Welcome to

OLIVE BRANCH
Eyecare

David L. Parker O.D.   Sean P. Aldinger O.D.   Nicole Monroe O.D.   Walter Pang O.D.   Mallory Bedford O.D.

Thank you for choosing our practice for your eye care needs.
If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Date: ____/____/______

Name: Dr. / Mr. / Mrs. / Miss / Ms. ______________________________
First   Middle   Last

Address: ______________________________

Home Phone: (____)__________ **Cell Phone:** (____)__________ **Work Phone:** (____)__________

Social Security #: __________ **Birth Date:** __________ **Email:** __________

Occupation: __________ **Employer:** __________

Person to contact in case of Emergency: __________ **Phone #:** __________

Referred By: Patient (name): __________ **Physician (name):** __________

The following will help us comply with new federal regulations regarding health care reporting.
Thank you for your assistance.

Race
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ White
- ☐ Other__________

Ethnicity
- ☐ Not Hispanic or Latino
- ☐ Hispanic or Latino
- ☐ Native Hawaiian/Pacific Islander

Primary Language Preference
- ☐ English
- ☐ Spanish
- ☐ Other__________

Olive Branch Eyecare

David L. Parker O.D. Sean P. Aldinger O.D. Nicole Monroe O.D. Walter Pang O.D. Mallory Bodford O.D.

6947 Crumpler Blvd, Ste. 100
Olive Branch, MS 38654
Phone # (662) 893-3300 Fax # (662) 893-3301

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name ______________________________

Social Security Number ______________________________

Patient Address ______________________________

Patient Phone Number ______________________________

I authorize the professional office of my optometrist named above to release health information identifying me (including if applicable, information about HIV infections or AIDS, information about substance abuse treatment and information about mental health services) under the following terms and conditions:

1. Information that may be release: Name, SSN, ID number, RX information, diagnosis, etc.
2. Where we might release your info: Health Insurance Company, labs that provide your glasses or contacts, pharmacies to fill or refill a prescription, a physician's office.
3. Information may be released at the request of the individual.
4. You may set an expiration date for this release: ______________

It is your decision to authorize release by signing this form. Olive Branch Eyecare cannot refuse treatment if you choose not to sign this authorization. If you sign this authorization, you may revoke it at any time. Please send a notification in writing to the office administrator at the above information to cancel this authorization. An exception may occur if we acted in reliance upon an active authorization. When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality; in many cases the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM AND HAVE BEEN OFFERED THE NOTICE OF PRIVACY PRACTICES FORM.

Signature ______________________ Date ______________

OR

Authorized Representative for Patient ______________________

Olive Branch Eyecare

David L. Parker O.D. Sean P. Aldinger O.D. Nicole Monroe O.D. Walter Pang O.D. Mallory Bodford O.D.

Patient Name ______________ **DOB** ______________ **Date** ______________

Current Height ______________ **Current Weight** ______________ **Pharmacy** ______________

Health History

When was your last eye exam: ______________

Reason for today's exam: ______________

Are you interested in being fit in Contact Lenses today? ______________
(Additional fees may apply. See receptionist)

Do you need to update your **Contact Lenses** or **Glasses**? ______________

Past/Present Ocular History
Please note any personal or family history for the following conditions.
(Parents, maternal/paternal grandparents, siblings, living or deceased)

	Self	Family	Relationship
Glaucoma	☐	☐	______
Cataracts	☐	☐	______
Macular Degeneration	☐	☐	______
Eye Injury	☐	☐	______
Blindness	☐	☐	______
High Cholesterol	☐	☐	______
Heart Disease	☐	☐	______
High Blood Pressure	☐	☐	______
Diabetes	☐	☐	______
Cancer	☐	☐	______
Stroke	☐	☐	______
Heart Attack	☐	☐	______

Please check any of the following that apply to you:

					Current	Former	Never
Dry Eye Syndrome	☐	Sensitivity to Light	☐	Smoker	☐	☐	☐
Floaters or Spots	☐	Double Vision	☐	Nursing	☐		
Cataract Surgery	☐	Lasik Surgery	☐	Pregnant	☐		

Other Eye Surgery? Please list. ______________

Please list ALL medications (including eye drops) you are currently taking. We would be glad to photocopy your **list.** ______________

Are you allergic to any medications or substances? ______________

Olive Branch Eyecare

David L. Parker O.D. Sean P. Aldinger O.D. Nicole Monroe O.D. Walter Pang O.D. Mallory Bodford O.D.

Patient Name: ______________________ **Date of Birth:** ______________

Consent to Treat. I hereby authorize the Doctors at Olive Branch Eyecare (OBEC) to treat me/my child.

Requirements at time of Service. I understand insurance cards must be presented at the time of service or patient will be self pay until cards are presented OR if insurance changes within treatment, cards must be presented before OBEC will file claims to new insurance. All Co-payments, Co-insurance, Deductibles, and Non-covered services are due at time of service. Not all services are a covered benefit. If your insurance company denies a service, the balance is due within 30 days. Verification of benefits is not a guarantee of payment. Some services are automatically discounted if no insurance is filed.

Assignment of Insurance Benefits. I hereby authorize and assign my insurance carrier to make payment directly to OBEC of insurance benefits for services herein specified and otherwise payable to the insured. OBEC files both primary and secondary insurance as a courtesy to patients for the companies with which we participate. I understand and agree that I am financially responsible to OBEC for all charges incurred regardless of potential insurance benefits including but not limited to Co-payments, Deductibles, and Non-covered services. I understand that it is my responsibility to verify with my insurance company the physician(s) treating me are covered under my insurance and to get referrals and/or authorization for services.

Minor Patients. Any patients under the age of 18 should be accompanied by a parent/guardian. I understand by signing OBEC's financial policy, I am solely responsible for any incurred charges for the below named patient. The parent who brings the child in for care is ultimately responsible for their bill. (We will not be involved in support disputes)

Returned Check Fee. I understand if OBEC receives a returned check, I may be charged $30 in addition to the amount on the check and will be on a cash only basis thereafter.

Non-Payment. We reserve the right to send an account to collections if not paid in full. If OBEC refers your account over to a collection agency, you will be responsible for your balance and any collection agency fees.

Medicare General Rules. Our office is a participating provider for Medicare. Medicare requires that you pay the annual deductible toward any qualified services before Medicare will pay for any services. Our doctors accept assignment on your bill and we will file, via electronic transmission, directly to Medicare. You will be responsible for any remaining amount they do not pay. As a courtesy to you, we will file any supplemental insurance.

Special Exceptions

a. Medicare does not cover eyeglasses unless you have had cataract surgery. (once per lifetime)

b. Medicare does not cover any services without a medical diagnosis. The need for glasses is not considered a medical diagnosis.

Mississippi Medicaid Advanced Beneficiary Notice. This constitutes Notice to you, the beneficiary, that if OBEC meets all program requirements and payment is not made by Mississippi Medicaid, you may be responsible for the charges if your services or materials are not covered by Mississippi Medicaid. This includes but is not limited to the eye exam, frame, lenses, coatings, or medically necessary contacts.

***CONTACTS AND CONTACT LENS SERVICES ARE NOT A COVERED BENEFIT OF MISSISSIPPI MEDICAID.**

Patient Signature ______________________________ **Date** ______________

OR

Authorized Representative ______________________________ **Date** ______________

Relationship to Patient ______________________________