



Thank you for choosing Downing-McPeak Vision Centers as your eyecare provider. Our practice is dedicated to meeting your entire family's special eye care needs. Our services can range from routine eye exams to advanced medical care, including laser and comprehensive surgical procedures.

Since this will be your first visit, we will perform a comprehensive dilated exam. Please allow two hours from the time you arrive for us to complete your examination. A dilated eye exam is necessary for the doctor to be able to get a good look at the inside part of your eyes. Expect to be very sensitive to light for a few hours after your exam because of your dilated eyes.

In order to expedite your first visit, please look over and complete the forms included in this packet before you arrive for your appointment. When you bring this complete packet to our office on the day of your appointment, you will receive a free gift.

Please be prepared to offer payment for services on the day of your appointment. Downing-McPeak Vision Centers accepts cash, checks, and major credit cards. Downing-McPeak Vision Centers also accepts many insurance plans including Medicare and Medicaid. Please call if you have questions about your insurance coverage. If you do not have insurance, please note that we require an initial down payment of \$65 to be paid before your first visit. The additional charges may be paid at the end of your exam. Downing-McPeak also accepts the Progressive Eye Plan (PEP) which you can save you 20% on most services. Call us if you would like information on how your employer can become a member of PEP.

Please remember to bring these items for your first visit:

- ✓ Medications you are currently taking
- ✓ Your eyeglasses
- ✓ Contact Lenses
- ✓ Insurance Cards
- ✓ Referral Authorization if required by insurance
- ✓ Driver's License/Photo ID or utility bill or other correspondence showing current address if the photo ID does not show current address

Thank you once again for choosing Downing-McPeak Vision Centers, Southern Kentucky's Eyecare Leader. Remember to fill out the attached forms and bring them on the day of your appointment to receive your free gift. If you have questions, please call the Bowling Green office at 270-781-4909, Glasgow office at 270-651-2181, or Franklin office at 270-586-3937 or log on to our website at www.Downing-McPeak.com.

Downing-McPeak Vision Centers

Date: _____

Appointment Time: _____ **Sex** _____ **MALE** _____ **FEMALE** _____ **Marital Status** _____

Ethnicity: Hispanic or Latino Non-Hispanic or Latino

Race: American Indian or Alaska Native
 Asian
 Black/African American
 Native Hawaiian or Pacific Islander
 White
 Other

Patient Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone #: _____ **Cell Phone #:** _____

Date of Birth: _____ **Medical Doctor:** _____

SS# _____ **Email address:** _____

Do you have routine vision coverage? _____ **YES** _____ **NO**

If yes, name of plan: _____

Work Phone #: _____

Employer: _____

In Case of Emergency, Contact: _____ **Phone #:** _____
(This should be someone outside your household)

Has Insurance Changed? _____ **YES** _____ **NO**

Name of Insurance: _____

• **Were you referred by a doctor for your exam today?** _____ **YES** _____ **NO**

If yes, what doctor referred you _____

- Are you here for a routine eye exam or a medical problem? _____ROUTINE_____MEDICAL

OFFICE PERSONNEL TO COMPLETE

INSURANCE INQUIRY

Insurance
Company _____ Date _____

Effective Date: _____

Spoke with _____

Routine Vision? YES NO

Vision
Benefits _____

Co-
Payment _____

Materials _____

Frames _____

Lenses _____

Contact
Lenses _____

Medical
Benefits _____

Co-
Payment _____

Deductible
Amount _____

Is a referral required? YES NO

MEDICAL/FINANCIAL RELEASE OF INFORMATION
AUTHORIZATION

I, _____, Date of Birth: _____, hereby authorize

Down-McPeak Vision Centers/Downing-McPeak Surgery Center to release information about my medical and financial records if requested by:

Name	Relationship	Daytime Phone Number
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Name	Relationship	Daytime Phone Number
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Name	Relationship	Daytime Phone Number
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Signature of Patient or Legal Guardian	Date
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Signature of Witness	Date
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New Patient Referral Source Information

Name: _____ Date of Appointment: _____
City: _____ County: _____
Doctor you are seeing today: _____
Are you a member of the Progressive Eye Plan (PEP)? [] Yes [] No

Why did you choose to come to Downing-McPeak today?

Please pick just ONE of the answers below.

- [] My Optometrist / Eye Doctor (O.D.) told me to come here Dr. _____ (Full Name)
[] A Medical Doctor (M.D.) told me to come here Dr. _____ (Full Name)
[] A Nurse Practitioner (A.R.N.P.) told me to come here Name: _____ (Full Name)
[] I heard/saw a commercial on the Radio or TV What Station? _____
[] I saw an advertisement or article in the Newspaper Which Paper? _____
[] I was looking in the Phone Book / Yellow Pages and found you Which Phone Book? _____
[] I got something in the mail What was it? _____
[] I saw Downing-McPeak at a Screening or Health Fair When / Where? _____
[] My Employer told me to come here Company: _____
[] I have to come here because of my Insurance/HMO Which Insurance? _____
[] A Downing-McPeak Employee suggested that I come here Employee's Name? _____
[] I was at the Hospital / Health Department and they told me to come Which one? _____
[] I read about Downing-McPeak Vision Centers on the Internet
[] I've just heard about Downing-McPeak from friends or relatives
[] I used to be a Patient here, but haven't been here in awhile
[] The reason I chose Downing-McPeak is not listed here, it's something else What? _____

Whatever the reason, Thank You for choosing Downing-McPeak Vision Centers as your eyecare specialists.

NOTICE OF PRIVACY PRACTICES

Downing-McPeak Vision Centers/Downing-McPeak Surgery Center
Glasgow, KY 270-651-2181 / 270-651-2183(fax)
Bowling Green, KY 270-781-4909 / 270-843-9678(fax)
Franklin, KY 270-586-3937 / 270-586-7671(fax)
Peggy Botts Contact Member

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU
MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO
THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

GENERAL RULE

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices.

Generally, we cannot use your health information in our office or disclose it outside of our office without your written permission. Sometimes the written permission will be called a consent form, and sometimes it will be called an authorization form. The type of permission form will depend upon the kinds of uses or disclosures that are involved. In some limited situations, the law allows or requires us to disclose your health information without either a written consent or authorization.

USES OR DISCLOSURES WITH CONSENT

We will ask you to sign a consent form allowing us to use and disclose your health information for purposes of treatment, payment, and health care operations of this office. We are allowed to refuse to treat you if you do not sign the consent form.

We use information for treatment purposes, when, for example, we set up an appointment for you, when our technician or doctor tests your eyes, when the doctor prescribes glasses or contact lenses, when the doctor prescribes medication, when the doctor recommends a surgical treatment, when our staff helps you select and order glasses or contact lenses, and when we show you low vision aids. We may disclose your health information outside of our office for treatment purposes if, for example, we send you to another doctor or clinic for eye care consultation, low vision aids, other medical services; if we send a prescription for glasses or contacts to another doctor or optical to be filled, when we provide a prescription for medication to a pharmacist, or when we phone to let you know that your glasses or contact lenses are ready to be picked up or a reminder of your upcoming appointment or a rescheduling of a missed appointment by phone or by postcard. Sometimes we may ask for copies of your health information from another professional that you may have seen before us.

We use your health information for payment purposes when, for example, our staff asks you about health or vision care plans that you may belong to, or about other sources of payment for our services, when we prepare bills to send to you or your health or vision care plan, when we process payment by credit card, and when we try to collect unpaid amounts due. We may disclose your health information outside of our office for payment purposes when, for example, bills or claims for payment are mailed, faxed, or sent by computer to you or your health or vision plan, or when we occasionally have to ask a collection agency or attorney to help us with unpaid amounts due.

We use and disclose your health information for health care operations in a number of ways. Health care operations mean those administrative and managerial functions that we have to do in order to run our office. We may use or disclose your health information, for example, for financial or billing audits, for internal quality assurance, for personnel decisions, to enable our doctors to participate in managed care plans, for the defense of legal matters, to develop business plans, and for outside storage of our records.

USES AND DISCLOSURES WITHOUT CONSENT OR AUTHORIZATION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;

- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the U.S. President or other high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures relating to worker's compensation programs;
- disclosures to business associates who perform health care operations for us and who agree to keep your health information private.

APPOINTMENT REMINDERS

We may call or send a postcard to remind you of scheduled appointments. We may also call to notify you of other treatments or services available at our office that might help you. We may also call you to notify you of the results of special testing that have been ordered for the on-going treatment of your eyes or associated organ systems.

OTHER DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written authorization form. You do not have to sign such a form. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to Peggy Botts % Downing-McPeak Vision Centers.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E-mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to Peggy Botts % Downing-McPeak Vision Centers.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us. You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally required. By law, we can have one 30-day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to Peggy Botts % Downing-McPeak Vision Centers.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30-day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to Peggy Botts % Downing-McPeak Vision Centers.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want), except disclosures for purposes of treatment, payment or health care operations and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30-day extension of time if we notify you of the extension in writing. If you want a list, send a written request to Peggy Botts % Downing-McPeak Vision Centers.
- get additional paper copies of this Notice of Privacy Practices upon request, no matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written notice to Peggy Botts % Downing-McPeak Vision Centers.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time in compliance with and as allowed by law. If we change this Notice, the new privacy practices will apply to your

health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to:

Peggy Botts % Downing-McPeak Vision Centers at

1507 Bravo Boulevard, Glasgow, KY 42141

1403 Andrea Street, Bowling Green, KY 42102

1300 Bluegrass Road #A, Franklin, KY 42134

or fax to the number shown at the beginning of this notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit Peggy Botts % Downing-McPeak Vision Centers. A copy of this notice is posted on our Website at www.downing-mcpeak.com/hipaa.htm

This notice was published and becomes effective on April 14, 2003.

Signature Form

- I acknowledge that I have received Downing-McPeak Vision Center's/Downing McPeak Surgery Center's Notice of Privacy Practices

 - I acknowledge that I have received Downing-McPeak Vision Center's/Downing McPeak Surgery Center's Insurance Alert Form
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Contact Lens Design Fee

If you are a first time contact lens wearer or if you have worn contact lenses previously and are being established as a new contact lens patient to our office, precise measurement of the front of your eyes are made to determine the correct lens size and curvature. In addition to our routine exam fee, we have a contact lens fee to establish you as a contact lens patient with our center. The nonrefundable fee is \$75.00 for most fittings and \$115.00 for special fittings, which include bifocal, gas permeable (hard), and any post surgical contact lenses. This fee is charged on your initial visit. On future visits the fee may be charged only if the lens design is changed. Any contact lens related visits for the **first six months** are included in this fee (medical eye problems are not included).

- I acknowledge that I understand the above paragraph regarding contact lens design fees

- I am not interested in contacts at this time

Name (Printed)

Signature

Date