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Creve Coeur, MO 63141  
300 Medical Plaza, Suite 140  
Lake St. Louis, MO 63367

112 Magnolia Drive  
Glen Carbon, IL 62034

Dear \_\_\_\_\_:

**Welcome to Hill Vision Services!**

Your appointment is scheduled on: Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_\_

At our: ☐ Creve Coeur Office ☐ Lake St. Louis Office ☐ Glen Carbon, IL Office

In order to make your first visit go as smoothly as possible, please review and/or complete the following prior to your visit.

- If you have been treated by another optometrist or ophthalmologist, please contact that doctor to authorize sending us any pertinent records prior to your appointment.
- Check your medical insurance very carefully. If you are being seen for a medical reason, your insurance may require that you get a referral from your primary care physician prior to your visit with us. If you are being seen for a routine eye exam, check your insurance to see if you have routine vision benefits. **In order to maximize your insurance benefits, it is very important for this information to be obtained prior to your visit.**
- **Bring your insurance card(s) and a photo I.D. with you to your visit.**
- Complete the enclosed **Patient Information Record** and **Patient Medical History** and bring the completed forms with you.
- Read the enclosed **Hill Vision Services LLC Notice of Privacy Practices** prior to your visit. Complete the enclosed **Acknowledgment of Receipt of Notice of Privacy Practices and Authorization to Release Information** and bring the completed form with you
- Read and sign the **Patient Financial Policy** and bring the signed form with you
- Remember to bring your most current eyeglasses and/or contact lenses.

**There may be a \$50.00 charge for canceled or missed appointments not canceled 48 hours (2 business days) prior to the scheduled appointment time.**

We look forward to seeing you!

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**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 a message 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 ☐ Other \_\_\_\_\_RACE: ☐ America Indian/Alaska Native ☐ Asian ☐ Black or African American  
☐ Hispanic ☐ Native Hawaiian/Other Pacific Island ☐ WhiteETHNICITY: ☐ Hispanic or Latino ☐ Native Hawaiian/Other Pacific Island ☐ Not Hispanic or LatinoPREFERRED COMMUNICATION: ☐ Telephone ☐ Mail ☐ EmailPREFERRED OFFICE: ☐ Creve Coeur ☐ Lake St. Louis ☐ Glen Carbon

PHARMACY: \_\_\_\_\_ Location \_\_\_\_\_ Phone: \_\_\_\_\_

HOW DID YOU HEAR ABOUT OUR PRACTICE: \_\_\_\_\_

**SPOUSE INFORMATION:** Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ 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 foregoing, I authorize the release of my medical information by or between any of my treating physicians and the Centers of 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 \_\_\_\_\_

|                                          |                                          |
|------------------------------------------|------------------------------------------|
| Reviewed (by patient): _____ Date: _____ | Reviewed (by patient): _____ Date: _____ |
| Reviewed (by patient): _____ Date: _____ | Reviewed (by patient): _____ Date: _____ |

## Hill Vision Services – NEW PATIENT Medical History

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

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

### 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) | Floater ( R / L / Both)                           | Other: _____                        |

### Ocular Surgeries – Please circle all that apply

|                                         |                                                  |                                   |
|-----------------------------------------|--------------------------------------------------|-----------------------------------|
| Cataract Surgery Right Eye ~ Left Eye   | Glaucoma Surgery Right Eye ~ Left Eye            | Lasik                             |
| Yag Capsulotomy Right Eye ~ Left Eye    | Eyelid Surgery – Right Eye ~ Left Eye            | Other <b>Eye</b> Surgeries: _____ |
| Corneal Transplant Right Eye ~ Left Eye | Retinal Detachment Repair - Right Eye ~ Left Eye | _____                             |

### EYE DROPS (INCLUDING ARTIFICIAL TEARS)

\_\_\_\_\_  
\_\_\_\_\_

### Medical History / Review of Systems

|                                            |                         |                     |                      |
|--------------------------------------------|-------------------------|---------------------|----------------------|
| <b><u>Please circle all that apply</u></b> | Coronary Artery Disease | High Blood Pressure | Migraine/Headache    |
| 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

|                              |                     |                              |                  |
|------------------------------|---------------------|------------------------------|------------------|
| Heart Surgery                | Hip Replacement     | Brain Surgery / Neurosurgery | Knee Replacement |
| Organ Transplantation        | Skin Cancer Removal | Hysterectomy                 |                  |
| Other major surgeries: _____ |                     |                              |                  |

### Medications (Names ONLY – dosage and frequency NOT NEEDED -including over-the-counter and supplements – OR – provide list)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medication Allergies:** No \_\_\_\_\_ Yes (Please list): \_\_\_\_\_

### Social History

Tobacco use: **By selection 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: \_\_\_\_\_ Never Smoker ~ \_\_\_\_\_ Former Smoker (Date quit: \_\_\_\_\_) ~ \_\_\_\_\_ Current Smoker (\_\_\_\_\_ pack(s) per day)

Alcohol Use: \_\_\_\_\_ Never drink ~ \_\_\_\_\_ Occasional drink ~ \_\_\_\_\_ 1 drink per day ~ \_\_\_\_\_ 3 or more drinks per day

Recreational Drug Use: \_\_\_\_\_ No ~ Yes (If yes, please specify) \_\_\_\_\_

### Family History – Please circle all that apply, if known

|                                                         |                                                         |
|---------------------------------------------------------|---------------------------------------------------------|
| Glaucoma: (Father/Mother/Siblings/Children)             | Macular Degeneration: (Father/Mother/Siblings/Children) |
| Retina Detachment: (Father/Mother/Siblings/Children)    | High Blood Pressure: (Father/Mother/Siblings/Children)  |
| Corneal Dystrophy: (Father/Mother/Siblings/Children)    | Diabetes: (Father/Mother/Siblings/Children)             |
| Crossed Eye/Lazy Eye: (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 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. For worker's compensation, if your visit is deemed not work related, your medical insurance will be billed (or self pay if you have no insurance).

**INSURANCE/OPTICAL MATERIALS:** We participate with VSP, VBA, Eyemed, Davis, and Spectera vision plans and we will bill these insurance companies as a courtesy to you. You are responsible for your co-payment at the 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, Eyemed, Davis, or Spectera but still choose to purchase your eyewear from Hill Optical, we assume that you are waiving your right to use your other vision benefits. Payment is expected at the time orders are placed. You are responsible for all charges.

**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 an **insurance 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 REFFERALS 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 (two business days) prior to the appointment. There may be a \$50.00 charge for canceled or missed appointments not canceled 48 hours (two 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 been offered a copy of this policy.

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Date

---

Signature of Responsible Party

---

Printed Name

# 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 or your decision to revoke your authorization.

**ADDITIONAL USES OF INFORMATION:** Your health information will be used by our staff to call or send you appointment reminders.

# HILL VISION SERVICES, LLC

## NOTICE OF PRIVACY PRACTICES

**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 and 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 general 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  
12601 Olive Blvd  
Creve Coeur, 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.

**Hill Vision Services, LLC**  
***Acknowledgment of Receipt of Notice of Privacy Practices & Authorization to Release  
Information to Specified Family Members and Close Friends***

**PATIENT NAME:** \_\_\_\_\_ **D.O.B.:** \_\_\_\_\_

**ACKNOWLEDGMENT OF RECEIPT**

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

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

\_\_\_\_\_  
Signature of patient/parent/guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship of Patient Representative to Patient

**INABILITY TO OBTAIN ACKNOWLEDGMENT OF RECEIPT**

An attempt was made to obtain an acknowledgment of receipt of the Notice of Privacy Practices on \_\_\_\_/\_\_\_\_/\_\_\_\_. The acknowledgment was not obtained because:

\_\_\_\_ The patient/parent/guardian declined to sign the acknowledgment

\_\_\_\_ 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 SSN | NAME | D.O.B. OR SSN |
|------|---------------|------|---------------|
|      |               |      |               |
|      |               |      |               |
|      |               |      |               |
|      |               |      |               |

\_\_\_\_\_  
Signature of patient/parent/guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship of Patient Representative to Patient

Reviewed (by patient): \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed (by patient): \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed (by patient): \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed (by patient): \_\_\_\_\_ Date: \_\_\_\_\_

Map to Hill Vision Services New Location ★  
(Beginning 9/1/17)

