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## WELCOME:

We Look forward to being of assistance to you on your first visit with Hollingshead Eye Center. In order to provide the best possible service, we have enclosed several forms. Please be sure to read through each of them.

### Please bring the following information with you to your appointment:

- Completed New Patient forms (or have submitted electronically)
- A list of all prescribed medications with dosages and quantity
- Insurance card(s)
- Completed New Patient forms (or have submitted electronically)
- A valid Photo ID (preferably a Driver's License)
- Copays and refraction fees are due at the time of service
- Power of Attorney (POA) needs to be presented at registration if applicable

### IMPORTANT INFORMATION:

- \_\_\_ At your first visit with us you could be here up to two hours or more. **Dilating** your eyes will increase your sensitivity to light and make your vision a little blurry, it may be best to have a driver.
- \_\_\_ When entering the **parking** lot be sure to drive around to the right side of the building and park in the marked Patient Parking areas located in front of the building. Many parking spots in the lot are not ours and are reserved.
- \_\_\_ **Directions** to our office are available on our web site at [www.hollingsheadeyecenter.com](http://www.hollingsheadeyecenter.com)
- \_\_\_ **If you are submitting forms online, please be sure you receive a note that the document has been executed after clicking on the submit button. Alternatively, you might receive an email asking you to confirm submission and you will need to respond for us to be able to access the form.**
- \_\_\_ In order to ensure high quality customer service, we would like to share some facts about **refractions**. A refraction is a test to determine if you need glasses or if you have another problem with your eyes or vision. Most medical insurance plans, including Medicare and most Medicare supplements, do not cover routine eye examinations and they do not consider the refraction to be part of a medical eye exam. Regulations require we bill the refraction charge separately from the office visit. If requested, we will provide a form which you can submit to your vision insurance for reimbursement of the refraction fee. Hollingshead Eye Center is not contracted with any vision insurance plans; Vision Service Plan (VSP), Davis Vision, Cole Vision, EyeMed, Spectera, Avesis or Advantica. Please be sure to advise the technician if you need a new prescription for glasses.

We look forward to seeing you in our office and if you need any assistance, please give our office a call at 208-336-8700.

Sincerely,

Hollingshead Eye Center

PATIENT NAME \_\_\_\_\_  
Last First MI

HOME ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

EMPLOYER \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_

SPOUSE / PARENT \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

SPOUSE / PARENT EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

SPOUSE SOCIAL SECURITY # \_\_\_\_\_

**Automated Messages:**

To the extent consent is required by the Telephone Consumer Protection Act ("TCPA") or other applicable law, Patient hereby authorizes Hollingshead Eye Center and its designees to deliver messages containing non-health care messages to the phone number (provided at registration) through the use of an automatic telephone dialing system or an artificial or prerecorded voice. Patient is not required to agree to receive such automated calls, and Patient's agreement is not a condition to receiving items or services from Hollingshead Eye Center. Notwithstanding the foregoing, Hollingshead Eye Center does not waive and expressly reserves the right to contact Patient by any means, included email, for any purpose as otherwise permitted by law. You will have the option to opt-out of email and text messages upon receipt. Please call our office if you have any trouble with opting-out.

**PLEASE LIST TWO EMERGENCY CONTACTS**

1. \_\_\_\_\_ PHONE # \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

2. \_\_\_\_\_ PHONE # \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

**HOW DID YOU HEAR ABOUT OUR OFFICE?** \_\_\_\_\_

**WHO IS YOUR OPTOMETRIST?** \_\_\_\_\_

**Have you registered for the Follow My Health Patient Portal?**

\_\_\_ Registered \_\_\_ Decline \_\_\_ I would like assistance today to get registered

I guarantee that the information listed above to be accurate and precise. I authorize Hollingshead Eye Center to utilize this information on my behalf.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# GENERAL MEDICAL HISTORY / REVIEW OF SYMPTOMS

Patient \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

Occupation: \_\_\_\_\_ Pharmacy and location \_\_\_\_\_

Name of your **PRIMARY CARE PHYSICIAN:** \_\_\_\_\_

Please list all present medications: (if you need more space, please use a separate sheet)

	Name	Dosage (mg)	How Often	Why
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____

Are you allergic to any medications or substances and what are your reactions to each? \_\_\_\_\_

Please list all previous major surgeries or injuries (other than the eye) and their approximate dates:

Do you now have, or have you previously had any of the following medical conditions and/or symptoms?

Condition/Symptom	yes		no		yes		no	
	yes	no	yes	no	yes	no	yes	no
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Graves' Disease	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
COPD/Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Rosacea	<input type="checkbox"/>	<input type="checkbox"/>
Headache/Migraine	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Lupus/Other	<input type="checkbox"/>	<input type="checkbox"/>	Sjogrens Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding/Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Depression/Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Syphilis/Gonorrhea	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers/Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid/Hormonal	<input type="checkbox"/>	<input type="checkbox"/>	Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Tumor/Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Weight/Appetite Loss	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Gynecological/Urinary	<input type="checkbox"/>	<input type="checkbox"/>	MRSA	<input type="checkbox"/>	<input type="checkbox"/>

Other: \_\_\_\_\_

Do you smoke? No/Yes Packs per day \_\_\_\_\_ How many years? \_\_\_\_\_ Former smoker? No/Yes

Do you drink alcohol? No/Yes How much? \_\_\_\_\_ How often? \_\_\_\_\_

## EYE HISTORY

**Referring Physician/Optomtrist** \_\_\_\_\_

Please describe briefly and clearly the main reason for your visit? \_\_\_\_\_

Please list for each eye all previous eye injuries, surgeries, lasers, or other treatments, the reasons for these, and their approximate dates: \_\_\_\_\_

Please list all eye drops or eye medications you are now using, how often, and in which eye: \_\_\_\_\_

Has anyone in your biologic (blood) family had any of the following

	yes	no	relationship		yes	no	relationship
Blindness/low vision	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____	Uveitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	_____	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cataract	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	_____
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	_____	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

We are required by law to obtain information regarding the race and ethnicity of our patient population. If you prefer not to report this information, you may choose the boxes that state you prefer not to report.

**Ethnicity:**

- Hispanic or Latino
- Non-Hispanic or Latino
- Prefer not to report

**Race:**

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian
- White
- Other
- Prefer not to report

**Language:**

- English
- Spanish
- French
- Chinese
- Indian
- Other: \_\_\_\_\_
- Prefer not to report

**If your appointment is in Boise:**

*Hollingshead Eye Center*  
360 E Mallard Dr, Ste 110  
Boise, Idaho 83706  
208-336-8700



<https://goo.gl/maps/zEqCKbBAvsu>

**Parking** is restricted, so please park in the spots labeled “patient” in front of the Park Center entrance to the clinic. We do not have control of any other spaces, and are not liable for tickets issued by those businesses.

**If your appointment is in Ontario Oregon.**

*Family Eye Center*  
1257 Southwest 4th Avenue  
Ontario, OR 97914  
208-336-8700



<https://goo.gl/maps/jjdLGQNX2PG2>

If you need to change or confirm your appointment, please call our Boise office at 208-336-8700



Hollingshead  
Eye Center, P.C.<sup>SM</sup>

Powered by

FollowMyHealth<sup>®</sup>  
Universal Health Record



## Bring Your Health Home!

You will be receiving an email invitation to sign up for our patient portal and gain a **SECURE** and **PRIVATE** online tool that makes it easy to:

- Access your personal health information online
- Control who has access to your health information
- Communicate with your doctor via private online messaging
- Request prescriptions renewals
- View your Statement and Pay your bills online
- Manage your medication list, and print the list for other offices
- View and manage appointments
- View educational materials for your specific condition
- Connect to other physician offices within FollowMyHealth

Do all this and **MORE** from the comfort of your own home—or on-the-go! Sign up and start bringing your health home today.

# Hollingshead Eye Center and SurgiCare Center of Idaho

## **BILLING POLICY AND INSURANCE INFORMATION**

Dr. Mark Hollingshead, M.D, and the staff at Hollingshead Eye Center/SurgiCare Center of Idaho are committed to providing the best possible care for our patients. In order to ensure high quality customer service, we would like to inform you of our office billing policies and share some facts about medical and vision insurance.

### **PAYMENT:**

**Due to insurance contracts, it is our policy to collect the insurance co-payments, co-insurance and deductible amounts at the time of service.** For patients without vision or medical insurance coverage, payment arrangements are available with our billing service, but need to be discussed prior to your visit.

Outstanding balances after the second billing statement could generate an automated phone notification of past due balance and may subsequently be sent to an outside billing or collection agency. Payment arrangements may be set up with the billing service subject to finance charges up to 18%. (Medicare patients will not be charged finance charge.) If payment arrangements cannot be agreed upon, the amount due will be considered delinquent and may result in termination of care from our practice

### **INSURANCE BILLING:**

There are many types of health insurance carriers who provide many different types of medical and vision coverage. Because of this, it is impossible for us to know specific coverage and benefits for all of our patients. This office will do its best to obtain your benefit information while you are here; however, should questions arise regarding your benefits it is best for you to contact your insurance company directly. As a courtesy we will bill any medical insurance provided by the patient. **In the event the insurance does not pay, the patient is ultimately responsible for the charges.**

Hollingshead Eye Center/SurgiCare Center of Idaho **is contracted** with the following insurance plans: Medicare, Medicaid, Tricare, Blue Cross/Blue Shield, Regence, Mail Handlers, GEHA, First Choice Health, Coventry, Medicare Advantage Plans, True Blue, Select Health, Pacificsource, Humana, Cigna and United Healthcare.

Hollingshead Eye Center/SurgiCare Center of Idaho is **not contracted** with the following vision insurance plans: Vision Service Plan (VSP), Davis Vision, Cole Vision, Eye Med, Spectera or other vision plans. However, the visit may be covered under the insured's medical plan.

Being a contracted provider with an insurance carrier means that our office has agreed to charge the patient a contracted rate for services provided. If our fee schedule is above this amount, we must write off the difference between our fee and the contract rate. In the event we are not contracted with your insurance, we will file the claim and accept payment from them. However, you will be responsible for out of network costs. In these cases, patients may also be responsible for any fees that are considered above "usual and customary" with a non-contracted carrier.

There are other insurances we may be contracted with. Therefore, if you are unsure as to whether or not we are contracted with your individual insurance, it is best for you to contact your insurance company directly.

**VISION vs. MEDICAL INSURANCE: Depending on your insurance policy patients may have separate vision coverage through a different insurance company.**

### **VISION INSURANCE:**

Vision insurance is specific coverage for routine exams that result in refractive diagnosis. Myopia, hyperopia and presbyopia are examples of refractive diagnosis. We are not participating providers with many vision insurance carriers. It is our policy to collect in full for the visit. We will provide the paperwork needed for the patient to submit the claim to the insurance, and the insurance will reimburse the patient directly.

**MEDICAL INSURANCE:**

Medical insurance applies to medical eye exams that are the result of a problem or an illness. Depending on your policy there will either be a co-payment or co-insurance amount due for each office visit.

Co-payments are based on your insurance plan and are a set amount per office visit or surgery.

Co-insurance refers to the percentage the patient is responsible for after the deductible has been met and before the out of pocket has been reached.

Deductibles are set by contract between the patient and their insurance company. Deductibles are the amount that the patient owes before the insurance company begins to make payments.

**Refraction Exam:**

Refraction is a test to determine if you need glasses or establish the general health your eyes. Refraction for the purpose of determining a prescription is billed separately from a medical office visit as it is considered a routine service by most insurance companies including government plans.

**Insurance coverage for the Refraction:**

Most medical insurance plans, including Medicare and supplemental plans do not cover routine eye examinations and they do not consider the refraction a component of a medical exam. When the refraction is performed for the purpose of a prescription for glasses, our office will collect your refraction charge of \$50 along with any copayment or deductible due at the time of service. If requested, we will provide a form which you can submit to your vision insurance for reimbursement of the refraction fee.

**FEES FOR SERVICES:**

Fees for services are available upon request. Please contact the business office for more information.

**The doctors and staff at Hollingshead Eye Center/SurgiCare Center of Idaho know that insurance issues can be confusing and at times frustrating. Please do not hesitate to ask questions. We will do our best to help you in any way possible.**

Our sincere thanks!

The Staff at Hollingshead Eye Center and SurgiCare Center of Idaho

**Initials \_\_\_\_\_**