



**VOLD VISION**

YOUR SIGHT IS OUR VISION

2783 N. Shiloh Drive,  
Fayetteville, AR 72704

Phone: (479) 442-8653  
Fax: (479) 442-2678

**PATIENT REGISTRATION INFORMATION**

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

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Sex: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Contact Preference: \_\_\_\_\_ Consent to call:  Yes  No Consent to email  Yes  No

Patient Email: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Language: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

**SPOUSE OR RESPONSIBLE PARTY (IF PATIENT IS A MINOR)**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**REFERRAL INFORMATION**

How did you hear about Vold Vision? \_\_\_\_\_

If your doctor referred you, please list Doctor: \_\_\_\_\_ Clinic: \_\_\_\_\_



U of A Razorback Athletes: Please list sport(s) \_\_\_\_\_

We are proud to be the Official Eye Care Provider of the Arkansas Razorbacks

3919 Mall Ave., Fayetteville, AR 72703  
1517 Gene George Blvd., Springdale, AR 72762  
1102 NW Lowes Ave., Bentonville, AR 72712

INSURANCE INFORMATION

Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

PRIMARY INSURANCE

Policy holder name: \_\_\_\_\_

DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Insurance Name: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Relationship to policy holder:  Self  Spouse  Child  Other

Employer's Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

SECONDARY INSURANCE

(OR VISION INSURANCE)

Policy holder name: \_\_\_\_\_

DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Insurance Name: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Relationship to policy holder:  Self  Spouse  Child  Other

Employer's Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

DISCLOSURE OF HEALTH INFORMATION

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatments. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operation and that the organization is not required to agree to the restriction requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I grant permission to speak with the following people regarding my health information: \_\_\_\_\_

Signature of Patient or Legal Representative/Witness

Date, Notice Effective Date or Version

CONSENT TO CALL

I consent to receive  calls  texts from Vold Vision for my protected healthcare and other services.

Patient Signature: \_\_\_\_\_

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

NOTICE OF NONCOVERED REFRACTION SERVICES TO PATIENTS

Definition of REFRACTION: The refraction test is an eye examination that measures a person’s ability to see an object at a specific distance.

Medicare and most commercial insurance plans do not cover refractions. If it is determined that you need to have this test and your insurance does not pay for it, you will be held responsible for paying that portion of the exam fees at the time of service along with your co-pay and deductible if not met yet.

By signing, I understand that the refraction may not be a covered service under my insurance plan. If I want a glasses prescription update/renewal or other eye services performed today, I agree to pay any fees related to this non-covered service along with my co pay and deductible.

Patient Signature: \_\_\_\_\_

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

MEDICAL HISTORY

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

DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Last Eye Exam: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Have you ever had surgery on your eye(s):  No  Yes If yes, please list surgery: \_\_\_\_\_

Do you have any allergies to medication?  No  Yes If yes, please list medication name and explain reaction(s): \_\_\_\_\_

Do you have any allergies to latex?  No  Yes If yes, explain reaction: \_\_\_\_\_

Do you have any allergies to Betadine or Iodine?  No  Yes If yes, explain reaction: \_\_\_\_\_

Do you take any medications?  No  Yes If yes, list the name of medication, milligram dosage and how often you take it (including oral contraceptives, aspirin, over-the-counter medications, and home remedies) \_\_\_\_\_

List all major injuries, surgeries, and/or hospitalizations you have had: \_\_\_\_\_

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, cataracts, retinal disease, eye infections or injury: \_\_\_\_\_

Are you pregnant and/or nursing?  No  Yes If yes, what trimester? \_\_\_\_\_

Do you wear glasses?  No  Yes If yes, how old is your present pair of lenses? \_\_\_\_\_

Do you wear contact lens?  No  Yes If yes, how old is your present pair of lenses? \_\_\_\_\_

Type of current contact lenses:  Rigid  Soft  Daily  Bi-Weekly  Monthly  Extended Wear  
 Mono Vision  Multi-Focal  Other \_\_\_\_\_

Are they comfortable?  No  Yes

SOCIAL HISTORY

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

DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Yes, I prefer to discuss my Social History information directly with the doctor.

No, I will discuss my social history with a technician

Do you drive?  Yes  No If yes, do you have visual difficulty when driving?  No  Yes If yes, please describe here: \_\_\_\_\_

Do you use Tobacco products?  No  Yes  Current  Past If past, when did you stop? \_\_\_\_\_

If Yes,  cigarettes  chew  cigar  smokeless tobacco How much do you use/how long? \_\_\_\_\_

Do you drink alcohol?  No  Yes If yes  Beer  Wine  Liquor

Do you drink daily?  No  Yes

Do you use illegal drugs?  No  Yes If yes, type/amount/how long: \_\_\_\_\_

Have you ever been exposed to or infected with:  Gonorrhea  Hepatitis  HIV  Syphilis

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children, living or deceased) for the following conditions:

Disease/Condition	No	Yes	?	Relationship
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other: _____				_____

REVIEW OF SYSTEMS

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

DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Do you currently, or have you ever had, any problems in the following areas? Circle All that Apply:

<p>Constitutional Fever, Weight Loss/Gain, Fatigue, Night Sweats, Weakness</p> <p>Integumentary Skin, Hair Loss, Rash, Skin Lesions</p> <p>Neurological Headaches Migraines Seizers Stroke Numbness Tingling Balance Problems</p> <p>Eyes Loss of Vision Blurred Vision Distorted Vision/Halos Loss of Side Vision Double Vision Dryness Mucous Discharge Redness Sandy or Gritty Feeling Itching Burning Foreign Body Sensation Excess Tearing/Watering Glare/Light Sensitivity Eye Pain or Soreness Chronic Eye/Lid Infection Sties or Chalazion Flashes/Floaters in Vision Tired Eyes</p> <p>Genitourinary Genital Discharge Genital Lesions Painful Urination Urgency Frequent Urinary Tract Infection Have you ever been on dialysis?</p> <p>Cancer</p> <p>Thyroid Problems</p>	<p>Ear, Nose, Mouth, Throat Seasonal Allergies Itching Hives Sinus Congestion Runny Nose Post-Nasal Drip Chronic Cough Dry Throat/Mouth</p> <p>Respiratory Asthma Chronic Bronchitis Emphysema Cough Trouble Breathing Wheezing Shortness of Breath COPD Pneumonia Use Oxygen</p> <p>Vascular/Cardiovascular Heart/Chest Pain Vascular Disease Heart Attack Rheumatic Fever Heart Failure Irregular Heartbeat High Cholesterol</p> <p>Gastrointestinal Chronic Diarrhea Chronic Constipation</p> <p>HEENT Dizziness Hearing Loss Hoarseness Ringing in Ears Sore Throat</p> <p>Bones/Joints/Muscles Rheumatoid Arthritis Muscle Pain Joint Pain Back Pain Stiffness or Swelling</p>	<p>Lymphatic/Hematologic Anemia Bleeding Problems Bruising Tender Nodes Hepatitis Cirrhosis</p> <p>Allergic/Immunologic</p> <p>Psychiatric Anxiety Depression Insomnia Irritability Nervousness</p> <p>Endocrine Thyroid/Other Glands</p> <p>High Blood Pressure: Well Controlled Borderline Control Poor Control Unknown BP Control</p> <p>Diabetic Well Controlled Borderline Control Poor Control Unknown Diabetic Control</p> <p>Metabolic Cold Intolerance Excess Hunger Excessive Thirst Frequent Urination Heat Intolerance</p> <p>Heart Burn/GERD</p> <p>Assistive Devices Dentures Hearing Aides Cane Walker Wheelchair</p>
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If you answered yes, or have a condition not listed, please explain and list medications: \_\_\_\_\_

Doctor Signature: \_\_\_\_\_

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

HIPAA ACKNOWLEDGEMENT

I hereby acknowledge that I have been made aware that Vold Vision has a privacy policy in place in accordance with the Health Insurance Portability Act of 1996 (HIPAA). As a patient, I acknowledge that Vold Vision has a privacy policy in effect and has made this policy available to me. I am entitled to an additional copy of the privacy policy if I desire. I authorize the release of any previous results or images in the event Vold Vision is in need of them to help with the diagnosis of my procedure today. I permit a copy of this authorization to be used in place of the original. I understand and acknowledge that I am personally responsible for the services rendered at this facility. Vold Vision will bill my insurance carrier as a courtesy. In the event of non-payment I understand I will be responsible for any outstanding balances.

Patient Signature: \_\_\_\_\_

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

MEDICAID WAIVER

Medicaid will only pay for services that they deem "necessary" and that are filed in a timely manner. If for any reason Medicaid does not pay your charges due to your lack of benefit knowledge or the correct procedures are not followed, you as the patient are responsible for all charges. Your signature is required to ensure that you are aware of your responsibilities. This is an agreement that you are willing to pay any charges that Medicaid denies. If for any reason you do not present to the office with your Medicaid card before your scheduled appointment with the physician you will be asked to reschedule or you will be considered self-pay for the duration of care.

Patient Signature: \_\_\_\_\_

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

Witness Signature: \_\_\_\_\_

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

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Vold Vision any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services as well as obtaining a copy of my credit report in order to conduct daily operations if needed. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated on this form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible coinsurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature of Insured or Beneficiary: \_\_\_\_\_

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

FINANCIAL POLICY

PAYMENT & FEES Payment for your care is due at the time provided. The only exception to this policy is if we are contracted with your health insurance plan (see instructions below). The fee for an office visit will range from \$90.00 to \$300.00. Cash, check, MasterCard, Visa, and Discover are acceptable payment methods.

INSURANCE You are required to present your insurance identification card at the time of your appointment. We will file a claim for your services if we are contracted with your health insurance plan. Please, verify in advance that the physician you have chosen to see is contracted with your plan. Any co-payment, co-insurance, and/or deductible is due at the time of service. Please be prepared to pay this amount. A co-payment is normally a fixed dollar amount per office visit, identified on your insurance card. Co-insurance is the percentage of the bill that is the patient’s responsibility. A deductible is a fixed dollar amount that must be paid before the insurance will begin to pay. Again, if you do not have your current insurance identification card or other acceptable proof of insurance, your visit will be considered private pay and you will be responsible for full payment at the time of service.

It is, at all times, your responsibility to follow up on all requests from your insurance company regarding claims and to question any unpaid insurance claims. If you do not receive an explanation of benefits from your insurance within 60 days of your visit, please call them. After insurance has processed your claim, you will be billed for any remaining balance or non-covered services. This amount is due upon receiving your statement. Your insurance makes the final determination regarding payment at the time the claim is processed.

REFERRAL If your insurance plan requires a referral, it is your responsibility to request the referral from your primary care physician to be sent to our office. Failure to obtain a referral when required can result in reduced benefits or non-payment by your insurance company, making you responsible for payment of the visit.

I, the undersigned, have read and understand the financial policy as described above and agree to pay for any and all medical services including, portions not covered or denied by my insurance. Failure to pay in a timely manner will result in my account being turned over to an outside collection agency.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with \_\_\_\_\_ And assign directly to Vold Vision all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits to include obtaining a copy of my credit report as needed. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_



## 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 it carefully. You have the right to obtain a paper copy of this notice upon request.

<p><b>Patient Health Information</b> Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.</p> <p><b>How we use your patient Health Information</b> We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission</p> <p><b>Examples of Treatment, Payment, and Health Care Operations</b> Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacist who are filling your prescriptions, and to family members who are helping with your care.</p> <p>Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.</p> <p><b>Health Care Operations:</b> We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it. <b>Special Uses</b> We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. <b>Other Uses and Disclosures</b> We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes: <b>Required by Law:</b> We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events. <b>Research:</b> We may use or disclose information for approved medical research.</p>	<p><b>Public Health Activities:</b> As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.</p> <p><b>Health oversight:</b> We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.</p> <p><b>Judicial and administrative proceedings:</b> We may disclose information in response to an appropriate subpoena or court order.</p> <p><b>Law enforcement purposes:</b> Subject to certain restrictions, we may disclose information required by law enforcement officials.</p> <p><b>Deaths:</b> We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies</p> <p><b>Serious threat to health or safety:</b> We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.</p> <p><b>Military and Special Government Functions:</b> If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.</p> <p><b>Workers Compensations:</b> We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.</p> <p><b>Individual Rights</b> You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.</p> <p><b>Request Restrictions:</b> you may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions. Also, if you have paid for your healthcare treatment out-of-pocket and in full, and if you request that we limit disclosure of your information to a health plan for purposes of payment or healthcare operations, we will abide by your request.</p> <p><b>Confidential Communications:</b> You may ask us to communicate with you confidentially by, for example, sending notices to a special address</p>	<p>or not using postcards to remind you of appointments.</p> <p><b>Inspect and Obtain Copies:</b> In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for copies.</p> <p><b>Amend Information:</b> if you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.</p> <p><b>Accounting of Disclosures:</b> You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.</p> <p><b>Our Legal Duty</b> We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect</p> <p><b>Changes in Privacy Practices</b> We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.</p> <p><b>Complaints</b> If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.</p> <p><b>Contact Person</b> If you have any questions, request, or complaints, please contact:  <div style="text-align: center;">                     Vold Vision                      2783 N. Shiloh Drive Fayetteville, AR 72704                      479-442-8653                 </div> </p> <p><b>Effective Date:</b> _____                  I, _____ Hereby acknowledge receipt of the Notice of Privacy Practices given to me.                  Signed: _____                  If not signed, reason why acknowledgement was not obtained: _____                  _____                  Staff Witness seeking acknowledgement: _____</p>
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