

To Our Valued Patient:

Thank you for choosing Heartland Eye Consultants! We are looking forward to seeing you for your appointment. Enclosed you will find a location map and a couple of forms. We would greatly appreciate your taking the time to fill out these forms at home. This will save valuable time in-office so that you will have plenty of time with the doctor. Please fill-out the forms immediately and fax or mail them to the office several days prior to your appointment. You may bring them with you to your appointment if there is not sufficient time for faxing or mail.

Your appointment is on _____ at _____AM/PM.

Please bring the following with you to your appointment:

1. The enclosed Patient Information Form
2. The History form
3. Your insurance card (or a copy)
4. Your co-pay
5. A list of your medications and dosages
6. Your glasses

Please note that all co-payments and applicable yearly deductibles are due at the time of your visit. Please make sure you have a credit card, your check book or cash with you.

This examination will NOT be considered a ROUTINE visit so we will be using your major medical insurance, not your 'eye' or 'eye glasses' insurance.

If your insurance requires a referral from your primary care doctor (pediatrician or family doctor, *not* your eye doctor), it is your responsibility to request the referral **before** your appointment at Heartland Eye Consultants. If that is not done **by you** ahead of time, we may have to reschedule your appointment because some doctor's require a day's notice or more to get those completed and faxed to us.

Handicapped Parking and Senior Parking is available on the **west** side of the building. Parking there will eliminate the need to climb stairs.

If you have any questions or need to reschedule your appointment, please call us at (402)493-6500 or 888-837-3937. Please have a friend or family member help you fill-out the following forms.
Thank you for entrusting your vision to us!

Sincerely,

Patient Services

Heartland Eye Consultants
Low Vision Demographics

Last Name: _____ First Name: _____ M.I. _____
Street Address: _____ Apt # _____ Gender: M F Date of Birth: ___/___/___
City: _____ State: _____ Zip Code: _____ Soc. Sec. No. ___-___-___

When we contact you to confirm or change an appointment, which method(s) do you prefer? (Please place an X in the circles.)

Call Text Cell Phone: (____) _____ Home Phone: (____) _____

Work Phone: (____) _____ Email Address: _____

City, State, Zip: _____

Which doctor referred you to our office? _____ Date: ___/___/___

Family Physician: _____

Name of Emergency Contact: _____ Relationship: _____ Phone: _____

If the patient is married, please complete spouse information:

Spouse's Last Name: _____ First Name: _____ M.I. _____ Birthdate: ___/___/___

Cell Phone: _____ Home Phone: _____ Email Address: _____

SSN: _____ Employer: _____ Occupation _____ Title: _____

We will file major medical insurance coverage for you if you provide us with a copy of your current card. For patients without insurance coverage, you will be responsible for payment. Please indicate your preferred method of payment:

Cash Check Credit Card (Mastercard/Visa)

Photo Release:

I hereby grant Heartland Eye Consultants, L.L.C. and Developmental Vision Associates, P.C. permission to have my photograph taken for patient information. This does not allow them to use my likeness in photographs and/or video in any of its publications or media.

AUTHORIZATION TO RELEASE INFORMATION TO YOU INSURANCE COMPANY AND ACKNOWLEDGEMENT OF PERSONAL RESPONSIBILITY FOR PAYMENT

I hereby assign all medical benefits (to which I am entitled) to the doctor caring for me. This includes major medical benefits, Medicare, Medicaid, private insurance and any health plans in which I am enrolled. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not they are paid by my insurance. I hereby authorize the holder of my medical and patient registration records to release any information need to process my insurance claims. I understand that I am the guarantor of this account.

A copy of my medical records can be requested in writing and will be provided to me or whomever I designate for \$15.00. There is a \$25.00 fee for returned checks.

Authorized Signature: _____ **Date of Signature:** _____

Low Vision History

Please answer the following 14 questions. This will help the doctor to better understand your problems. Thank you.

1) Do you understand your diagnosis to your satisfaction? Yes No

Comments:

2) Do you have problems with any of the following? (Please mark all that apply.)

Hearing, which side? _____ Walking without falling Tremors, which side? _____

3) Have you been diagnosed with any allergies? (circle) Yes No

List _____

4) Are you presently taking any prescription medications? (circle) Yes No

List medications and amount taken.

5) Which of the following conditions do you have? (Please mark all that apply.)

Alzheimer's disease _____	Dementia _____	High blood pressure _____
Arthritis _____	Depression _____	Lupus _____
Asthma _____	Diabetes _____	Osteoporosis _____
Cancer _____	Emphysema _____	Sinus condition _____
COPD _____	High Cholesterol _____	Stroke _____

6) Which of the following describes your living situation?

Independent living Nursing home With a son/daughter Alone

7) Have you ever had training with any low-vision devices?

Extensive Moderate Very little None

8) Which of the following low-vision devices do you utilize?

<input type="checkbox"/> None	<input type="checkbox"/> Closed-circuit television (CCTV)
<input type="checkbox"/> Hand-held magnifier	<input type="checkbox"/> Electronic magnification device
<input type="checkbox"/> Binoculars	<input type="checkbox"/> Other _____

9) Which of the following activities would you enjoy if your vision permitted?

- Bingo Social gatherings Sporting events
 Card games Church Other _____

10) How would you describe your attitude towards your vision loss?

- Coping Denial Accepting Angry Depressed

11) Do you have any family members that help you with daily activities?

- Spouse Sister Brother Children Grandchildren

12) Most low-vision devices are not covered by insurance. Some devices are expensive, while others cost less than \$50. Most devices cost about the same as a pair of no-line bifocals. Which of the following describes you?

- Cost is not a concern, seeing better is my highest priority right now.
 Cost is a minor concern, but will not be a factor if the doctor finds a device that significantly improves my visual performance.
 Cost is a major concern and I will not purchase a device, even if it significantly helps improve my visual performance.

13) Which methods of transportation do you use? (Please check all that apply)

- I drive I get rides from family members and friends I use public transportation

14) Which of the following are DIFFICULT for you?

Near Activities:

- Reading newsprint Reading large print Reading books
 Reading headlines Reading the mail Dialing the phone
 Seeing colors of clothing Cooking Seeing food on plate
 Seeing the stove dials Personal grooming (shaving, lipstick, etc)

Distance Activities:

- Watching television Recognizing faces Driving



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Patient Name: _____

If patient is a minor, Parent Name: _____

In today's hectic world unplanned issues come up for all of us. We recognize this fact, but we respectfully request that if you need to cancel your appointment with us that you call at least **24 hours prior to your appointment**. With your prompt cancellation, we will be able to schedule another patient in need of an appointment.

If you cancel, reschedule, or miss your scheduled appointment **without** 24 hours notice, the first time will be excused. However, if you miss a second appointment you will be responsible to pay a **\$50.00** fee. If a third appointment is missed, a **\$100.00** fee will be charged. This fee is **not** covered by insurance carriers, Medicare or Medicaid and will be your responsibility to pay before rescheduling.

I understand the above Cancellation Policy implemented by Heartland Eye Consultants.

Patient/Parent Signature

Date

HEC Employee Witness

Date