WEBB
eyecare

Hello,

I would like to take this opportunity to thank you for choosing Webb Eyecare for your eyecare needs. We look forward to meeting and exceeding your expectations at your upcoming visit and building a lasting relationship with you and your family.

We are excited to tell you about all of the things that make us different from everyone else. Things like our ***2-year frame and lens warranty***, our ***guaranteed contact lens success program***, and our ***60 day love your glasses guarantee***. We strive to provide the most comprehensive eyecare available and offer only the highest quality products. We'll back it up with great service, and a worry free warranty. Our motto is *We'll Change The Way You Look At Eyecare.* We hope you find that to be true.

As a healthcare provider there is always information that we need to receive from you to best serve you. We therefore have a *'Welcome to our office'* form that we need to have you fill out. We've enclosed this form to give you the opportunity to fill it out at your convenience before arriving for your appointment. This will save you time when you arrive at our office. Just bring it with you to your exam and we can get started right away.

We promise at Webb Eyecare to do the best we can to honor your time by always striving to stay on schedule and keep your wait time to a minimum. We also ask that you help us, and other patients, by showing up on time (or early) for your appointment and calling us in advance to let us know if you will be late or cannot make your appointment. By doing this, we can move other patients into your slot and prevent people from having to wait very long for appointments.

When you arrive for your appointment we ask that you bring in your old glasses and contacts with you, if you have them. It always helps us to know if you have had a prescription change or to know what your favorite contact lens brand is. By bringing your previous eyewear with you we can often prevent extra visits to the office.

If you have vision insurance, bring your insurance card with you or have the information of the primary insured available. If you're not sure what you need, let our staff know which insurance you have and we'll be happy to help you out. Remember that co-pays and non-covered expenses are due at the time of service.

We look forward to meeting your highest expectations.

Sincerely,

Dr. Jason A. Webb, O.D.
Webb Eyecare
308-635-0800

WEBB eyecare

We'll change the way you look at eyecare

WELCOME TO OUR OFFICE

Jason A. Webb, O.D.
308-635-0800
www.webbeyecare.com

Patient Information

Today's Date: ___/___/_____

Last: _____

First: _____ MI: ____

Street: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

May We Contact You By Text?: ☐ Yes ☐ No

Email Address: _____

May We Contact You By Email?: ☐ Yes ☐ No

SS#: _____ ☐ Male ☐ Female

Date of Birth: ___/___/_____ Age: _____

Height: _____ Weight: _____

Employer (or School): _____

Occupation (or Grade): _____

Spouse (or Parent's) Name: _____

Spouse (or Parent's) Work: _____

Preferred Language: ☐ English ☐ Spanish

Race: ☐ White ☐ Hispanic ☐ American Indian
☐ Alaska Native ☐ Asian ☐ African American
☐ Native Hawaiian/Other Pacific Island

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino
☐ Native Hawaiian/Other Pacific Island

Communication Preference:
☐ Email ☐ Postal ☐ Telephone

Insurance Information

Primary Medical Insurance: _____

Vision Insurance: _____

Subscribers Employer: _____

Subscriber Name: _____

Subscriber SS#: _____

Subscriber Date of Birth: ___/___/_____

Group Policy #: _____

Subscriber ID #: _____

Do you participate in a flex spending account?
☐ Yes ☐ No

How will you settle your account today?
☐ Cash ☐ Check ☐ Card

VERY IMPORTANT! NEW PATIENTS ONLY

Who may we thank for referring you to our office?

Name of friend or relative: _____

If not referred, how did you choose our office?
☐ Another Doctor ☐ Insurance List
☐ Saw Sign/Building ☐ Newspaper/Radio/TV
☐ Yellow Pages: Which Directory? _____
☐ Web Page: Website? _____
☐ Other: _____

What is the primary reason for your visit?

_____

Are you currently experiencing any of the following problems?
☐ Blurry Vision ☐ Vision Loss ☐ Eye Abrasion
☐ Eye Allergy ☐ Double Vision ☐ Eye Turn
☐ Side Vision Problems ☐ Flashes or Floaters
☐ Headache:
☐ *New* ☐ *Chronic*
☐ Lumps or Bumps on Eyelids ☐ Painful Eye
☐ Red Eye ☐ Eye Injury ☐ Other
☐ No Problems / Annual Exam

Patient Medical History

Name of Family Physician: _____

Town: _____

Date of Last Physical Check-up: ____/____/_____

CURRENT MEDICATIONS (Rx or Over the Counter)
(Including eye drops, vitamins, and birth control pills):

_____

_____

Allergies to medications? ☐ Yes ☐ No
If so, please explain: _____

_____

Have you had any surgeries? ☐ Yes ☐ No
If so, please explain: _____

_____

Do you use? ☐ cigarette/tobacco ☐ alcohol
☐ other substances

Have you ever been diagnosed or treated for the following health problems?	Currently	In the past	Never
Allergies	☐	☐	☐
Arthritis	☐	☐	☐
Blood/Lumph	☐	☐	☐
Bronchitis	☐	☐	☐
Cancer	☐	☐	☐
Cholesterol	☐	☐	☐
Diabetes	☐	☐	☐
Digestive	☐	☐	☐
Ears/Nose/Throat	☐	☐	☐
Eczema/Rashes	☐	☐	☐
Endocrine	☐	☐	☐
Eye Injury	☐	☐	☐
Fatigue	☐	☐	☐
Fevers	☐	☐	☐
Flashes of light/floaters	☐	☐	☐
Genitourinary	☐	☐	☐
Glaucoma	☐	☐	☐
Headaches	☐	☐	☐
High Blood Pressure	☐	☐	☐
Integumentary (Skin)	☐	☐	☐
Kidney	☐	☐	☐
Macular Degeneration	☐	☐	☐
Muscle/Bone	☐	☐	☐
Neurological	☐	☐	☐
Psychological	☐	☐	☐
Respiratory	☐	☐	☐
Retinal Detachment	☐	☐	☐
Sinus	☐	☐	☐
Throat Infections	☐	☐	☐
Thyroid	☐	☐	☐
Unusual weight loss/gain	☐	☐	☐

Other _____

Patient Eye History

Date of Last Eye Exam: ____/____/_____

By Whom? _____

Do you currently wear glasses? ☐ Yes ☐ No

☐ SV ☐ Bifocal ☐ Trifocal ☐ Progressive

If you wear bifocals, do the lines or head tilting bother you?

☐ Yes ☐ No

Do you currently wear contact lenses? ☐ Yes ☐ No

What kind? _____

Solutions used: _____

If no, are you interested in wearing contact lenses?

☐ Yes ☐ No

Are you satisfied with the vision and comfort of your contact lenses?

☐ Yes ☐ No

Would you prefer clear or colored contact lenses?

☐ Clear ☐ Colored

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following?
(Please indicate mother, father, maternal/paternal, grandmother, grandfather)

☐ Blindness _____
☐ Cataracts _____
☐ Corneal Problems _____
☐ Diabetes _____
☐ Glaucoma _____
☐ Heart Disease _____
☐ Lazy Eye _____
☐ Macular Degeneration _____
☐ Retinal Detachment _____

Lifestyle Questions

Do you . . . . . (check box if your answer is yes)

☐ . . . have children?
☐ . . . work at a computer?
☐ . . . think you may benefit from thinner, lighter lenses?
☐ . . . have interest in a "test drive" of latest contact lens designs?
☐ . . . spend time outdoors? How many ____ hrs/week?
☐ . . . have prescription sunwear?
☐ . . . prefer not to wear your glasses at times?
☐ . . . want information on Laser Correction Surgery?
☐ . . . have more than one pair of current Rx eyewear?
☐ . . . have family members in need of eyecare?

Treatment

Are you interested in treating dark spots, redness, and/or fine lines around the eyes?

☐ yes ☐ no

NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION AND HOW YOU CAN GET ACCESS TO SUCH INFORMATION. PLEASE READ IT CAREFULLY. Your "health information," for purposes of this Notice, is generally any information that identifies you and is created, received, maintained or transmitted by us in the course of providing health care items or services to you (referred to as "health information" in this Notice).

We are required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable laws to maintain the privacy of your health information, to provide individuals with this Notice of our legal duties and privacy practices with respect to such information, and to abide by the terms of this Notice. We are also required by law to notify affected individuals following a breach of their unsecured health information.

USES AND DISCLOSURES OF INFORMATION WITHOUT YOUR AUTHORIZATION

The most common reasons why we use or disclose your health information are for treatment, payment or health care operations. Examples of how we use or disclose your health information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we must carry out in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

OTHER DISCLOSURES AND USES WE MAY MAKE WITHOUT YOUR AUTHORIZATION OR CONSENT

In some limited situations, the law allows or requires us to use or disclose your health information without your consent or authorization. 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 federal 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 president or 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 of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" and their subcontractors who perform health care operations for us and who commit to respect the privacy of your health information in accordance with HIPAA;
- [specify other uses and disclosures affected by state law].

Unless you object, we will also share relevant information about your care with any of your personal representatives who are helping you with your eye care. Upon your death, we may disclose to your family members or to other persons who were involved in your care or payment for heath care prior to your death (such as your personal representative) health information

relevant to their involvement in your care unless doing so is inconsistent with your preferences as expressed to us prior to your death.

SPECIFIC USES AND DISCLOSURES OF INFORMATION REQUIRING YOUR AUTHORIZATION

The following are some specific uses and disclosures we may not make of your health information **without** your authorization:

Marketing activities. We must obtain your authorization prior to using or disclosing any of your health information for marketing purposes unless such marketing communications take the form of face-to-face communications we may make with individuals or promotional gifts of nominal value that we may provide. If such marketing involves financial payment to us from a third party your authorization must also include consent to such payment.

Sale of health information. We do not currently sell or plan to sell your health information and we must seek your authorization prior to doing so.

Psychotherapy notes. Although we do not create or maintain psychotherapy notes on our patients, we are required to notify you that we generally must obtain your authorization prior to using or disclosing any such notes.

YOUR RIGHTS TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES

- Other uses and disclosures of your health information that are not described in this Notice will be made only with your written authorization.

- You may give us written authorization permitting us to use your health information or to disclose it to anyone for any purpose.

- We will obtain your written authorization for uses and disclosures of your health information that are not identified in this Notice or are not otherwise permitted by applicable law.

- We must agree to your request to restrict disclosure of your health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law and such information pertains solely to a health care item or service for which you have paid in full (or for which another person other than the health plan has paid in full on your behalf).

Any authorization you provide to us regarding the use and disclosure of your health information may be revoked by you in writing at any time. After you revoke your authorization, we will no longer use or disclose your health information for the reasons described in the authorization. However, we are generally unable to retract any disclosures that we may have already made with your authorization. We may also be required to disclose health information as necessary for purposes of payment for services received by you prior to the date you revoked your authorization.

YOUR INDIVIDUAL RIGHTS

You have many rights concerning the confidentiality of your health information. You have the right:

- **To request restrictions on the health information we may use and disclose for treatment, payment and health care operations.** We are not required to agree to these requests. To request restrictions, please send a written request to us at the address below.

- **To receive confidential communications of health information about you in any manner other than described in our authorization request form**. You must make such requests in writing to the address below. However, we reserve the right to determine if we will be able to continue your treatment under such restrictive authorizations.

- **To inspect or copy your health information.** You must make such requests in writing to the address below. If you request a copy of your health information we may charge you a fee for the cost of copying, mailing or other supplies. In certain circumstances we may deny your request to inspect or copy your health information, subject to applicable law.

- **To amend health information.** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, you must write to us at the address below. You must also give us a reason to support your request. We may deny your request to amend your health information if it is not in writing or does not provide a reason to support your request. We may also deny your request if the health information:

- was not created by us, unless the person that created the information is no longer available to make the amendment,
- is not part of the health information kept by or for us,
- is not part of the information you would be permitted to inspect or copy, or
- is accurate and complete.

- **To receive an accounting of disclosures of your health information.** You must make such requests in writing to the address below. Not all health information is subject to this request. Your request must state a time period for the information you would like to receive, no longer than 6 years prior to the date of your request and may not include dates before April 14, 2003. Your request must state how you would like to receive the report (paper, electronically).

- **To designate another party to receive your health information.** If your request for access of your health information directs us to transmit a copy of the health information directly to another person the request must be made by you in writing to the address below and must clearly identify the designated recipient and where to send the copy of the health information.

Contact Person:

Our contact person for all questions, requests or for further information related to the privacy of your health information is:

_____
_____

Complaints:

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or to 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 the office contact person at the address, fax or E mail shown above. If you prefer, you can discuss your complaint in person or by phone.

Changes to This Notice:

We reserve the right to change our privacy practices and to apply the revised practices to health information about you that we already have. Any revision to our privacy practices will be described in a revised Notice that will be posted prominently in our facility. Copies of this Notice are also available upon request at our reception area.

Notice Revised and Effective: February 17, 2014

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Jason Webb, O.D., Notice of Privacy Practices.

Date _____ Patient name_____ Signature _____

Webb Eyecare
Financial Agreement

As a courtesy to our patients we will bill your insurance company for you. If our office has not received payment or a denial within 60 days of the date of service the charges will be made the patients responsibility. It will be your responsibility to contact your insurance company in regards to payment.
Please initial _____

The following paragraphs explain your financial responsibility with Webb Eyecare.

1. **Financial Agreement:** I individually obligate myself to pay the account to Webb Eyecare. For patients with no insurance coverage, payment is due at the time of service for all examinations, ½ down is required on all glasses and contacts when ordered. The remainder of the balance will be paid in full in order to receive products ordered, unless prior financial arrangements have been made with the business manager, and documented. For patients with insurance, an estimate of insurance co-pays and surcharges will be given to you, and are due at the time products are ordered. These are just estimates and adjustments will be made after receipt of the explanation of benefits. Payment on these non-covered services will be due 30 days after issuance of statement to the patient.
2. **Assignment of Insurance Benefits:** I authorize payment directly to Webb Eyecare of the group or personal benefits or any other insurance benefits otherwise payable to me, for services rendered by Webb Eyecare. I authorize Webb Eyecare to act as my agent in helping me obtain payment of my insurance and or Medicare benefits. My signature authorizes release of my medical information to the insurer.
3. **Collection Fees:** I agree that if payment on this account is not made in accordance with the above mentioned terms, I will pay reasonable attorney's fees and other costs incurred for collections.

I certify that I have read the above and wish to receive services today. I plan to settle my account today by:

Credit card_____ Check_____ Cash_____

Responsible Party Signature_____

Relationship to Patient _____

Date _____

Monthly Giveaway

__ Yes, I want to be entered in the monthly giveaway. If chosen as the winner, I understand that I have one week to pick up the prize.

__ No, I do not want to be entered in the monthly giveaway.

Signature:_____

Date:_____

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