InfantSEE™ Confidential Infant History
Assessment Date: ____/____/____

Name: _____ Male ___ Female___ DOB:_____/_____/_____

Home Phone: _____ Hispanic | Caucasian | African American | Native American | Asian | Pacific Islander

Home Address: _____
Street City State Zip Code

Parent(s) or Guardian(s): _____ Adult(s) Occupation:_____

How did you learn about our program? ☐Current patients ☐Referred by friends/family ☐Print Ads ☐Radio Ads ☐Website ☐Story in Newspaper/on TV ☐ Referred by Dr._____

Eye History
Have you ever noticed any of the following happening with your baby's eyes? (please check any that apply)

Eye turn: ☐ in ☐ out ☐ Eyes watering ☐ Eyes red ☐ Swelling around the eyes ☐ White appearance in pupil

Explain any eye concerns noted by observing child: _____

Developmental and Health History

PREGNANCY
Length of pregnancy: _____ weeks List any complications during pregnancy: _____

Other pregnancy issues: _____

DELIVERY
Birth Weight _____ Parents ages at time of birth: Mother _____ Father _____

List any complications during delivery: _____

Was oxygen used? ☐ No ☐ Yes APGAR score at birth: _____ (if known)

MEDICAL
Child's Doctor: _____ Last Exam Date: _____ Are immunizations up to date? ☐ Yes ☐ No

Does your baby have any known food or drug allergies? ☐ No ☐ Yes: _____

List ALL medications taken regularly: ☐ None List: _____

List any developmental delays: _____

Check all of the following that your baby can do at this time: ☐ Roll Over ☐ Sit ☐ Crawl ☐ Stand ☐ Walk

Has your baby ever had a high temperature (fever)? ☐ No ☐ Yes, how high? _____

Please list any childhood illnesses your baby has had:

_____ Illness _____Age at the time. Was the illness? ☐ Mild ☐ Moderate ☐ Severe

_____ Illness _____Age at the time. Was the illness? ☐ Mild ☐ Moderate ☐ Severe

List any accidents, eye, or head injuries, and age they occurred:_____

Please list any other conditions we should know about:_____

Family History
Do any family members have: Lazy eye (amblyopia) Yes No Eye turn (strabismus) Yes No Eye tumor Yes No

Please list any family members with a history of other eye or medical problems. List the relation and type of problem:

I acknowledge that this information is accurate to the extent that I can be certain, and will disclose additional information as necessary. This information can only be used in the management of my child's eyes and vision.

I understand that the InfantSEE™ vision assessment is without charge. If further services or treatments are recommended, I may choose any eye care professional to provide those services.

_____ Date: _____/_____/_____
Parent/Guardian Signature

Thank you for carefully completing this confidential questionnaire. This information will allow for a more efficient use of examination time and will contribute to the understanding of infant eye and vision development.

WELCOME TO

SPRING HILL EYECARE PLLC

See What You've Been Missing!

1. ABOUT YOU

Today's Date:____/_____/_____
Patient Name:_____
LAST FIRST MI
Preferred Name:_____ ☐Male ☐Female
Title: ☐Mr. ☐Mrs. ☐Ms. ☐Miss ☐Dr. ☐Rev. ☐Other:_____
Birthdate:___/____/_____ SS#____-____-_____
Mailing Address:_____
City:_____ State:_____ Zip:_____
Home Phone #: (_____)_____-_____
Cell Phone #:(_____)_____-_____
E-mail Address:_____

Employer Name: _____
Occupation:_____

Status: ☐Minor ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed
Spouse's Name:_____

Responsible Party If patient is a minor:
Name: _____ Birthdate: __/___/___
SS#: _____
Relationship to Patient:_____
Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____

Note: The parent/guardian/adult accompanying a minor child is responsible for full payment on the day services are provided, if not covered by insurance.

2. VISION INSURANCE INFO

VISION **Insurance**
Insurance Company:_____
Subscriber/Member ID# _____
Group #:_____
Subscriber's Name:_____
Subscriber's SS# _____
Subscriber Birthdate:___/____/____
Relation to Patient:_____
Subscriber's Employer:_____

3. MEDICAL INSURANCE INFO

Primary *MEDICAL* Insurance
Insurance Company:_____
Subscriber/Member ID# _____
Group # : _____
Subscriber's Name:_____
Subscriber's SS# _____
Subscriber Birthdate:___/____/____
Relation to Patient:_____
Subscriber's Employer:_____

Supplemental *MEDICAL* Insurance
Insurance Company:_____
Subscriber/Member ID# _____
Group # :_____
Subscriber's Name:_____
Subscriber's SS# _____
Subscriber Birthdate:___/____/____
Relation to Patient:_____
Subscriber's Employer:_____

4. IN CASE OF EMERGENCY

Whom should we contact?_____
Relation:_____
Phone #: (_____)_____-_____

Name of Primary Care Doctor:_____
Primary Care Doctor's Office:_____

Preferred Pharmacy: _____

6. CONSENT

By signing this form, I consent to treatment for myself. I give permission for the doctor(s) to examine, diagnose and initiate treatment as deemed appropriate.
Patient's Signature:_____ Date:___/___/____

SPRING HILL
EYECARE
PLLC

See What You've Been Missing!

Robert R. Szeliga, O.D.
Virgilio Gozum, O.D.
Kathryn Beckman, O.D.
5238 Main Street
Spring Hill, TN 37174

ACKNOWLEDGEMENT OF PRIVACY POLICY AND PRACTICES

I understand that in an attempt to protect the privacy of my identifiable health information, Spring Hill Eyecare, PLLC has established a ***Privacy Policy*** and guidelines for ***Privacy Practices*** within their office. This information details the use and/or disclosure of information contained in my personal medical/optometric records kept for the purpose of diagnosis, treatment, payment and health care operations. In accordance with HIPAA Regulations, a copy of the ***Notice of Privacy Practices*** of Spring Hill Eyecare, PLLC has been made available to me while in the office today. Should I choose to have a personal copy, one will be given to me at no charge.

☐ I have read, understand, and acknowledge the ***Notice of Privacy Practices*** of Spring Hill Eyecare, PLLC.

☐ I have elected not to read the ***Notice of Privacy Practices*** of Spring Hill Eyecare, PLLC.

Patient name _____

Signature (or patient's representative)_____Date_____

I understand that the Practice may wish to contact me for purposes related to my treatment such as to remind me of appointments, leave messages, or to discuss financial/billing business, or to indicate other necessary contacts.

Please Initial

_____ Yes, I authorize the Practice to contact me at the contacts (phone #s/email) I have provided. I understand and authorize the practice to leave me a voicemail message if I am unavailable.

The following people may have access to my personal health information:

Name:_____Relationship:_____

Name:_____Relationship:_____

5238 Main Street
Spring Hill, TN 37174
www.springhilleyecare.com

SPRING HILL EYECARE PLLC
See What You've Been Missing!

Phone: 931-489-1950
Fax: 931-489-1953

FINANCIAL POLICY

Thank you for choosing our office as your eye care provider. The following is a statement of our financial policy. Please read carefully prior to any services performed.

INSURED PATIENTS:

Your insurance policy is a contract between you and your insurance company. All insurance plans must be brought to our attention **prior** to receiving services/products, and we must have a copy of the most current insurance card. We will submit charges to your insurance company if we are a participating provider and if you have given us all the required information. You must notify us immediately of any change in your insurance coverage. Our staff will attempt to verify insurance coverage prior to your appointment. Although we provide this research as a courtesy, it is still the patient's responsibility to check with their insurance plan regarding their coverage and in network status. If the benefits cannot be verified, the full charge of the visit must be paid before leaving the office. Benefits are not determined by our office. It is the responsibility of the patient to know their benefits. We will not bill insurance plans after the date of service. If incorrect or expired insurance information is provided, the patient will assume full financial responsibility. Please be aware that some, and perhaps all the services provided may be considered "non-covered services" according to your policy or your eligibility. You will still be responsible for payment of these services. Additional charges may not be discovered until we receive the explanation of benefits from your insurance company, and we may be required to collect additional charges. Our office will not enter into a dispute with an insurance company, although we will work with the insurance company to sort out any confusions or questions that might arise. We cooperate fully with the regulations and requests of the insurance companies. It will be however, the responsibility of the patient to handle with the insurance company any type of dispute over payment by the company. ***If we are a non-participating provider with your insurance company, you will be responsible for charges at the time of service.*** If a patient's insurance company has not made payment to our office within 90 days, we will require the patient to pay the balance due and then seek reimbursement from the insurance company.

NON-INSURED PATIENTS:

Non-insured patients are responsible for charges in full at the time of service.

AUTHORIZATION AND REFERRALS:

If the patient's insurance plan requires a referral, it is the patient's responsibility to obtain the referral. If the referral or authorization is not received, the patient is responsible for all professional fees and materials. You will be responsible for payment of any copays, deductibles, co-insurance, or non-covered services.

MINOR PATIENT (UNDER 18 YEARS):

All minors under 18 years old must be accompanied by their parent or legal guardian. The parent/guardian accompanying the minor child is responsible for full payment of services/products that day.

PRODUCTS: When purchasing contact lenses or glasses, we require at least a 50% deposit with the balance due upon delivery of those materials. If products are not picked up within 30 days, products will be returned, the deposit will not be refunded, and any benefits will be forfeited. All materials directly shipped to you must be paid in advance. Spectacle prescription and contact lens changes must be requested within 30 days of dispensing. Eyewear and contact lenses are special order items and once ordered cannot be cancelled. There are NO RETURNS/REFUNDS for prescription or non-prescription spectacles, non-prescription sunglasses, contacts lenses or any other custom-made products. ALL SALES ARE FINAL.

PAYMENT OPTIONS:

We accept Visa, Master Card, Discover, American Express, Care Credit, cash, and checks. Please note: There will be a $30 charge for any checks returned to our office – plus any magistrate fees if further collection proceedings are deemed necessary.

COLLECTION BALANCES:

If you have a previous balance or are presently in collection, it will be required that you pay your previous balance prior to being seen again or ordering any materials. A late fee of 2% per month will be added to all balances over 30 days. Accounts past 90 days may be sent to collections. Patient agrees to pay all expenses of collection including reasonable attorney fees.

INSURANCE SIGNATURE ON FILE

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits. **I request that payment of the authorized Medicare or other insurance benefits be made on my behalf to Spring Hill Eyecare, PLLC and/or Dr. Robert R. Szeliga and Associates for services and/or materials furnished to me by Spring Hill Eyecare, PLLC and/or Dr. Robert R. Szeliga and Associates.** I authorize any holder of medical information about me to release to the Centers of Medicare and Medicaid Services and its agents any information needed to determine those benefits payable for related services. **I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If I have "other health insurance" as indicated on item 9 of the HCFA-1500 form,** or elsewhere on other approved claim forms or electronically submitted claims, **my signature authorizes releasing of the information to the insurer or agency shown.** In insurance and/or Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge; however, the patient is responsible for the deductible, copay, and coinsurance (both based upon the charge determination of the Medicare carrier) and any non-covered services.

SIGNATURE FOR ABOVE POLICIES

I HAVE READ AND UNDERSTAND ALL AREAS ABOVE. MY SIGNATURE BELOW INDICATES THAT I UNDERSTAND AND AGREE TO THESE POLICIES.

X_____

SIGNATURE of Adult Patient or Parent/Guardian of Minor Patient

_____

PRINTED NAME of Patient

Date: _____