Chart #__________________

Michael K. Haskett, OD
Welcome to Our Office

Patient Information (Please Print)

First Name _____________________ MI _ Last Name _____________ (Jr, Sr, Etc.)_____

Preferred Name _______________ Soc. Sec #________________ DOB______________

Sex M F Marital Status S M D W Preferred Language: English / Spanish

Address ____

City, State, Zip ____

Primary Phone # ____________________ Alternate Phone#________________________

Employer __________________________ Occupation_____________________________

Please Circle:
Preferred Communication: Postal Telephone Text Message
Email (address)____

Race: American Indian
Asian
Black or African American
Hispanic
Native Hawaiian
White

Ethnicity: Hispanic or Latino
Non Hispanic or Latino

I hereby acknowledge that I have seen and/or read a copy of Michael K. Haskett, O.D. PC's notice of Privacy Practices. I understand that I have the option of receiving a copy of the privacy notice and can refuse to sign this acknowledgement if I so choose.

Responsible Party (Please print) ____

Relationship to patient____

Please circle if applicable

Court Appointed Guardian *Executor/Administrator of estate* *Power of Attorney*

Court papers are required for these relationships

Responsible Party (Signature) ____

Date ____

Chart #________________________

Michael K Haskett OD PC

2047 HAMILTON BLVD | SOUTH BOSTON VA, 24592 | (434) 572-9733

Written Financial Policy

Thank you for choosing Michael K Haskett OD PC. Our primary mission is to deliver the best and most comprehensive eye care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, MasterCard or Discover
- CareCredit healthcare credit card. CareCredit is the preferred healthcare credit card providing special financing and payment options* for out-of-pocket medical expenses. Ask about how the CareCredit healthcare credit card can help you.

Please note:

It is customary to pay for professional services when rendered. However, if you have a medical problem then we will bill your insurance on your behalf. A refraction is a measurement of the lens power necessary to prescribe glasses or other corrective lenses. Most medical insurance plans, including Medicare, do not cover routine refractions or routine eye exams (exams with no medical diagnosis). Medicare, and most other insurance plans, insists that we charge separately for that portion of the examination, since it is not a covered service. You will receive an explanation of benefits from them itemizing your responsibilities. You will be responsible for any co-payments, deductibles or non-covered services as determined by your insurance company.

If you have a separate plan that covers routine or annual eye examinations and/or glasses, please let us know. Your vision plan may assist you with your eye care needs that are not covered by your medical plan.

We are a Medicare participating practice. If you are a Medicare Beneficiary, we will file a claim for you. You will be responsible for the annual deductible and the 20% co-payment if not covered by a supplement insurance plan.

MINORS ACCOMPANIED BY AN ADULT; The adult accompanying a minor and his/her parents (or guardian) are responsible for payment of their exam or consultation.

In accordance with our contract and with your insurance provider, we are responsible for collecting, and you are responsible for paying, co-payments at the time of service and will verify your insurance eligibility prior to your appointment.

Michael K Haskett OD PC requires a 50% deposit collected prior to delivery of your optical purchase. Payment in full is required upon pick-up of product.

Protected Health Information can be released to the following:

1. ____ Relationship ____________________

2. ____ Relationship ____________________

3. ____ Relationship ____________________

____

Patient, Parent or Guardian Signature Date

____

Patient Name (Please Print)

* Subject to credit approval

PATIENT FORM

EYE HISTORY

Date of Last Eye Exam

Currently Wear Glasses?

Currently Wear Contacts?

Reason for Today's Visit

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

Condition			
Cataracts	*yes*	*no*	*family*
Crossed Eye	*yes*	*no*	*family*
Glaucoma	*yes*	*no*	*family*
LASIK or RK	*yes*	*no*	*family*
Lazy Eye	*yes*	*no*	*family*
Macular Degeneration	*yes*	*no*	*family*
Retinal Detachment	*yes*	*no*	*family*

Are you currently experiencing, or have experienced, any of the following? Check all that apply.

- ☐ Blurry Vision *near or distance*
- ☐ Burning
- ☐ Discharge
- ☐ Double Vision
- ☐ Dryness
- ☐ Excess Tearing/Watering
- ☐ Eye Infection
- ☐ Eye Pain or Soreness
- ☐ Floaters or Spots
- ☐ Halos
- ☐ Headaches
- ☐ Itching
- ☐ Light Flashes
- ☐ Light Sensitivity
- ☐ Redness
- ☐ Sandy or Gritty Feeling

MEDICAL HISTORY

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

Condition			
AIDS/HIV	*yes*	*no*	*family*
Allergies	*yes*	*no*	*family*
Arthritis	*yes*	*no*	*family*
Asthma	*yes*	*no*	*family*
Blood/Lymph Disorder	*yes*	*no*	*family*
Cancer	*yes*	*no*	*family*
Diabetes	*yes*	*no*	*family*
Ears, Nose, Throat Conditions	*yes*	*no*	*family*
Gastrointestinal Conditions	*yes*	*no*	*family*
Heart Disease	*yes*	*no*	*family*
High Blood Pressure	*yes*	*no*	*family*
High Cholesterol	*yes*	*no*	*family*
Kidney Disease	*yes*	*no*	*family*
Lupus	*yes*	*no*	*family*
Neurological Conditions	*yes*	*no*	*family*
Psychiatric Disorder	*yes*	*no*	*family*
Seizures	*yes*	*no*	*family*
Skin Conditions	*yes*	*no*	*family*
Stroke	*yes*	*no*	*family*
Thyroid Dysfunction	*yes*	*no*	*family*

Current Medications (prescription and over-the-counter and dosage)

Medication Drug Allergies

Height **Weight**

Are you pregnant or nursing?

Do you smoke?

Have you ever smoked?

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