ASHBAKER VISION CLINIC FINANCIAL POLICY

All fees will be collected the day of your examination; this includes co-pays, fees for ordering contacts and/or glasses, as well as balances insurance will not cover. As a courtesy, we will file your insurance claim on your behalf, however, you or your legal guardian are responsible for payment in full no later than 30 days after services have been rendered.

Using past payments as an example or a telephone call to your insurance company, we can estimate your fees. We work with your insurance company on your behalf, but are not their employee. If you have two insurances that will pay, one as primary and the other as secondary. we still expect payment in a timely manner, which is defined in the state of Washington as 30 days.

Should we get paid by your insurance company after receiving your payment, we will reimburse you the amount of payment we received from your insurance company. Should the payment on the balance of the account be delayed longer than 30 days, the account may be charged at the rate or 12% per annum (which is 1% per month), and will be charged a $5.00 re-billing fee. Billing statements will be sent out approximately every 30 days.

We accept Cash, Visa, MasterCard, and Personal Checks. Non-sufficient funds checks will be charged up to $40.00 but will not exceed the face value of the check. We reserve the right to charge $25.00 for appointments canceled or rescheduled less than 24 hours before the scheduled time. Order for glasses and/or contacts will be processed when at least 50% of the total cost is paid. We will dispense your glasses and/or contacts when your balance is paid in full. When a years worth of contacts have been ordered and paid for in full, they can be shipped directly to your home.

INSURANCE NOTE

We will check coverage and file your insurance for you, however, insurance coverage is an agreement between you and your insurance company. Occasionally, insurance carriers will deny procedures or reimbursements they have verbally approved, saying they are "not indicated", "not a covered procedure", or "not covered without a referral." We expect all benefit information to be confirmed by the patient. We are not responsible for any denied claim for any reason; however, we will reasonably assist you in claim authenticity and preliminary filing. You are responsible for your fees whether you have insurance or not. We will accept your payment today for your services and/or hardware (glasses and/or contacts) with Visa, MasterCard, Cash or Personal Check, whichever works best for you today.

I understand and agree to the financial policies outlined above. Date: _____/_____/_____

Printed
Name of Responsible Party: _____

Signature of Responsible Party: _____

REFUSAL TO FILL THIS FORM OUT IN FULL RELEASES THIS CLINIC FROM PROVIDING CARE

THIS FORM IS TO BE FILLED OUT IN FULL EVERY YEAR BY EVERY PATIENT

Patient Name(PRINT):_____Date of Birth:_____

Patient Name (PRINT):_____Date of Birth:_____

Patient Name (PRINT):_____Date of Birth:_____

Address:_____City:_____State:_____ Zip: _____

Home Phone: _____ Cell Phone:_____

Social Security #:_____-_____-_____Email: _____

(If under 18 please provide social security # of responsible party)

Whom may we contact in case of an emergency? _____ Phone:_____

RESPONSIBLE PARTY

Whether I have Insurance or not, any and all fees incurred during my exam are ultimately my responsibility, or the responsibility of my legal guardian, and will be paid in full no later then 30 days after services have been rendered. I agree to pay these fees in full for the balance of my exam fees and glasses and/or contacts.

Signature: _____ Date: _____/_____/_____

SIGNATURE ON FILE

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct to the best of my knowledge. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits. I authorize payment of these benefits directly to Dr. Jonathan C. Ashbaker, O.D., 8217 East Mill Plain Blvd, Vancouver, Wa. 98664 on my behalf for any and all services and materials furnished. I authorize any holder of medical information to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to the related services. If I have any other health insurance coverage (as indicated in item 9 of the HCFA_1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent.

Signature: _____ Date: _____/_____/_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES

Signature: _____ Date: _____/_____/_____

OFFICE USE ONLY:

On _____/_____/_____, an acknowledgment of Notice of Privacy Policies form was delivered. This form was not signed due to: ___ communication barriers ___ an emergency ___ refusal to sign.

Ashbaker Vision Clinic, P.C.

8217 East Mill Plain Blvd.
Vancouver, WA 98664

Notice of Privacy Practices

Our office holds all of your health information confidential. We will use the information for your individual treatment, payment, and health care procedures. Our office will use your information to bill your insurance company for the procedures, treatments, services provided and to be able to contact you for return appointments.
In case of default of payment for services rendered, the office will use your information for collections action. The collections process has nothing to do with HIPPA, but has to do with extending credit for services not paid for the same day they are rendered, regardless if an insurance company or an individual is being billed. Ultimately, the individual or the individual's legal guardian is responsible for the payment of any and all services.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Right to access your records: You have the right to obtain a copy of your health information for a copy and processing fee of $25.00. You must submit your request in writing and allow up to five days to process your request.

Right to request restrictions: You may request a restriction in our use or disclosure of your health information for treatment, payment, and health care operations.

Right to amend the record: You may ask to amend your health information if you disagree with its content. Your request must be made in writing to the physician. You must provide us with a reason that supports your request.

Right to an accounting of disclosures: You have the right to know everyone to whom the office discloses your health information for the purposes other than treatment, payment, and health care operations.

Right to have a copy of this notice.

Right to file a complaint: If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services.

If you have any questions regarding this notice or our health information policies, please contact the office manager.

Policy effective: April 14, 2003

MEDICAL HISTORY QUESTIONNAIRE

THIS FORM IS TO BE FILLED OUT EVERY YEAR

Name: _____ Date: ____/____/_____

Date of Birth: ____/____/_____

Please list ALL medications you are taking, including over-the-counter: _____

_____

Please list any and all allergies:_____

Current Occupation: _____

Marital Status: Divorced Married Single Significant Other Widowed

Do you live alone? No Yes Do you drive? Yes No

Do you wear contacts? Yes No If yes, what brand? _____

Have you considered Lasik surgery? Yes No

Do you have prescription: Glasses? Yes No Sunglasses? Yes No

Please <u>circle</u> any problem you currently have.

Blurry Vision Burning Sensation Dryness Drooping Eyelids Distorted Vision

Double Vision Discharge Cataracts Glare Glaucoma Itching Tired

Infection Lazy Eye Macular Degeneration Pain Redness Tearing

FAMILY HISTORY

Please <u>circle</u> any problems you know your blood relatives (Grandparents, Parents, Siblings) have:

Arthritis Blindness Cancer Cataracts Diabetes Glaucoma Heart

Disease High/Low Blood Pressure Hypo/Hyper Thyroid Lupus Stroke

Macular Degeneration Other: _____

PLEASE CONTINUE TO SECOND PAGE

Please circle any and all problems you currently have.

Allergic / Immunologic: Aids Seasonal Lupus Sjorgrens Arthritis

Blood / Lymph: Anemia Cholesterolemia Other: _____

Cardiovascular: Heart Blood Vessels High/Low Blood Pressure

Ears, Nose, Throat: Chronic Cough Dry Mouth Ear Infection Sinus Infection

Endocrine: Diabetes: HbA1c ____% Hypothyroid Hyperthyroid

Gastrointestinal: Intestinal Disease Stomach Ulcers Other: _____

General/Constitutional: Fever Weight Loss Other: _____

Genital, Kidney, Bladder: What? _____

Muscles, Bones, Joints: What? _____

Neurological: Multiple Sclerosis Other: _____

Psychiatric: Anxiety Depression Other: _____

Respiratory: Asthma Emphysema Other: _____

Skin: Acne Skin Cancer Warts Other: _____

In accordance with the Affordable Health Care Act, it is now required that we ask you:

Do you want your personal information below made available to the federal government?

Yes No

Height:_____ **Weight:**_____

Race: American Indian or Alaska Native Asian
Black or African American Hispanic Indian Native Hawaiian/other Islander
Russian/Ukrainian White Other:_____

Ethnicity: African Hispanic/Latino Not Hispanic or Latino Hawaiian/Other
IslanderIndian Other:_____

Tobacco Use:
Never Smoked Stopped Smoking; 1 2 3 4 5> 5 >10 Days Months Years ago
Current every day smoker : _____ Cigarettes/Day _____ Packs/Day
Current some day smoker: _____ Cigarettes/Day _____Packs/Day

Narcotic Use: None Recreational Chemical Dependent

Alcohol Use: None 1-2 drinks/day Social Dependent

Sexually Transmitted Disease: None Yes HIV +

Blood Transfusions: None Yes

Birth Order: 1st 2nd 3rd 4th 5th >5th Only Child Twin