Hollingshead Eye Center, P.C.℠

208.336.8700
360 East Mallard Dr., Suite 110
Boise, Idaho 83706

WELCOME _____ ACCOUNT# _____

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 on _____ at _____:

- ❑ Completed New Patient forms (or have submitted electronically)
- ❑ A list of all prescribed medications with dosages and quantity
- ❑ Insurance card(s)
- ❑ 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

___ **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 and 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, Eye Med, 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.

Our sincere thanks!

The Staff at Hollingshead Eye Center and SurgiCare Center of Idaho

Your appointment is with: _____ Mark Hollingshead, MD _____ Ryan Barrett, MD

_____ Jason Besecker, OD _____ Dylan Hatfield, OD

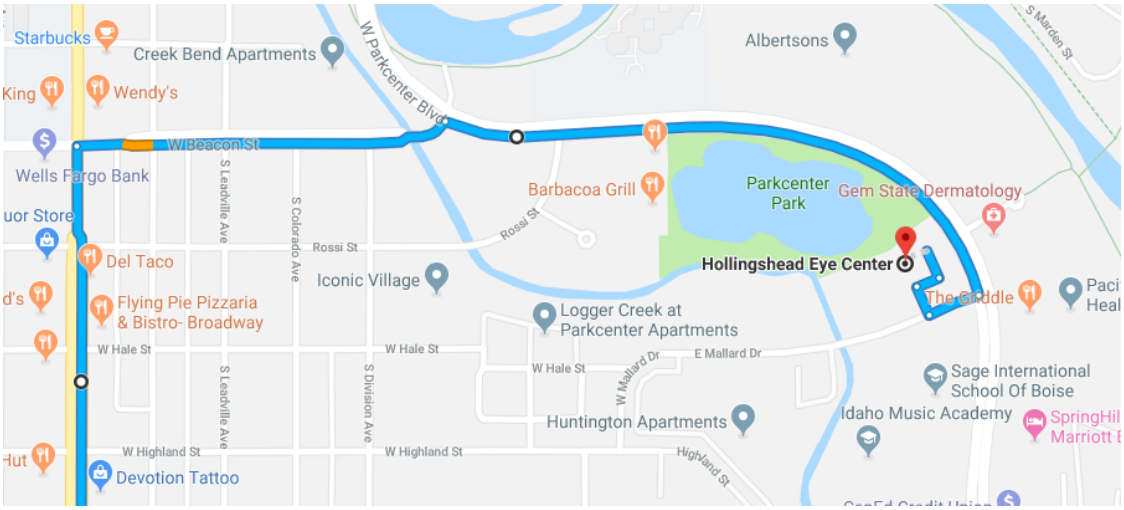
❑ *Hollingshead Eye Center Boise Office*
360 E Mallard Dr, Ste 110
Boise, Idaho 83706

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.

I-84 to exit number 54 onto Broadway Ave, north, turn right at the 4th stoplight onto Beacon, turn right at the first stoplight onto Park Center, turn right at the next light onto Mallard Dr. We are right on the corner. Come around to the right of the building, which faces Park Center and park in the parking spots labeled "patient".



❑ Your appointment is in Ontario Oregon at

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

PATIENT NAME_____
Last First MI

HOME ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____

HOME PHONE_____ WORK PHONE_____ CELL PHONE_____

DATE OF BIRTH_____ SOCIAL SECURITY # XXX-XX-_____

EMAIL ADDRESS_____

SPOUSE / PARENT_____ DATE OF BIRTH_____

SPOUSE / PARENT EMPLOYER_____ WORK PHONE_____

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

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. This list is subject to change, please feel free to ask if you have any questions.

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 or Spectera. 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. As a service to you, the doctor will write a prescription for glasses if needed. You may choose not to take the prescription and you will not be charged a fee.

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.

After Hours Fee

A $50 after hour's fee may be charged if visit does not occur during normal office hours. This charge is not usually paid for by insurance companies and patient will be responsible for payment.

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 _____

Hollingshead Eye Center, P.C.SM

SurgiCare Center of Idaho

HOLLINGSHEAD EYE CENTER - GENERAL MEDICAL HISTORY

Name: _____ Date of Birth: _____ Today's Date: _____

Age: _____ Height: _____ Weight: _____ Sex: ☐ M ☐ F ☐ O Pharmacy & location: _____

Primary Care Physician: _____ Optometrist: _____

Preferred Language: _____ Race: _____ Ethnicity: _____

PERSONAL MEDICAL HISTORY – Please mark if you have ever been diagnosed with or are currently being treated with medications for the following medical conditions:

☐ Anxiety
☐ Asthma
☐ GI Problems
☐ Atrial Fibrillation
☐ Back Problems
☐ Bleeding Disorder
☐ Bronchitis
☐ Cancer: _____
☐ Chest pain / Angina
☐ Congestive Heart Failure
☐ COPD
☐ Depression
☐ Diabetes (type) _____
Recent HbA1c _____
☐ Emphysema
☐ OTHER _____

☐ ENT Problems
☐ Neck Problems
☐ HIV / AIDS
☐ Hard of Hearing
☐ Heart Attack
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis: Type _____
☐ High Blood Pressure
☐ High Cholesterol
☐ Kidney / Bladder Problems
☐ Liver Disease
☐ Malignant hyperthermia
☐ MRSA
☐ Multiple Sclerosis

☐ Osteoporosis
☐ Psychiatric Problems
☐ Pacemaker
☐ Palpitations
☐ Prostate Problems
☐ Restless Leg Syndrome
☐ Seizures
☐ Shortness of Breath
☐ Sleep Apnea
CPAP use? ☐ Yes ☐ No
☐ Stroke / CVA / TIA
☐ Syphilis / Gonorrhea
☐ Urinary / Gynecological Problem
☐ VRE
☐ **NONE**

ADDITIONAL OPHTHALMIC RELATED MEDICAL HISTORY – Please mark if you have ever been diagnosed with or are currently being treated with medications for the following medical conditions:

☐ Ankylosing Spondylitis
☐ Behcet's Disease
☐ Blepharitis
☐ Cataract
☐ Crohn's Disease
☐ Corneal Scarring
☐ Dry Eye Syndrome
☐ Eczema
☐ Other Autoimmune Disease _____

☐ Glaucoma
☐ Grave's Disease
☐ Hashimoto's Disease
☐ Herpes Simplex (Cold Sores)
☐ Herpes Zoster (Shingles)
☐ Keloid Disorder
☐ Keratoconus
☐ Lupus

☐ Macular Degeneration
☐ Meibomian Gland Dysfunction
☐ Retina Problems
☐ Rheumatoid Arthritis
☐ Sjogren's Syndrome
☐ Thyroid Disorder
☐ Ulcerative Colitis
☐ **NONE**

Date of last Autoimmune Condition flare up: _____

Previous Eye Surgery or Injury? ☐ Yes ☐ No (Please list any previous eye surgeries, lasers, injections, injuries, or other treatments and approximate dates)

_____

Please list all eye drops or eye medications you are currently using. Include frequency and which eye:

_____

Do you wear any of the following? ☐ Glasses (distance) ☐ Glasses (readers) ☐ Glasses (bifocals)
Do you currently have, or have ever required Prism in your glasses? ☐ Yes ☐ No
Do you currently suffer from double vision? ☐ No ☐ Yes – if so, while wearing glasses? ☐ Yes ☐ No
Do you currently wear contact lenses? ☐ No ☐ Yes: Type _____ Number of years_____
Where did you purchase your last pair of glasses / contact lenses? _____

SOCIAL HISTORY:
Do you drink alcohol? ☐Yes ☐No Drinks per week? _____
Do you smoke? ☐Yes ☐No Packs per Day? _____ How many years? _____ Former smoker? ☐Yes ☐No
Occupation: _____

FAMILY HISTORY: (Please mark any that apply below and indicate your relationship)

☐ Arthritis _____	☐ Glaucoma _____	☐ Melanoma _____
☐ Blindness _____	☐ Hypertension _____	☐ Thyroid _____
☐ Cataract _____	☐ Keratoconus _____	☐ Stroke _____
☐ Cancer _____	☐ Macular Degeneration _____	☐ Other _____

SURGICAL HISTORY: Please list **all** prior surgeries within the past 10 years to the best recollection, include approximate dates:

Procedure	**Date**
_____	_____
_____	_____
_____	_____
_____	_____

Complications with previous anesthesia / sedation?
☐ NO ☐ YES:_____

ALLERGIES (medication, food, latex & adhesives)	
☐ **NONE**	
Allergy	**Reaction**

Are you taking a blood thinner? ☐ **NO** ☐ **YES:** Reason: _____
(Aspirin, Coumadin / Warfarin, Eliquis, Plavix, Xarelto, Pradaxa)

Are you on Oxygen? ☐ **NO** ☐ **YES:** _____ **liters** **Reason:** _____

Do you have mobility restrictions? ☐ **NO** ☐ **YES - Do you use the following?** ☐ **Walker/Cane** ☐ **Wheelchair**

Are you able to lay on your back for a time period of at least 20 minutes or longer? ☐ **YES** ☐ **NO:** _____
(reason)

_____ _____/_____/_____
Patient Signature **Date**

Reviewed By: _____

Medication Reconciliation Section

Please list all current medications (including over the counter and prescription medication)

(Patient to complete section below) **(THIS SECTION IS FOR OFFICE USE ONLY)**

Medication Name	Dose	Frequency	Last taken (eye 1)	Continue meds after discharge	Last taken (eye 2)	Continue meds after discharge
				Y N		Y N
				Y N		Y N
				Y N		Y N
				Y N		Y N
				Y N		Y N
				Y N		Y N
				Y N		Y N
				Y N		Y N
				Y N		Y N
				Y N		Y N

ALLERGIES (medication, food, latex & adhesives)			
☐ **NONE**			
Allergy	**Reaction**	**Allergy**	**Reaction**

Patient Signature: _____ Date: _____/_____/_____

FOR OFFICE USE ONLY

New Medications

Start Date (eye 1)	Start Date (eye 2)	Medication name	Dose	Instructions	Ordered	Prescriber
					Y N	**MEH RTB**
					Y N	**MEH RTB**
					Y N	**MEH RTB**
					Y N	**MEH RTB**
					Y N	**MEH RTB**

(SIGNED ON DAY OF SURGERY IF APPLICABLE)

Patient Signature:_____ Date:_____/_____/_____

Nurse Signature:_____ Date:_____/_____/_____

Physician Signature:_____ Date:_____/_____/_____

BMI: _____

NO CHANGES FOR SECOND EYE SURGERY

Patient initials:_____ Date: _____ Nurse initials: _____ Date: _____ Physician initials: _____Date: _____