CONCORD FAMILY VISION, PLLC

8 N State St, Concord, NH 03301 ♦ www.concordfamilyvision.com
Office: 603-225-2512 ♦ Fax: 603-225-3249

To our valued new patient, **Your appointment: ___/___/___ @ ___:___ AM PM**

Thank you for scheduling an appointment with us. It is my pleasure to welcome you to Concord Family Vision, PLLC, in advance of your first visit.

The following is some information that will help familiarize you with our practice.

Our doctors
Dr. Christopher Udina
Dr. Joseph P Larochelle
Dr. Alyssa Jann
Dr. Raymond Chew

Business hours
Monday, Tuesday, Thursday and Friday 6:50am-6:00pm
Wednesday 7:50am-5:30pm
Holiday or special hours are always updated on our website.

Payment policy
It is our payment policy to collect the appropriate payment due from the patient at the time the service is rendered or products ordered. This may only be your co-payment, deductible and/or co-insurance, but we do ask for payment at the time of your visit. We accept cash, checks and all major credit cards except American Express.

If you have any questions after reading this information, we will be happy to answer them for you prior to your visit by telephone at 603-225-2512. Also enclosed is a patient registration form, our financial acknowledgement form, the HIPAA Information and Consent, and the medical history questionnaire, to be completed prior to your scheduled visit. These forms may be faxed to 603-225-3249 or you can bring the completed forms with you to your appointment.

Please bring the following information to your visit, if you have not already faxed or brought this information to the practice prior to your scheduled visit:

* Insurance card(s) * Completed forms: Patient Info, Financial Acknowledgement, Medical history

If you are a contact lens wearer, please wear them into your appointment. If you have had previous issues with your vision, please also provide records from your past doctor. We have the release forms in the office or on our website should you need them.

We appreciate your selecting Concord Family Vision, PLLC for your medical care, and will work hard to serve your needs

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PATIENT INFORMATION SHEET

Patient Name: _____ *SS#: _____
Mailing Address: _____ Date of Birth: _____
City: _____ State: _____ Zip: _____ Home Phone: _____
Employer: _____ Work Phone: _____
Cell Phone: _____ Sex: ___M ___F Marital Status: ___M ___S ___D ___W

GUARANTOR

Must be completed if patient is under the age of 18.

Responsible Party: _____ Relationship: _____
Name: _____ *SS#: _____
Address: _____ Date of Birth: _____
Home Phone: _____ Cell Phone: _____
Employer: _____ Work Phone: _____

PRIMARY INSURANCE INFORMATION

Primary Insurance Company: _____
Identification #: _____ Group#: _____
Subscriber's Name: _____ SS#: _____
Subscriber's Date of Birth: _____ Sex: ___M ___F Relationship: _____

SECONDARY INSURANCE INFORMATION

Primary Insurance Company: _____
Identification #: _____ Group#: _____
Subscriber's Name: _____ SS#: _____
Subscriber's Date of Birth: _____ Sex: ___M ___F Relationship: _____

I certify that the above information is true and complete and consent to treatment by CFVC. I authorize the release of medical information necessary to process claims for medical benefits. I assign all insurance payments for services rendered to be paid directly to CFVC. I understand that I am financially responsible for all charges whether or not they are covered by insurance. * Social Security # is required for all.

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Signature: _____ **Date:** _____

PATIENT NAME: (print) _____

I authorize payment of medical benefits to one of the providers listed above, for professional services rendered.

I am aware that I will be responsible for any amount not paid for by my insurance.

For services provided without a referral authorization (if needed): I acknowledge that I do not have a referral today and will be responsible for payment of services should this be denied by my health plan.

For Medicare patients: Medicare does **not** cover eyeglasses or exams for eyeglasses.
There will be a charge at time of service to cover the eyeglass refraction.

I authorize the release of medical information necessary to process my claims.
I authorize the release of any insurance information and diagnosis codes to any lab used for my care.

Office policy is to give out your information only with your written approval.
Please list anyone you wish us to share your medical information with below:

_____ _____

FINANCIAL POLICY

Copayments are due at the time of service as required by ALL insurance plans.
We do participate with most insurance plans, but not all. We cannot be sure until we see your insurance card.
If you require a referral for medical visits, it is your responsibility to obtain the referral.

50% of balance on spectacle orders must be paid before order will be processed. Remaining balance must be paid at pick up. A 20% discount will be given for all orders paid in full at time of order. Contact lens orders must be paid in full at time of pick up.

Our office accepts cash, checks, VISA/MASTERCARD, and DISCOVER as payment. We will charge additional fees for all returned checks.

We reserve the right to charge patients $50 each time they do not show for their scheduled appointment or cancel an appointment with less than a 24 hour notice.

Patient Signature: _____ Date: _____

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HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

By signing this form, I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this

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consent shall remain in force from this time forward.

Signature: _____ Date: _____

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date: _____/_____/_____
Date of last eye examination: _____/_____/_____ DOB: _____/_____/_____

List all Current Medications *(prescription and over the counter)*:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Do you have ***allergies*** to any medication? ☐Yes ☐No ***If Yes, please list:***

Medication		Symptoms
1. _____	-	_____
2. _____	-	_____
3. _____	-	_____
4. _____	-	_____

ILLNESS PAST & PRESENT	YES	NO	DURATION		FAMILY HISTORY	YES	NO	RELATIONSHIP
Glaucoma					Glaucoma			
Arthritis					Arthritis			
Cancer					Cancer			
Diabetes					Diabetes			
Heart Disease					Heart Disease			
High Blood Pressure					High Blood Pressure			
Kidney Disease					Kidney Disease			
Stroke					Stroke			
Thyroid Disease					Thyroid Disease			
Asthma					Asthma			
Hay Fever or Sinus					Hay Fever or Sinus			
Emphysema					Emphysema			
Others:					Others:			

List any eye surgeries you have had *(cataract, corneal transplant, etc)*: _____

_____

List any surgeries you have had *(appendectomy, tonsillectomy, etc)*:

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_____

_____

_____

Occupation: _____

Marital Status *(check one)*: ☐Married ☐Divorced ☐Single ☐Widowed

Do you drive? ☐Yes ☐No

Have you ever had a blood transfusion? ☐Yes ☐No If yes, what year? _____

Do you smoke? ☐Yes ☐No If yes, how many packs per day? _____

Do you drink alcohol? ☐Yes ☐No If yes, how many drinks per week? _____

Do you currently have any problems in the following areas? If "YES", please provide information.

Review of Systems (examples)	**Yes**	**No**	**Explanation of Problem**
General (glaucoma, cataracts, blurred vision)			
Ears, Nose, Throat (fever, weight loss, fatigue)			
Cardiovascular (chest pain, palpitations)			
Respiratory (cough, shortness of breath, wheezing)			
Gastrointestinal (nausea, vomiting, heartburn, loss of appetite)			
Genitourinary (frequent urination, kidney stones) blood in urine)			
Musculoskeletal (joint pain, muscle weakness or pain			
Skin (rash, acne, skin cancer, warts)			
Neurological (headaches, paralysis, seizures)			
Psychiatric (depression, anxiety, memory loss)			
Endocrine (diabetes, hypothyroid)			
Hematologic (anemia, bleeding or bruising tendencies)			
Allergic/Immunologic (hay fever, lupus)			

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Office Use Only:

History reviewed. ☐No changes ☐Changes as noted above.

Date: _____/_____/_____ Doctor's Signature: _____