PATIENT INFORMATION FORM

REVISED 07 - 15

PLEASE GIVE ALL FORMS, INSURANCE INFORMATION, MEDICAL CARDS, VOUCHERS AND/OR REFERRAL FORMS TO RECEPTIONISTS BEFORE SERVICES ARE RENDERED

WHICH AGENCY OR SCHOOL REFERRED YOU? _____ ***VISION VOUCHER*** **ATTACHED** ☐☐

PATIENT'S NAME _____ HOME PHONE _____

SOCIAL SECURITY # _____ DATE OF BIRTH _____ MALE ☐ FEMALE ☐

HOME ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMPLOYER _____ OCCUPATION _____ WORK PHONE _____

ETHNICITY (*circle only one*) Hispanic or Latino Not Hispanic or Latino.

RACE (*circle one or more*) American Indian Alaska Native Asian Black or African American Pacific Islander White

Number of people in the household: _____ Please circle the annual income of the household according to the number of people living with you.

	30%	50%	80%
1 Person	Less than $14,700	Less than $24,500	Less than $39,200
2 Persons	Less than $16,800	Less than $24,550	Less than $44,800
3 Persons	Less than $18,900	Less than $31,500	Less than $50,400
4 Persons	Less than $21,000	Less than $35,000	Less than $56,000
5 Persons	Less than $22,700	Less than $37,800	Less than $60,500
6 Persons	Less than $24,400	Less than $40,600	Less than $65,000
7 Persons	Less than $26,050	Less than $43,000	Less than $69,450
8 Persons	Less than $27,750	Less than $46,200	Less than $73,950

ADDITIONAL INFORMATION:

SPOUSE OR PARENT'S NAME _____ PHONE _____

EMAIL _____

WHOM MAY WE CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

I WILL BE PAYING THE EXAM FEE TODAY BY: CASH ☐☐ CHECK ☐☐ CREDIT CARD ☐ VOUCHER ☐☐ MEDICAID ☐

MEDICAID INFORMATION:

INSURANCE COMPANY _____ PHONE _____

ADDRESS _____ SUBSCRIBER # _____ OTHER # _____

GROUP # _____

EXAM INFORMATION:

THIS EXAM IS FOR: EYEGLASSES ☐ MEDICAL ☐ CONTACT LENSES ☐ DATE OF LAST EYE EXAM _____

WHAT SEEMS TO BE THE PROBLEM YOU ARE HAVING WITH YOUR EYES? _____

DUTY TO WARN: Children are much more physically active than adults, so their eyewear must provide maximum protection. Polycarbonate is a very impact-resistant lens material. Therefore, EYE CARE 4 KIDS recommends polycarbonate lens material as the lens of choice for all children, 17 years and under.

I give the staff of the EYE CARE 4 KIDS permission to treat my eye, vision or medical problem. I understand that Eye Care 4 Kids staff may elect to dilate my or my child's eyes and accept the adverse risks and will hold them harmless. I understand and agree that, (regardless of my insurance status), I am ultimately financially responsible for any and all services rendered in my behalf. I am responsible for the balance on my account.

I hereby give EYE CARE 4 KIDS permission to use me and my child's likeness; either by video tape, photograph or interview in possible relations to marketing, fundraising and promoting.

I have read all the information on both sides of this sheet and have answered the above questions. I certify this information is true and correct. I will notify this office of any changes in my health status or the above information.

SIGNATURE _____ DATE _____

SIGNATURE OF PARENT OR GUARDIAN (IF MINOR) _____ DATE _____

Notice to all patients:

Policy and Procedure

Eye Care 4 Kids is a charitable, not-for-profit organization. Our clinic is limited and committed to helping low to moderate-income families in our community receive professional vision services and eyecare at no charge or for a nominal fee.

Eye Care 4 Kids is not liable for eye glasses that get damaged during adjustments or repairs. We do not assume any responsibility for eye glass frames that are brought in from outside our clinic, whether used or new.

Since we are a not-for-profit organization, we recommend lined, straight top, bifocal lenses. These lenses are much less expensive and generally easier to adapt to. Eye Care 4 Kids does not offer progressive, no line bifocals.

The voucher or fee structure you receive is for one (1) eye exam and one (1) pair of single vision eyeglasses. If you feel, for any reason, that you need another eye exam or a different pair of eyeglasses, there will be additional fees.

It costs a great deal to provide these services and maintain this facility and Eye Care 4 Kids works hard to keep the costs in an affordable range for those that would not normally be able to afford it. All specialty products, additional service or replacement items will be at additional cost. Payment is required in full at the time of service, all sales are final and we do not offer any refunds.

I have read, understand and agree to these conditions. INITIALS:_____

Confidentiality Notice

Information about your treatment and care is protected by federal law: The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Under this law the clinic may not disclose any other protected information without your written permission except as permitted by the federal laws referenced below.

1. To program staff for the purposes of providing treatment and maintaining the clinical record;
2. Pursuant to an agreement with a business associate (e.g. Clinical laboratories, pharmacy, billing services, etc.);
3. For research, audit or evaluations;
4. To report a crime committed on the program's premises or against program personnel;
5. To medical personnel in a medical / psychiatric emergency;
6. To appropriate authorities to report suspected child abuse or neglect;
7. To report certain infectious illnesses as required by state law;
8. As allowed by a court order.

Before the clinic can use or disclose any information about your health in a manner which is not described above, it was first obtain your specific written consent allowing it to make the disclosure.

Signature:_____ Date:_____

Signature of Parent or Guardian:_____ Date:_____