HILL VISION SERVICES
PATIENT INFORMATION RECORD

Today's Date _____

Name: (Last) _____ (First) _____ (MI) _____

Date of Birth: _____ Age: _____ Social Security No. _____

Address: (Street) _____ (City) _____ (State) _____ (Zip Code) _____

Home Phone: ( ) _____ Daytime Phone: ( ) _____

Cell Phone: ( ) _____ Email Address: _____
Hill Vision Services has my permission to leave messages on my voicemail: Yes____ No____

Patient's Sex: Male ____ Female ____ Marital Status: Single____ Married____ Widow____ Divorced____

Patient's Occupation: _____ Patient's Employer: _____

Patient's Employment Status: Full Time_____ Part Time____ Retired_____ Not Employed_____

IS YOUR CONDITION RELATED TO EMPLOYMENT: Yes _____ No _____

PREFERRED LANGUAGE: ☐English ☐Spanish

RACE: ☐ American Indian/Alaska Native ☐Asian ☐Black or African American ☐Hispanic

☐Native Hawaiian/Other Pacific Island ☐White

ETHNICITY: ☐Hispanic or Latino ☐Native Hawaiian/Other Pacific Island ☐Not Hispanic or Latino

PREFERRED COMMUNICATION: ____Telephone ____Mail ____Email

PHARMACY: _____ Location_____ Phone: _____

HOW DID YOU HEAR ABOUT OUR PRACTICE: _____

SPOUSE INFORMATION: Name: _____ Date of Birth: _____
Social Security No._____ Employer: _____

IN CASE OF EMERGENCY NOTIFY: _____ Daytime Phone ( ) _____

WHO IS YOUR PRIMARY CARE PHYSICIAN?_____

GUARANTOR INFORMATION (Person responsible for account):
Name: (Last) _____ (First) _____ Birth Date: _____
Address: (Street) _____ (City) _____ (State) _____ (Zip Code) _____
Phone: ( ) _____Employer_____ SSN No._____

MEDICAL INSURANCE INFORMATION:

Primary Insurance Co. _____Secondary Insurance Co. _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION:
I hereby authorize release of information necessary to file a claim with Medicare and/or my insurance company and assign benefits otherwise payable to me to the doctor or group indicated on the claims. In addition to the foregoing, I authorize the release of my medical information by or between any of my treating physicians and the Centers for Medicare & Medicaid Services (if applicable), my insurer and/or any other entity involved in the administration of my health benefits. I understand I am financially responsible for payment of this account regardless of insurance or other third party involvement. If the account is sent to an attorney or collection agency, I will be responsible for any collection fees and/or court costs. A copy of this signature is as valid as the original.

Signature_____ Date _____

Hill Vision Services

Patient Name:_____ Date:_____

Medical History / Review of Systems - Please circle all that apply

Allergies (list) _____	Coronary Artery Disease	High Blood Pressure	Migraine/Headaches
Anxiety/Depression	COPD	High Cholesterol	Radiation Treatment
Asthma	Diabetes Type I / Type II	HIV/AIDS	Rheumatoid Arthritis
Atrial Fibrillation/Arrhythmia	Dialysis/Kidney Disease	Hyperthyroidism	Seizures
BPH	GERD	Hypothyroidism	Sjogrens Syndrome
Cancer (list type)_____	Heart Attack	Leukemia/Lymphoma	Stroke
_____	Hepatitis	Lupus	Other_____

Past Surgeries - Please circle all that apply (Write the date if known)

Heart Surgery (Date/type, if known)_____

Brain Surgery/Neurosurgery (Date/type, if known)_____

Organ Transplantation (Date/type, if known)_____

Skin Cancer Removal (Date/type, if known)_____

Hysterectomy (Date, if known)_____

Other major surgeries: _____

_____

_____

_____

_____

Ocular History - Please circle all that apply (Circle which eye, if known)

Allergies/Allergic Conjunctivitis	Diabetic Retinopathy (R/L/Both)	Glaucoma (R/L/Both)
Blepharitis	Dry Eye	Macular Degeneration (R/L/Both)
Cataract (R/L/Both)	Eye Injury (R/L/Both)	Retinal Detachment (R/L/Both)
Corneal Dystrophy	Epiretinal Membrane/Macular Pucker (R/L/Both)	Red Eyes (R/L/Both)
Crossed Eye/Lazy Eye (R/L/Both)	Floaters (R/L/Both)	Other: _____

Ocular Surgeries - Please circle all that apply (Write the date if known)

Cataract Surgery R (Date)_____	Glaucoma Surgery R (Date)_____	Intravitreal Injection R (Most recent date)_____
Cataract Surgery L (Date)_____	Glaucoma Surgery L (Date)_____	Intravitreal Injection L (Most recent date)_____
Corneal Transplant R (Date)_____	YAG Capsulotomy R (Date)_____	Other Eye Surgeries:_____
Corneal Transplant L (Date)_____	YAG Capsulotomy L (Date)_____	_____
LASIK (Date)_____	Retinal Detachment Repair R (Date)_____	_____
Eyelid Surgery (Date)_____	Retinal Detachment Repair R (Date)_____	_____

Medications (List all, including over the counter and supplements):_____

_____

Medication Allergies: No ___ Yes (Please list):_____

Social History

Tobacco Use: **By selecting an option below, I am acknowledging that HVS recommends non-smoking or discontinuation of smoking to prevent macular degeneration, cataracts, dry eye, and other eye diseases.**

Tobacco Use (Please circle one below):

- Never Smoker
- Former Smoker (Date quit:_____)
- Current Smoker (_____ pack(s) per day)

Alcohol Use (Please circle one below):

- Never drink
- Occasional drink
- 1 drink per day
- 3 or more drinks per day

Recreational Drug Use (Please circle one below):

- No
- Yes (if yes, please specify)_____

Family History – Please circle all that apply, if known

Glaucoma: (Father/Mother/Siblings/Children)

Retinal Detachment: (Father/Mother/Siblings/Children)

Corneal Dystrophy: (Father/Mother/Siblings/Children)

Crossed Eye/Lazy Eye: (Father/Mother/Siblings/Children)

Macular Degeneration: (Father/Mother/Siblings/Children)

High Blood Pressure: (Father/Mother/Siblings/Children)

Diabetes: (Father/Mother/Siblings/Children)

Physician Signature:_____ Date:_____

Hill Vision Services, LLC

Patient Financial Policy

Thank you for choosing our practice. We are committed to the success of your medical care. Please understand that payment of your bill is part of this care. To help avoid misunderstandings, we ask our patients to read and acknowledge the following financial policy.

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and co-payments for participating insurance companies. Hill Vision Services, LLC accepts cash, personal checks (in-state and Illinois only), VISA, MasterCard and Discover.

Patients with an outstanding balance of 60 days overdue must make arrangements for payment prior to scheduling appointments.

INSURANCE/SERVICES:
We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and co-payment at the time of service. If we have not received payment from your insurance company within 45 days of the date of service, you will be expected to pay the balance in full. You are responsible for all charges.

INSURANCE/OPTICAL MATERIALS:
We participate with VSP, VBA and Eyemed and will bill these insurance companies as a courtesy to you. You are responsible for your co-payment at time of purchase. You are responsible for knowing your optical benefits. If you have vision benefits with a different vision carrier other than VSP, VBA or Eyemed but still choose to purchase your eyewear from Hill Vision Services, Hill Vision Services assumes that you are waiving your right to use your other vision benefits. Payment is expected at the time order is placed. You are responsible for all charges.

If you need assistance or have questions, please contact Hill Vision Services between 8:00 a.m. and 4:00 p.m. Monday through Friday at 314-567-7771.

REFUNDS:
Overpayments will be refunded upon written request to the responsible party within 30 days.

MANAGED CARE:
If you are enrolled in a managed care insurance plan that requires a **referral** to see our doctors, you must bring the **referral** with you or make arrangements to have it sent to our office prior to your appointment.
NO retroactive referrals are allowed.

MISSED APPOINTMENTS/LATE CANCELLATIONS:
Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 48 hours prior to the appointment. There will be a $50.00 charge for all canceled or missed appointments not canceled 48 hours (2 business days) prior to the scheduled appointment time. Excessive abuse of scheduled appointments may result in discharge from the practice.

Acknowledgment

I have read, understand and agree to the above Financial Policy. I understand that charges not covered by my insurance, as well as applicable co-pays and deductibles, are my responsibility. I authorize insurance benefits be paid directly to Hill Vision Services, LLC, and I authorize them to release any pertinent medical information to facilitate payment of a claim.

I have received a copy of this policy.

Date	Signature of Responsible Party	Printed Name	Printed Name (if different)

HILL VISION SERVICES, LLC

Acknowledgement of Receipt of Notice of Privacy Practices
&
Authorization to Release Information to Specified Family Members and Close Friends

PATIENT NAME:_____ **D.O.B.:**_____

Acknowledgement of Receipt

Hill Vision Services, LLC reserves the right to modify the privacy practices outlined in the notice.

Signature

I have received a copy of the Notice of Privacy Practices for **Hill Vision Services, LLC.**

_____ _____

Signature of Parent/Guardian/Patient Date

_____

Relationship of Patient Representative to Patient

Inability to Obtain Acknowledgement of Receipt

An attempt was made to obtain an acknowledgement of receipt of the Notice of Privacy Practices on _____. The acknowledgement was not obtained because:

- ☐ The parent/guardian/patient declined to sign the acknowledgement
- ☐ Other_____

_____ _____

Signature/Printed Name of Staff Member Date

Authorization to Release Health Information to Family Members & Close Friends

I authorize **Hill Vision Services, LLC** to disclose health information to the following family members and/or close friends to the extent necessary to help with your healthcare or with payment for your healthcare.

Name	D.O.B. or S.S.N	Name	D.O.B. or S.S.N

_____ _____

Signature of Parent/Guardian/Patient Date

_____

Relationship of Patient Representative to Patient

HILL VISION SERVICES, LLC
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW CAREFULLY

Uses and Disclosures

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided and the medical condition being treated.

Health care operations: Your health information may be used when necessary to support day-to-day activities and management of Hill Vision Services, LLC. For example, information on the services you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality.

Law enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations and to comply with government mandated reporting.

Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment reminders: Your health information will be used by our staff to call or send you appointment reminders.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- the right to request restrictions in the use and disclosure of your protected health information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected health information has been disclosed
- the right to receive a printed copy of this notice

Hill Vision Services, LLC Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in your policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Request to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the receptionist(s) or the Privacy Official. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Attn: Privacy Official
Hill Vision Services, LLC
522 North New Ballas Rd. Suite 113
St. Louis, MO 63141

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Effective Date: This notice is effective on or after **July 4, 2007.**