HEARTLAND EYE CONSULTANTS

9900 Nicholas Street ○ Suite 250 ○ Omaha, NE 68114
402-493-6500 ○ Fax: 402-493-4370

To Our Valued Patient:

Welcome to Heartland Eye Consultants! We are looking forward to seeing you and your child for their appointment. Please fill out the New Patient paperwork. We would greatly appreciate your taking the time to fill out these forms at home. This will save valuable time in-office and make available more time with your doctor. Please bring them with you to your appointment.

Please bring the following with you to your appointment:

1. The enclosed Patient Information Forms:
2. Your child's insurance card
3. Your child's co-pay
4. A list of any medications your child takes with the dosages
5. Your child's glasses (Even if they do now wear them)

Please note that all co-payments and applicable yearly deductibles are due at the time of your visit. Please make sure you have a credit card, your check book or cash with you.

This examination will NOT be considered a ROUTINE visit so we will be submitting to your major medical insurance, not your 'vision' or 'eye glasses' insurance.

If your child's insurance requires a referral from your primary care doctor (pediatrician or family doctor, *not* your eye doctor), it is your responsibility to request the referral **before** your appointment at Heartland Eye Consultants. If that is not done **by you** ahead of time, we may have to reschedule your appointment because some doctor's require a day's notice or more to get those completed and faxed to us.

Handicapped Parking and Senior Parking is available on the **west** side of the building. Parking there will eliminate the need to climb stairs.

If you have any questions or need to reschedule your appointment, please call us at (402)493-6500. Thank you for entrusting your vision to us!

Sincerely,
Patient Services

Heartland Eye Consultants
Pediatric Patient Demographics

Patient:
Last Name: _____ First Name: _____ M.I. _____

Street Address: _____ Apt #_____ Gender: ○M ○F Date of Birth: _____/_____/_____

City: _____ State: _____ Zip Code: _____ Home: (_____) _____ Soc. Sec. No. _____-_____-_____

Primary Language: ○English ○Spanish ○French ○Other_____ ○I decline.

Race: ○American Indian or Alaska Native ○Asian ○African-American ○Pacific Islander ○White ○Other Race ○I decline

Ethnicity: ○Not Hispanic or Latino ○Hispanic or Latino ○I decline ○ Other _____

Special Needs: ○Hearing Impaired ○Wheelchair ○Translator ○None ○ Other _____

Which doctor referred you to our office? _____ If not, please list _____

Who performed your last eye exam? _____ Date: ____/____/_____

Pediatrician/Family Physician: _____

Emergency Contact: _____ Relationship: _____ Phone: _____
(Not living in household) (Area Code)

Please place an X in the boxes to indicate with whom the child lives:
☐**Father's Last Name**:_____**First Name**:_____ M.I.____ Birthdate: _____/_____/_____

Address _____ City:_____ State:_____ Zip Code:_____

Cell Phone: (_____)_____ Home Phone:(_____)_____ Work Phone(_____)_____

Please provide your EMAIL address for appointment purposes only:_____

SSN:_____ Employer: _____Occupation_____Title: _____

Employer's Address:_____ City_____State_____Zip_____ Work Phone_____

☐**Mother's Last Name**:_____**First Name**:_____ M.I.____ Birthdate: _____/_____/_____

Address _____ City:_____ State:_____ Zip Code:_____

Cell Phone: (_____)_____ Home Phone:(_____)_____ Work Phone(_____)_____

Please provide your EMAIL address for appointment purposes only:_____

SSN:_____ Employer: _____ Occupation_____Title: _____

Employer's Address:_____ City_____State_____Zip_____ Work Phone_____

☐Step-Parent's Last Name: _____ First Name:_____M.I.____ Birthdate: _____/_____/_____

The person requesting services for a minor is the responsible party.

We will file major medical insurance coverage for you if you provide us with a copy of your current card. For patients without insurance coverage, you will be responsible for payment today by cash, check or credit card. (We accept MasterCard or Visa.)

Photo Release: I hereby grant Heartland Eye Consultants, L.L.C. and Developmental Vision Associates, P.C. permission to have my child's photograph taken for patient information. This does not allow them to use my child's likeness in photographs and/or video in any of its publications or media.

AUTHORIZATION TO RELEASE INFORMATION TO YOUR INSURANCE COMPANY AND ACKNOWLEDGEMENT OF PERSONAL RESPONSIBILITY FOR PAYMENT

I hereby assign all medical benefits (to which my child is entitled) to the doctor caring for my child. This includes major medical benefits, Medicare, Medicaid, private insurance and any health plans in which I am enrolled. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not they are paid by my insurance and 15% APR will be applied to all accounts not paid within 30 days. I hereby authorize the holder of my medical and patient registration records to release any information need to process my insurance claims. I understand that I am the guarantor of this account.

$15 Fee may incur if a copy of my medical records are requested in writing and will be provided whomever I designate.
$25 Fee will incur for all returned checks.
$50 A deposit will be required to schedule an appointment if you fail to keep an appointment or if you repeatedly reschedule your appointment with less than a 48 hour notice. This deposit will be credited to your bill if you keep your appointment as scheduled. However, you will forfeit the deposit if you No Show or reschedule again with less than a 48 hour notice.

Authorized Signature: _____Date of Signature: _____
PLEASE INITIAL _____ You have read and are aware of the HIPAA privacy policy and agree with its provisions.