Bowden Eye & Associates

Patient Name: _____
DOB: _____

List your current medication allergies:_____

List the current medications you are taking:

_____ _____ _____
_____ _____ _____

Please check the box if the condition applies to you, and explain when necessary.

_____ Eye pain
_____ Red eyes
_____ Watery eyes
_____Film over eyes
_____ Road signs are blurry
_____ Small print is blurry
_____ Dry or scratch eyes
_____ Eye swelling or itch
_____ Migraine Headaches
_____ Droopy Eyelids
_____ Fluctuation in Vision

_____Other Headaches? Explain _____
_____ Difficulty driving due to vision
_____Glare from car lights or sunlight
_____Glare from car lights or sunlight
_____ Double vision
_____ Vision blackout
_____ Flashes of light, floaters or spots in vision. Explain _____
_____ Do you wear glasses? If yes, are they:
_____Prescription and/or _____Reading glasses

_____ Do you have a known eye disease? If yes, what type? _____
_____ Have you ever had eye surgery? If yes, when? _____

Please check the box if you are experiencing any symptoms or have been diagnosed with a condition in these areas:

_____ Chronic fever, unexpected weight gain/loss, fatigue? If yes, when? _____
_____ Ear, nose, throat problems? (e.g. Murmur, CHF, stroke, heart attack, irregular heart beat) _____
_____High blood pressure? If yes, is it _____ controlled or _____ uncontrolled?
_____ Respiratory problems? (e.g. Asthma, emphysema, TB, shortness of breath) If so, when? _____
_____ Urinary problems? (e.g. Pain or discomfort, kidney stones, dialysis, kidney disease) _____
_____ Diabetes or other endocrine problems? _____
_____ Blood or lymphatic disease? (e.g. Free bladder, bleeding disorders, leukemia, etc) _____

Have you ever been told that you have:

Gastrointestinal problems? (stomach ulcer, abdominal pain, etc) If yes, when? _____
Allergic or immunologic problems? _____
Cancer? If yes, what type _____ skin _____ pituitary _____ lung _____ colon _____ breast _____ stomach Other: _____
Musculoskeletal problems? (e.g. Joint pain, arthritis) If so, when?_____
Skin conditions? Please describe: _____
Neurological problems? (e.g. Numbness, weakness, tingling, headache) _____
Psychological problems? (e.g. depression, anxiety) _____

PAST HISTORY:

Do you have any other medical conditions that you have NOT listed in the categories above? _____
Have you had any surgery in the past 10 years? _____ YES _____ NO If yes, when? _____

CURRENT HISTORY:

Have you ever had general anesthesia? _____ YES _____ NO
Have you ever been diagnosed with HIV? _____ YES _____ NO
Do you have hepatitis of any form? _____YES _____ NO If so, what type? _____
Have you had any type of blood transfusion since 1980? _____ YES _____ NO If yes, why? _____
Have you ever been diagnosed or treated for alcoholism or drug abuse? _____ YES _____ NO

FAMILY HISTORY: Does/Did anyone in your immediate family have any of the following:

Glaucoma	_____ YES _____ NO	_____ Father _____ Mother _____ Brother _____ Sister _____ Grandparent
Blindness	_____ YES _____ NO	_____ Father _____ Mother _____ Brother _____ Sister _____ Grandparent
Diabetes	_____ YES _____ NO	_____ Father _____ Mother _____ Brother _____ Sister _____ Grandparent
Heart Disease	_____ YES _____ NO	_____ Father _____ Mother _____ Brother _____ Sister _____ Grandparent
High Blood Pressure	_____ YES _____ NO	_____ Father _____ Mother _____ Brother _____ Sister _____ Grandparent

DOCTOR'S SIGNATURE: _____ **DATE:** _____

Bowden Eye & Associates

Notice of Privacy Practices **Effective Date: _____04/07/2025_____**

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.

At **Bowden Eye & Associates**, protecting your privacy is a priority. This Notice explains how we may use and disclose your Protected Health Information (PHI) and describes your rights under the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act.

OUR LEGAL RESPONSIBILITIES

We are required by law to:

- Maintain the privacy and security of your PHI.
- Provide you with this Notice outlining our privacy practices.
- Notify you promptly if a breach occurs that may compromise your PHI.
- Follow the terms of this Notice.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

1. Treatment

We may use and share your PHI to provide, coordinate, and manage your eye care. This includes sharing information with ophthalmologists, optometrists, opticians, certified nurse anesthetists, and other healthcare professionals involved in your treatment.

2. Payment

We may use and disclose your PHI to bill and collect payment from you, your insurance provider, or a third party. This can include verifying eligibility, obtaining prior authorization, or processing claims.

3. Healthcare Operations

We may use and disclose your PHI for business and operational purposes, such as quality improvement, staff training, licensing, and auditing.

4. Appointment Reminders & Health-Related Services

We may contact you to remind you of upcoming appointments or to inform you of services or treatment options that may benefit your care.

5. As Required by Law

We will disclose your PHI when required by federal, state, or local law.

6. Public Health & Safety

We may disclose your PHI to public health authorities for reasons such as preventing disease, reporting abuse or neglect, or to reduce a serious threat to health and safety.

7. Research

We may use or share your PHI for research purposes under certain conditions and with proper safeguards.

8. Legal and Law Enforcement

We may disclose your PHI in response to court orders, subpoenas, or other lawful processes, as required by law enforcement or regulatory bodies.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

1. Right to Access

You may request to review or obtain copies of your PHI.

2. Right to Request Amendments

You can request corrections to your PHI if you believe it is incomplete or incorrect.

3. Right to an Accounting of Disclosures

You may request a list of certain disclosures of your PHI made outside of treatment, payment, or healthcare operations.

4. Right to Request Restrictions

You may request restrictions on the use or disclosure of your PHI. While we may not always be legally required to agree, we will comply where applicable by law.

5. Right to Confidential Communications

You may request that we communicate with you in a specific way or at a specific location.

6. Right to a Paper Copy of This Notice

You can request a paper copy of this Notice at any time, even if you receive it electronically.

7. Right to Revoke Authorization

You may revoke your consent for the use or disclosure of your PHI in writing, except where actions have already been taken.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice. Any changes will apply to all PHI we maintain, and a current version will be posted in our office and on our website.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the appropriate government agency. We will not retaliate against you for filing a complaint.

1. Contact Our Privacy Officer:

Bowden Eye & Associates
7205 Bentley Rd
Jacksonville, FL 32256
Phone: 904-296-0098

2. U.S. Department of Health and Human Services - Office for Civil Rights (OCR):

Phone: 1-800-368-1019
TTY: 1-800-537-7697
Website: https://www.hhs.gov/hipaa/filing-a-complaint/

3. Medicare Beneficiary Ombudsman:

Phone: 1-800-MEDICARE (1-800-633-4227)
Website: https://www.medicare.gov/claims-appeals/file-a-complaint/complaints-about-your-care-or-services

4. Florida Agency for Health Care Administration (AHCA) - Consumer Complaint Hotline:

Phone: 1-888-419-3456
Website: https://ahca.myflorida.com/Complaint

5. Georgia Department of Community Health - Healthcare Facility Regulation:

Phone: 1-800-878-6442
Website: https://dch.georgia.gov/divisionsoffices/hfrd/hfr-complaints

6. South Carolina Department of Health and Environmental Control (DHEC):

Phone: 1-800-922-6735
Website: https://scdhec.gov/healthcare-facility-complaints

Bowden Eye & Associates

Patient Acknowledgment of Receipt of Notice of Privacy Practices & Designation of Authorized Persons

Patient Acknowledgment

By signing below, I acknowledge that I have received or been offered a copy of **Bowden Eye & Associates**'s Notice of Privacy Practices. I understand that this Notice describes how my health information may be used and disclosed in accordance with HIPAA and the HITECH Act and details my rights regarding my health information.

Patient Information

Patient Name: _____ **Date of Birth:** _____
Phone Number: _____ **Email Address (optional):** _____

Designation of Authorized Persons

In accordance with HIPAA, you may designate individuals who are authorized to receive your Protected Health Information (PHI) on your behalf. This includes appointment details, test results, billing information, and other health information.

I authorize **Bowden Eye & Associates** to release my PHI to the following individuals:

1. Name: _____
Relationship to Patient: _____
Phone Number: _____

2. Name: _____
Relationship to Patient: _____
Phone Number: _____

3. Name: _____
Relationship to Patient: _____
Phone Number: _____

☐ **I do not wish to authorize anyone at this time.**

Authorization Terms

- This authorization will remain in effect until I revoke it in writing.
- I understand that this authorization is voluntary and that I may restrict or revoke this consent at any time.
- Revocation will not apply to information that has already been released under this authorization.

Patient Signature

Patient Signature: _____ **Date:** _____

If signed by legal representative, print name and relationship to patient:

Name: _____ **Relationship:** _____

Bowden Eye & Associates

Patient Information

Name: _____
First Middle Last

Primary Billing Address: _____

City: _____ State: _____ Zip: _____

Mobile: _____ Home: _____ Work: _____ Email: _____

Birth Date (Mo/Day/Yr): _____ Age: _____ Sex: _____ Social Security #: _____

Primary Name of Insurance: _____ Policy Holder Name: _____

Birth Date (Mo/Day/Yr): _____ Social Security #: _____
Policy Holder Policy Holder

Secondary Name of Insurance: _____ Policy Holder Name: _____

Birth Date (Mo/Day/Yr): _____ Social Security #: _____
Policy Holder Policy Holder

Family Physician: _____

Optometrist Name: _____

Referring Physician Name: _____

Emergency Contact (Relationship): _____ Tel: _____

How Did You Hear About Us?

Friend ☐ Referring Doctor ☐ E-blast ☐ Website ☐ Billboard ☐ Radio ☐ Print ☐ Other ☐

Patient Electronic Information Disclosure

Patients in our practice may be contacted via email or text messaging for appointment reminders, eyewear ready notifications, and other communications related to Bowden Eye & Associates services, health care news, new technology, special offers, etc. If, at any time, you do not wish to receive these communications, you can revoke permission by following the "unsubscribe" information at the bottom of any email or by replying "STOP" to any text message you receive from us.

Patient Signature: _____ **Date:**_____

Financial Policy

EHA Company-wide Practice Financial Policy 20250228 v2
Effective Date: 04/07/2025
Thank you for choosing Bowden Eye & Associates for your eye care needs. To ensure clarity regarding financial responsibilities, we ask all patients to read and sign our financial policy.

1. Insurance & Billing

- We participate with many insurance plans; however, it is the patient's responsibility to verify coverage and provider participation with their carrier.
- Patients must present valid insurance information and patient identification at each visit.
- Copayments, deductibles, and any non-covered services must be paid at the time of service.
- Patients are responsible for any outstanding balances, as well as copays, estimated co-insurance, unmet deductibles, and any non-covered services at the time of service.
- If your insurance denies a claim related to incorrect insurance information, benefit design or maximum benefits reached, or non-covered items, you are responsible for the full balance.

Vision Plans vs. Medical Insurance

- Vision Plans cover only routine eye exams when there are no complaints or prior medical history. In addition, vision plans often have benefit designs that may limit how often you can be seen for routine care or obtain glasses or contact lens prescriptions.
- Vision benefit designs are authored by your employer, other insurance managers, or health insurance exchanges, and we must follow the coverage limitations they establish.
- Medical Insurance is used when there is an eye disease, the need for evaluation and management of an eye condition, or when a systemic disease (e.g., diabetes, hypertension) may affect eye health.
- It is possible to have a routine visit billed to a vision plan with a defined copay or co-insurance. However, during the exam, the doctor may discover the need to perform diagnostic testing or perform a minor procedure to address a medical concern. In this circumstance, you may incur a second copay or co-insurance from your medical insurance. You will be billed for these charges after your insurance has adjudicated the claim(s).

Refraction

- Refraction is a procedure that, when recommended and performed by your physician, is an essential tool used to determine both your glasses prescription and to rule out a refractive error that may be interfering with your medical eye diagnosis and treatment.
- Refraction is often not covered by insurance. If refraction is not covered by your insurance, you will be responsible for payment in full at the time of service.

2. No Surprises Act Billing

- In accordance with the No Surprises Act, patients who schedule elective operative procedures more than 3 days in advance will be presented with a Good Faith Estimate of their expected out-of-pocket costs.
- This estimate includes the anticipated costs for the procedure, provider fees, and any related services.
- The Good Faith Estimate is based on information available at the time of scheduling and may be subject to changes based on the actual services provided.

3. Pediatric Patients & Dependents

- Insurance for minor children (under 18 years old) will be billed in accordance with state insurance laws that govern coordination of benefits.
- We will not bill "the best insurance" but will follow the state-mandated order of coordination of benefits.
- By default, the parent holding the primary insurance policy will be billed unless we are specifically directed otherwise by court order or written instructions from the custodial parent.
- Once a child turns 18, they are considered a legal adult and will be held fully responsible for their own medical bills.
- Unpaid balances for patients 18 and older on the date of service may be sent to collections, which could impact their credit score.

4. Worker's Compensation

- If you are injured at work or if your visit is related to a prior work-related injury, we cannot bill your vision plan or medical insurance—we must bill your Worker's Compensation Managed Care Organization (MCO).
- You are responsible for providing:
    - The name of your Worker's Compensation MCO
    - Your case worker's information

- The original date of injury
- A history of where you were treated for the injury if this is not your first time seeking treatment for it

- If we do not receive this required information, you will be held responsible for the bill.

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5. Optical Materials (Glasses & Contact Lenses)

- All payments for optical materials (glasses and contact lenses) are due at the time of order.
- Materials will not be ordered without full payment in advance.
- Any remaining balance on optical materials not covered by insurance is due in full at the time of purchase.
- Optical materials are considered custom-made products and may not be eligible for refunds or exchanges once ordered.

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6. Charges for Medical Records & Forms Completion

- We may charge patients for paper copies of their medical records.
- Charges will be in accordance with state regulations, which determine the base fee and per-page rates.
- There is no charge when medical records are requested by another physician, hospital, or other qualified medical providers for continuity of care.
- Additional fees may apply for completion of medical forms, including but not limited to:
  - Disability forms
  - FMLA (Family and Medical Leave Act) paperwork
  - Insurance claim forms
  - Other administrative documentation
- Fees must be paid before forms are completed and released.

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7. Self-Pay Patients

- Patients without insurance or those receiving non-covered services must pay in full at the time of service.
- Self-pay fees are discounted from our regular fees.
- Payment plans are available and tiered based on the total balance owed. Payment plans cannot be extended beyond 6 months.

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8. Accepted Payment Methods

We accept the following forms of payment:

- Cash
- Personal Check (A fee of $45 will be charged for any returned checks.)
- Debit Cards
- Major Credit Cards (Visa, MasterCard, American Express, Discover)
- Flexible Financing through CareCredit (subject to approval)

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9. No-Show & Late Cancellation Policy

- In the event you miss your scheduled appointment, you may be charged a missed appointment fee up to $50 unless more than 24 hours advance notice is provided to our staff.

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10. Outstanding Balances

- Unpaid balances must be resolved before scheduling future appointments.
- Accounts overdue by 90 days will be referred to collections and may incur additional fees as well as impact your credit score.

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11. Refund Policy

- Refunds for overpayments will be issued after insurance claims are fully processed.
- Patients may request a refund for items they believe were overpaid or not received. A billing specialist will examine the account and determine refund eligibility.
- Refunds will be processed within a reasonable timeframe after review and approval.

By signing below, I acknowledge that I have read, understood, and agree to the terms outlined in this financial policy.

Patient Name: _____

Signature: _____

Date: _____

Bowden Eye & Associates

MEDICAL EXAM VS. VISION SCREENING EXAM

What is the difference between a Medical Exam and a Vision Exam?

Insurance coverage for eye exams vary. Some plans only cover routine, well eye exam visits. Other plans will not pay for your exam unless you have a medical eye condition or disease. Some plans require a referral from your primary care physician. Be sure to check your policy to determine your coverage prior to your appointment.

For insurance purposes, eye examinations are divided into two categories:

Vision Exam: These are routine or "Well Vision" exams for patients who have no eye conditions or systemic conditions that affect the vision or ocular health. Your eyes will be examined for any needed vision correction devices such as glasses or contact lenses. If your doctor finds anything abnormal during your well vision exam, further testing of a medical nature will be required at another visit. In rare cases during the technician's work up we will find medical conditions that require us to convert to a medical examination. Some conditions cannot simply be ignored by a physician solely because of one's insurance plan. This is best for your ocular health. If we must convert to a medical exam your insurance coverage would be utilized instead of your well care vision plan. ***Routine WELL vision exams do not include medication prescriptions of any kind. (New or Refills)*** Yearly diabetic eye exams will not be billed to insurances under vision coverage.

Medical Exam: This is a comprehensive ocular examination for the detection, diagnosis, and treatment of diseases and conditions of the eye performed by a physician or surgeon. This exam evaluates the reasons for the systems and assesses any treatment needed. Some conditions evaluated with medical eye exams include cataracts, glaucoma, diabetic retinopathy, macular degeneration, many other potentially sight-threatening diseases. There are many systemic health and family history conditions that can adversely affect the vision.

Patient Name: _____ DOB: _____

Patient Signature:_____ Date:_____

Most patients will have a refraction done during both types of exams. A refraction is a diagnostic test used to determine your best corrected vision. For some medical conditions, a refraction is needed even when eyeglasses are not prescribed. If your insurance does not cover your refraction, you will be asked to pay the fee of $70 at the time of service.