** \_\_\_\_\_ **Patient SSN** \_\_\_\_\_-\_\_\_\_-\_\_\_\_

**Patient's Employer** \_\_\_\_\_ **Occupation** \_\_\_\_\_

**Emergency Contact** \_\_\_\_\_  
Name Relationship Phone

**How did you hear of us?**  Physician Referral, if yes name of Physician \_\_\_\_\_

Mail  Internet  Yellow Pages \_\_\_\_\_  Friend/Family Member \_\_\_\_\_  Other \_\_\_\_\_

**In accordance with health care reform, please help our office report meaningful use measures:**

**Pref Language**  English  Spanish **Communication Preference**  Phone  Postal  Email

**Race**  Asian  Black/African American  Hispanic  Native Hawaiian/Other Pacific Islander  White

**Height** \_\_\_\_\_ **Weight** \_\_\_\_\_

## INSURANCE INFORMATION

Do you have vision insurance?

Yes  No

Insurance Co \_\_\_\_\_

Policyholder Name \_\_\_\_\_ DOB \_\_\_\_\_

ID# \_\_\_\_\_ SSN \_\_\_\_\_

Do you have medical insurance?

Yes  No

Primary Insurance Co \_\_\_\_\_

Policyholder Name \_\_\_\_\_ DOB \_\_\_\_\_

ID# \_\_\_\_\_ SSN \_\_\_\_\_

Secondary Insurance Co \_\_\_\_\_

Policyholder Name \_\_\_\_\_ DOB \_\_\_\_\_

ID# \_\_\_\_\_ SSN \_\_\_\_\_

## RESPONSIBLE PARTY

Self  Spouse  Parent  Guardian  Other \_\_\_\_\_

Name/Address same as above

Name \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ SSN \_\_\_\_\_

## ASSIGNMENT AND RELEASE

I hereby state the information given is true and complete. I hereby authorize and request the payment of services from Medicare, Medicaid, and/or other insurance plans or payers be made on my behalf to Mason Family Vision, PC.

I hereby assign to Mason Family Vision, PC all payments for treatment services. I understand and agree that I am responsible for paying any amount not covered by Medicare, Medicaid, and/or other insurance plans or payers.

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**Patient History** Date: \_\_\_\_\_ Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Name of family physician: \_\_\_\_\_

Do you think you are pregnant or possibly pregnant? Y N

Do you currently wear glasses? Y N Do you currently wear contacts? Y N

If not, are you interested in contacts? Y N

If yes, have you had an adverse reaction to any brand of contact lenses? Y N

If yes, which lens brand? \_\_\_\_\_

Check if you have any of the following problems (check all that apply):

- |                            |                       |
|----------------------------|-----------------------|
| Blurred Vision _____       | Crossed Eyes _____    |
| Loss of Vision _____       | Dry Eyes _____        |
| Macular Degeneration _____ | Eye Pain _____        |
| Tearing _____              | Headaches _____       |
| Discharge _____            | Cataracts _____       |
| Redness _____              | Glaucoma _____        |
| Light Sensitive _____      | Retinal Disease _____ |
| Light Flashes _____        | Eye Surgery _____     |
| Floaters _____             | Laser Treatment _____ |
| Droopy Eyelids _____       | Double Vision _____   |

Have you ever been exposed to:  HIV  Hepatitis  Gonorrhea  Syphilis

Check if you have/have had any of the following health problems:

- |                           |                         |
|---------------------------|-------------------------|
| Skin _____                | Bladder/Kidney _____    |
| Immune Disorder _____     | Mental _____            |
| Heart _____               | Nerve _____             |
| High Blood Pressure _____ | Bone/Joint/Muscle _____ |
| Cancer _____              | Gland/Blood/Lymph _____ |
| Allergies _____           | Breathing _____         |
| Stomach _____             | Diabetes _____          |
|                           | Other: _____            |

Check if someone in your family has or had: Diabetes \_\_\_\_\_ Retinal Disease \_\_\_\_\_ Glaucoma \_\_\_\_\_

Any other eye disease \_\_\_\_\_

Do you smoke? Y N Do you drink alcohol? Y N Are you able to care for yourself? Y N

List ALL medications you take: \_\_\_\_\_  
\_\_\_\_\_

List ALL medications you are allergic to: \_\_\_\_\_  
\_\_\_\_\_

Patient or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Policies and Procedures

Thank you for choosing us as your eye care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, as us any questions you may have and initial and sign in the spaces provided. A copy will be provided to you upon request.

\_\_\_ **Insurance.** Please provide the proper photo ID and insurance cards at check-in for each visit.

We participate in many insurance plans. If you are not insured by a plan we do business with, payment is expected at each visit. If you are insured by a plan we do business with but do not have an up-to-date ID number or medical insurance care, payment in full for each visit is required until benefits can be verified by our office. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding coverage.

\_\_\_ **Claims Submission.** We will submit and assist you in any way we can reasonably can to help you get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that there may be a balance on your claim which is your responsibility and is subject to collections if not paid in a timely manner.

\_\_\_ **Non-Payment.** If your account is over 90-days past due, we will refer your account to a collection agency and you may be discharged from this practice. If this is to occur, you will be notified via telephone and mail that you have an outstanding balance with the practice and may need to find an alternative optometrist.

\_\_\_ **Missed appointments.** Please understand it is our policy to charge \$30 for missed appointments. You will be required to pay these charges before your next appointment.

\_\_\_ **Personal and Medical Information.** Our staff is required to update your file yearly. Failure to update your records may make it difficult to get in touch with you, especially in regards to billing and the arrival of your contacts, glasses, etc.

\_\_\_ **Product returns.** When you choose to order glasses or contact lenses our staff will call you when they arrive. Failure to pick these items up within 60 days of arrival will result in a product return with no refund or credit to the patient's account.

\_\_\_ **Contact Lens Fitting.** A fitting fee must be paid at the time of service. For the patient's best interest they will be asked to remove trial lenses in the event that a fitting fee is not paid for at the time of service. In addition, all follow-up appointments must be kept in order to finalize the contact lens prescription. This policy is in place to help ensure the safety of the patient's ocular health.

Thank you for understanding our policies and procedures. Mason Family Vision is committed to providing the best care for their patients.

*I have read and understand the payment policy and agree to abide by its guidelines.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## DIGITAL RETINAL PHOTOGRAPHY

We believe using the best technology is crucial to maintain a good ocular health and preventing ocular diseases from going undiagnosed. As a result, we utilize Digital Retinal Photography, which gives a high definition picture of your retina, interior blood vessels and optic nerves. These images are vital in helping Dr. Mason assess your risks for serious ocular diseases. The photos also serve as a very important baseline; so every year, your eyes can be compared to past images to monitor for even the smallest changes. I understand this procedure aides a comprehensive dilated eye exam but DOES NOT replace it

- Yes, I elect to have Digial Retinal Photography preformed today (additional fee \$25, not covered by insurance)
- No, against the advice of Dr. mason, I refuse Digital Retinal Photography and understand the health risks involved.

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Patient/Guardian Signature

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Date

# Receipt of Notice of Privacy Policies & Consent Form

Mason Family Vision  
141 Wildewood Park Drive  
Columbia SC 29223  
(803)865-5520 Fax (803)865-5496

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Patient Name: \_\_\_\_\_

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The **Notice of Privacy Practices** you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our **Notice of Privacy Practices**, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our **Notice of Privacy Practices**. Our **Notice of Privacy Practices** will be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our **Notice of Privacy Practices**.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our **Notice of Privacy Practices**, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our **Notice of Privacy Practices** describes how to ask for a restriction.

**I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the Notice of Privacy Practices from Mason Family Vision.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

If signing as a personal representative of the patient, describe the relationship to the patient:

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Print Name