Hanover Family Eyecare

For All Your Eyecare Needs

Patient Name: _____ **DOB:** _____

Preferred Phone: H / W/ C _____

Patient Address: _____
Street *City* *State* *Zip*

Patient or Guardian Email Address: _____

Patient or Guardian Social: _____ **Guardian Name:** _____

Primary Insurance Member: _____ **Primary Member DOB:** _____

Relation to Primary Member: ❑Spouse ❑Child ❑Other _____

Acknowledgement of Privacy Policies (HIPPA)

I acknowledge that I have been educated on and offered a copy of this office's Notice of Privacy Policies.

INIT: _____

Insurance Authorization

I request that payment of authorized insurance benefits for any services furnished to me, be made on my behalf to Hanover Family Eyecare, PLLC. I authorize Hanover Family Eyecare, PLLC to release any medical records about me to my insurance company that may aid in determining benefits or payment. **I understand that I am responsible for charges not paid by the insurance plan.**

INIT: _____

Advanced Beneficiary Notice (ABN)

Non-covered services: By signing below, I acknowledge I have been notified by my physician that the services identified may not be covered for reasons stated. I agree to be personally and fully responsible for payment. I understand that my doctor may order (more in-depth versions of) these tests if medically necessary.
Refraction (Process by which glasses and contact lenses are prescribed as part of a regular eye examination) **not considered medically necessary by Medicare and other medical insurance carriers** **Fee: $40.00**
INIT: _____

Patient/Guardian Signature: _____ **Date:** _____

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Authorization to Release Protected Health Information

Name of Patient_____ Date of Birth_____

Hanover Family Eyecare is authorized to release protected health information about the above named patient to the entities name below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Appointment reminders and test results can be left on my answering machine	Yes	No
Medical and Financial information may be given to my spouse.	Yes	No
Other_____ Relationship_____	Yes	No

Patient Information:

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

Acknowledgement of Receipt of Notice of Privacy Practices

I have received or have been offered a copy of the Notice of Privacy Practices for the above named practice. I understand that I may ask questions to Hanover Family Eyecare if I do not understand any information contained in the Notice of Privacy Practices.

_____ _____ _____

Signature of Patient or Personal Representative (relationship to patient) Date

Description of Personal Representative's Authority (attach necessary documentation)

For Office Use Only

We were unable to obtain a written acknowledgement of the above because:

- ☐ An emergency existed & a signature was not possible at the time.
- ☐ The individual refused to sign.
- ☐ Unable to communicate with the patient for the following reason:_____

Prepared By: _____ Date:_____

OPTOS (OPTOMAP) RETINAL SCREENING

A better eye exam without the dilation drops (quick, painless & instant results)

Thank you for choosing Hanover Family Eyecare for your visit today. Our doctors and staff are committed to providing you with a premium eye care experience and evaluation.

We have chosen to practice in a way that embraces technology for your benefit. These recent advancements now allow for a better eye health exam without the inconvenience of having to be dilated, in most cases. In fact, the doctor sees more of the retina than even a dilated eye exam can provide! Plus, this eliminates having to wait hours for the blurred vision and light sensitivity side effects of the drops to wear off. You can leave with your normal vision and a safer drive back to work or home.

Optos retinal screening is very critical to verify that your eye is healthy. It can lead to early detection of common diseases, such as Diabetes, High Blood Pressure, Bleeding, Glaucoma, Macular degeneration, and even Cancer.

Because the Optos retinal screening is a superior way to view the inside of the eye, the doctors require this as part of your comprehensive eye examination.

Several vision plans now recognize the benefits of this technology and have contracted this part of the examination on your behalf for a $39 copay.

I have read and understand the benefits and requirement of the Optos retinal screening as part of my eye examination today.

_____ _____

Signature of patient or guardian (if under 18 years of age) Date