Dr. Black's eye associates

Kristopher Pugh, M.D.
Curtis Jordan, M.D.
Edwin Apenbrinck, M.D.
Steven Howell, M.D.
Jacob Yunker, M.D.
Thomas Harper, M.D.
Lori Williams, M.D.

Carolyn Hall, O.D.
Michael Dankovich, O.D.
Melinda Gunn, O.D.
Pat Moss, O.D.
Jessica Pugh, O.D.
Rob Steller, O.D.

Dana Conway, O.D.
Jennifer Kellems, O.D.
Renee Compton, O.D.
John Eagleson, O.D.
Laura Rose, O.D.
Cami Helton, O.D.

(888) EYE-CARE
www.Have2020.com

For Office Use Only:
Date:_____
Location:_____
Doctor:_____

REGISTRATION OF A MINOR PATIENT

PATIENT INFORMATION

NAME:_____ RACE_____

ADDRESS:_____ ETHNICITY_____

CITY:_____ STATE/ZIP:_____ LANGUAGE_____

HOME PHONE:_____ EMAIL:_____

SOCIAL SECURITY NUMBER:_____ SEX: ☐ MALE ☐ FEMALE

DATE OF BIRTH:_____

REFERRING DR.:_____ FAMILY DR.:_____

EMERGENCY CONTACT

Please list a friend or relative who lives outside your home:

_____

NAME PHONE NUMBER PATIENT'S RELATIONSHIP TO THIS CONTACT

RESPONSIBLE PARENT INFORMATION

NAME:_____

ADDRESS:_____

CITY:_____ STATE/ZIP:_____

HOME PHONE:_____ WORK PHONE:_____ EMAIL:_____

EMPLOYER'S NAME:_____

SOCIAL SECURITY NUMBER:_____ SEX: ☐ MALE ☐ FEMALE

DATE OF BIRTH:_____

EMAIL ADDRESS:_____

ACCOMPANYING PARENT INFORMATION

NAME:_____

ADDRESS:_____

CITY:_____ STATE/ZIP:_____

HOME PHONE:_____ WORK PHONE:_____ EMAIL:_____

EMPLOYER'S NAME:_____

SOCIAL SECURITY NUMBER:_____ SEX: ☐ MALE ☐ FEMALE

DATE OF BIRTH:_____

INSURANCE INFORMATION:

PRIMARY INSURANCE CO.:_____

SUPPLEMENTAL INSURANCE CO.:_____

*Please give your insurance cards to us so we may make a copy for our records.
* Please make sure to sign and date the indicated areas on the reverse of this form.

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PERMISSION "AUTHORIZATION" FORM

302 W. 14th Street, Suite100
Jeffersonville, IN 47130
812.284.0660

1407 Spring Street
Jeffersonville, IN 47130
812.590.6220

1919 State Street, Suite 140
New Albany, IN 47150
812.948.4680

1350 S. Jackson Street
Salem, IN 47167
812.896.1717

215 E. Chestnut Street
Corydon, IN 47112
812.738.2278

441 Green Road
Madison, IN 47250
812.273.2020

1356 N. Gardner Street
Scottsburg, IN 47170
812.752.2020

1154 S. Ripley Estates Drive
Versailles, IN 47042
812.689.4721

732 High Street
Brandenburg, KY 40108
270.422.4241

1102 Lyndon Lane, Suite A
Louisville, KY 40222
502.426.0307

102 Diagnostic Drive
Frankfort, KY 40601
502.223.8258

Permission, "Authorized" form:

This authorization gives Eye Associates of Southern Indiana the permission to disclose your health information to the designated person of YOUR choice. It is a "blanket" authorization.

If you want your authorization to be more precise and/or to "whom" we may disclose it, please let us know.

For example:

- It gives us permission to give your testing results and/or appointment information to your spouse or designated family member or significant other, at no specified time, date, tests or appointments.
- It gives us permission to leave your results and/or information about an appointment on your answering machine at no specified date, time, or appointment.
- It give us permission to give your medication samples to this designated person at no specific time or date.

I,_____, give the staff and physicians at Eye Associates of Southern Indiana permission to disclose my protected health information for patient _____ to the following person (s):

My spouse_____

My children_____

Another family member or significant other_____

Date:_____

Your rights are explained on the "Notice of Privacy Practices" that you have been given.
Any questions regarding this form may be directed to our Privacy Officer.

I authorize treatment of the person named on the front of this form. I have read the following "insurance claim filing" information and agree to pay all fees for such treatment if denied by my insurance carrier.

INSURANCE CLAIM FILING

MEDICARE: We will file all services to your Medicare. You will be responsible for any deductible, copayment, or non-covered services. We are a Medicare Provider. STATE MEDICAID: We will file all services to your State Medicaid. You will be responsible for any balance as determined by your Medicaid policy. We are a Medicaid Provider. ALL OTHER INSURANCE: We will file all services not covered by your carrier(s) as a courtesy to you. You will be responsible for any services not covered by your carrier that would not otherwise be adjusted due to any contract we may hold with your insurance carrier. Your responsibility may include, but will not be limited to copay, deductible, or charge derived due to an exclusion in your policy, such as routine eye exam coverage, or lack of a referral number if your policy requires one. I request that payment of authorized benefits be paid on my behalf to Eye Associates for any services furnished. I authorize any holder of medical information about me to release to the HCFA and its agents any information needed to determine these benefits payable for services.

Signature:_____ Date:_____

By signing below I give permission for Eye Associates, to access my pharmacy benefits data electronically through RxHub.

This consent will enable Eye Associates to:

- Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RxHub.

Signature:_____ Date:_____

Our practice, Eye Associates of Southern Indiana, participates with Nextgen Healthcare Information Systems, LLC and the Nextgen Patient Portal. To better communicate and allow you to manage your medical records we will create a login and password for you for your Patient Portal account. To do so, we accept the Terms and Conditions of the Next-gen Patient Portal website for you. When logging in for your first time, go to Have2020.com and select Patient Portal. The link provides you with the Terms and Conditions in its entirety. By signing this document, I agree to the Terms and Conditions of the Nextgen Patient Portal. By signing below, I ask Eye Associates to complete my enrollment and accept the Terms and Conditions on my behalf. I agree that I was offered a copy of the Terms and Conditions and that I may cancel this account at any time.

Signature:_____ Date:_____

I acknowledge and agree that Eye Associates and any affiliates, including collection and billing companies, may contact me by telephone, email or text message to any telephone number I provided to you, and any other telephone number associated with my account, including wireless or mobile telephone numbers. I further agree that you may use any method of contact to these numbers, such as Automated Telephone Dialing System (ATDS) or prerecorded message. I also agree that I will notify Eye Associates if I have given up ownership or control of any such telephone number.

Signature:_____ Date:_____

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CHILD MEDICAL HISTORY

Patient Name:_____ Date:_____

Pediatrician/Primary Care Physician_____ Pharmacy:_____

Date of Birth:_____ Date of Last Eye Exam:_____

Ethnicity: Hisp____ Non Hisp____ Preferred Language: English / Other_____ Race:_____

Eye Symptoms

	YES	NO		YES	NO		YES	NO		YES	NO
Eye Crossing			Burning			Redness			Floaters or Spots		
Eye Squinting			Tearing			Discharge			Blurred Vision		
Eye Drifting			Itching			Pain			Loss of Vision		

Other _____

Review of Systems - Please answer YES or NO for each question

	YES	NO		YES	NO		YES	NO		YES	NO
Fever			Cough			Rash			Muscle Weakness		
Fatigue			Chest Pain			Cold Intolerance			Bleeding/Bruising		
Increased Urination			Sore Throat			Heat Intolerance			Seasonal Allergies		
Increased Thirst			Congestion			Food Allergies			Dizziness		
Abdominal Pain			Nausea			Joint Pain			Shortness of Breath		
Irregular Heartbeat			Hearing Loss			Joint Swelling			Depression		

Please List medications you are currently taking (including eye medications)

Medication Name	Dosage	Medication Name	Dosage

Is patient allergic to any medications? YES ____ NO ____ If YES _____

Ocular History

	YES	NO		YES	NO		YES	NO		YES	NO
Injury			Crossed Eye			Cataracts			Retinal Detachment		
Surgery			Lazy Eye			Glaucoma			Laser Treatments		

Eye Surgery or Other Procedure _____

Medical History

	YES	NO		YES	NO		YES	NO		YES	NO
Diabetic ____yrs.			ENT/ Sinus			Cancer			Heart Disease/Stroke		
High Blood Pressure			Migraines			Thyroid			Lung Problems		
Kidney Disease			Skin Disorders			Arthritis			Immune Disorders		

Surgery/Other Procedures _____

Family History

Cataracts		Strabismus (Lazy Eye)		Near Sightedness		Retinal Detachment	
Diabetes		Amblyopia (Poor vision)		Far Sightedness		Glaucoma	

Other _____

Social History

Does anyone smoke in the child's home? YES _____ NO _____ Does the child smoke? YES _____ NO _____

Grade Level (If applicable) _____ Is the patient meeting developmental milestones? YES _____ NO _____

Hobbies _____