Hogan Eye Associates, Inc.
133 Loudon Rd., Suite 5, Concord, NH 03301
Phone: 603-224-3351 Fax: 603-225-7575

Donna M. Hogan, O.D.
Timothy J. Hogan, O.D.
www.hoganeye.com

Today's Date: ______________________

Name: ____ DOB: __________________

Mailing Address: ____

City: _________________________________ State: ____________ Zip Code: ______________

Home Phone: __________________ Work Phone: __________________ Cell Phone: ______________

Primary Care Physician: ____

Health Insurance: _________________________ Secondary Insurance: ______________________

Insurance Subscriber: __________________________________ Subscriber DOB: ______________

Subscriber Mailing Address: ____

City: ____________________________________ State: ____________ Zip Code: ______________

Relationship to Patient: ____

Financial Policy & Privacy Statement

- Patients must bring their insurance card(s) to every appointment.
- We only bill insurances that we are contracted with.
- All co-payments/payments are due at the time of check in. Any returned checks will result in a $15.00 fee.
- Patients are responsible for knowing who their primary/secondary insurance(s) is, what their insurance(s) covers and whether a referral from their primary care physician is needed.
- All previous balances must be paid in full before additional services are rendered.
- 24 hour notice is required to cancel an appointment. Patients may be billed for appointments that are cancelled/missed with less than a 24 hour notice.

Medicare:

I request that payment of authorized Medicare benefits be made on my behalf to **Hogan Eye Associates, Inc.** for any services furnished to me by that physician. I authorize the release of any medical information about me to the Health Care Financing Administration and its agents, as well as any information needed to determine these benefits payable for related services.

I hereby authorize Medicare to furnish to the above named Doctor or Group any information regarding my Medicare claims under title XVIII of the Social Security Act.

Commercial Insurance:

I hereby authorize the release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the Doctor or Group indicated on the claim.

Hogan Eye Associates, Inc. *does not* release any personal information unless authorized by the Patient or Parent/Guardian.

I understand that I am financially responsible for any balance not covered by my insurance carrier.

A copy of the signature is as valid as the original.

I understand that today's exam and/or materials will be billed to the insurance company provided by me, the patient. Once billed to the insurance company, it cannot be changed or cancelled.

I acknowledge that I have received a copy of the Hogan Eye Associates, Inc. HIPAA privacy statement.

By signing below, I acknowledge that I have read and understood all of the above.

____ ______________________

Patient or Parent/Guardian Signature Date

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Name: ______________________ **Date:** ____________
Date of Birth: ____________ **Occupation:** ____________

Do you currently wear:
Glasses? ______ Contacts? ______ Both? ______ None? ______

With current prescription, are you experiencing blurred vision?
Distance ______ Near ______ Both ______ None ______

If no current prescription, are you experiencing blurred vision?
Distance ______ Near ______ Both ______ None ______

Are you experiencing any of the following:
Eye Pain? Yes ______ No ______ Floaters? Yes ______ No ______
Red Eye? Yes ______ No ______ Flashing Lights? Yes ______ No ______
List any other symptoms: ______________________

Are you currently being treated or have you ever been treated for any of the following symptoms? (If you answer yes to any of the following please list the medication you are taking for it and the dosage.)

High Blood Pressure?	Yes	______	No	______	Medication	______
Cholesterol?	Yes	______	No	______	Medication	______
Diabetes?	Yes	______	No	______	Medication	______
Heart Disease?	Yes	______	No	______	Medication	______
Thyroid?	Yes	______	No	______	Medication	______
Cancer?	Yes	______	No	______	Medication	______
Arthritis?	Yes	______	No	______	Medication	______
Depression/Anxiety?	Yes	______	No	______	Medication	______

Please list any other medications or any eye drops you are currently taking:
____

Please list any known allergies to any medications:
____

Have you ever had any eye surgeries? Yes ______ No ______ What type/When? ______
____

List any other surgeries you have had and when you had them: ______________________
____

Social History:
Do you smoke? Yes ______ No ______ How many per day? ______
Do you drink alcohol? Yes ______ No ______ How often? ______

Family History: (Please check all that apply, list up to grandparents and specify maternal or paternal.)

Diabetes?	Yes	______	No	______	Who?	______
Hypertension?	Yes	______	No	______	Who?	______
Cardiovascular Disorders?	Yes	______	No	______	Who?	______
Cancer?	Yes	______	No	______	Who?	______
Cataracts/Cataract Surgery?	Yes	______	No	______	Who?	______
Glaucoma?	Yes	______	No	______	Who?	______
Macular Degeneration?	Yes	______	No	______	Who?	______

List any other ocular conditions: ______________________

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TEXT AND EMAIL COMMUNICATION AUTHORIZATION

We would like to send you text messages and/or email communications regarding appointment reminders and to let you know when your glasses or contact lens orders are ready for pick-up. When sending these texts and emails, we may inform you if you owe any balance to Hogan Eye Associates, Inc. However, text messages and emails are unencrypted and, therefore, a possibility exists that unauthorized individuals could obtain the information. For that reason, we will not send insurance identification numbers, credit card numbers, medical diagnosis or any medical information via text message or email.

Hogan Eye Associates, Inc. is not responsible for unauthorized access of protected health information while in transmission to the individual based on the individual's request. Further, Hogan Eye Associates, Inc. is not responsible for safeguarding the information once delivered to the individual.

______ I understand the risks of receiving unencrypted text/email communications and **I ALLOW** Hogan Eye Associates, Inc. to send me unencrypted text/email communications now and in the future.

Authorized (Text) Phone Number: ______________________________

Authorized Email Address: ______________________________

______ **I DO NOT ALLOW** Hogan Eye Associates, Inc. to send me unencrypted text/email communications now and in the future.

______________________________ Patient or Parent/Guardian Signature

______________ Date

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Authorization for the Release of Protected Health Information

Name: ____

DOB: ____________________ Phone Number: ____________________

Mailing Address: ____

I authorize the release of protected health information identifying me (including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services) under the following terms and conditions:

FROM:		TO:	
Name:	____________________	Name:	____________________
Address:	____________________	Address:	____________________
Address:	____________________	Address:	____________________
Phone:	____________________	Phone:	____________________
Fax:	____________________	Fax:	____________________

1. Detailed description of the information to be released:

2. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):

3. Expiration date ____________________ or the event relating to the individual or purpose for the release:
   ____

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization. If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send the note to the office contact information listed at the top of this form. 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. (For marketing authorizations, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your protected health information in accordance with this authorization.)

I have read and understood this form. I am signing it voluntarily. I authorize the disclosure of my protected health information as described in this form.

____ ____________________

Patient or Representative Signature Date

If you are signing as a representative of the patient, describe your relationship to the patient and the source of your authority.

Print Name: ____________________ Relationship to Patient: ____________________

Source of Authority: ____