



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

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 or the Glasgow office at 270-651-2181 or log on to our website at www.Downing-McPeak.com.

Downing-McPeak Vision Centers

Date: _____

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

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**

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
A Medical Doctor (M.D.) told me to come here
A Nurse Practitioner (A.R.N.P.) told me to come here
I heard/saw a commercial on the Radio or TV
I saw an advertisement or article in the Newspaper
I was looking in the Phone Book / Yellow Pages and found you
I got something in the mail
I saw Downing-McPeak at a Screening or Health Fair
My Employer told me to come here
I have to come here because of my Insurance/HMO
A Downing-McPeak Employee suggested that I come here
I was at the Hospital / Health Department and they told me to come
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

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

Downing-McPeak Vision Centers
1507 Bravo Blvd. Glasgow, KY 42141
270-651-2181 / 270-651-2183(fax)
1403 Andrea Street Bowling Green, KY 42104
(fax)
270-781-4909 / 270-843-9678(fax)
Peggy Botts, RHIT, COA

Downing-McPeak Surgery Center
1507 Bravo Blvd.
Glasgow, KY 42141
270-651-2181 / 270-651-2183

Peggy Botts, RHIT, COA

**CONSENT TO USE OR DISCLOSE HEALTH
INFORMATION FOR TREATMENT, PAYMENT AND
HEALTH CARE OPERATIONS**

Patient name _____

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office.

We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail. You are free to refer to this Notice at any time before you sign this consent document. As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and services provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; our submission of your health information to auditors hired by third-party payers and insurers, among other aspects of payment described in our Notice of Privacy Practices. Our Notice of Privacy Practices will be updated whenever our privacy practices change. You can get an updated copy at either of our two offices.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform health care operations. In the event my account is placed with an outside agency for collection, I agree to pay all collection cost, court cost, and attorney fees incurred to collect my account. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent. We can decline to serve you if you elect not to sign this consent form.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or health care operations, but as described in our Notice of Privacy Practices, we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for a restriction.

Specify Records Expressly Included. I expressly authorize release of the following information for the purposes of treatment, payment and health care operations, if it is part of my protected health information (CHECK ANY OR ALL YOU AGREE TO AUTHORIZE FOR RELEASE):

- Chemical Dependency/Substance Abuse
 - ◆ Drugs
 - ◆ Alcohol
- Sexually Transmitted Diseases

I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

UNLESS I REVOKE THIS PERMISSION, THE USE OF MY HEALTH INFORMATION WILL REMAIN IN FORCE FOR MY LIFETIME.

I further acknowledge the Practice has provided me a copy of its Notice of Privacy Practices which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

Date

Patient Signature

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient

Print Name

Source of Authority

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