



DEER EYE CLINIC

Philip J. Deer, III, M.D.

Holley Skinner, O.D.

COVID-19 Appointment Information

- Every person over the age of 5 who comes to the clinic is required to wear a face mask.
- Only 1 person other than the patient is allowed in the clinic. If the patient is over 18 years of age, it is best if they come alone, unless they need assistance.
- Upon arrival, patients should wait in the car and call (501) 224-4701 to inform the staff of your arrival.
- Please call to reschedule your appointment if within the last 14 days you:
 - Had a fever of 100.4 or higher
 - Had cough or shortness of breath
 - Had flu/pneumonia
 - Traveled out of the country
 - Have been in contact with anyone who tested positive for COVID-19
 - Have had a positive COVID-19 test
 - Are awaiting the results of a COVID-19 test

Thank you for your understanding!

DEC Staff



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New Patient Checklist

In order for your appointment to begin on time, please review the following checklist and bring each of the items listed on it with you to your appointment. If you need directions to our office, you can either visit our website or call us directly. We are here to help!

- Any patient under 18 MUST be accompanied by a parent or legal guardian for their office visit.**
- Picture ID (driver's license or other government issued identification card with photograph).
- Insurance Card (without this card, we will not be able to file your insurance claim). Please check your insurance to see if a **referral** is needed from your primary care physician prior to your appointment.
- Completed New Patient Registration Form (please fill out ALL applicable portions including social security number and date of birth).
- Completed Medical History Form (please be thorough). Please bring a list of all medications with you to your appointment.
- Signed HIPAA form.
- Signed Financial Policy form (if a minor, signature needs to be by the person who is financially responsible for patient).
- A form of payment (we accept all major credit cards as well as personal checks and cash).

We look forward to meeting you soon! If you have any questions regarding your new patient paperwork or have questions about anything else regarding your appointment, don't hesitate to call our office. If you find that you cannot arrive for your appointment on time, please make sure to give our office at least 24-hour notice.

OPHTHALMOLOGY • OPHTHALMIC SURGERY
4942 WEST MARKHAM • LITTLE ROCK, AR 72205
501-224-4701



Deer Eye Clinic
Patient Information

Patient Information- Complete all that Applies (Please Print)

Name _____ Date of Birth _____ Male [] Female []
Address _____ Soc Sec # _____
Street City State Zip Hispanic [] Not Hispanic [] Decline []
Phone Home (____) _____ Cell (____) _____ E-Mail _____
Family Physician _____
Occupation _____ Employer _____
Employer Address _____ Work Phone (____) _____
Marital Status: Single [] Married [] Widowed [] Divorced [] Other []
Spouse Name: _____ Date of Birth: _____ Phone (____) _____
Employer _____ Work (____) _____

Complete if Patient Under 18 Years or a Student (If information is same as patient, write "Same")

Name of Father _____ Date of Birth _____ Phone (____) _____
Address _____ Soc Sec # _____ Phone (____) _____
Name of Mother _____ Date of Birth _____ Phone (____) _____
Address _____ Soc Sec # _____ Phone (____) _____

Insurance Information

Name of Insurance Company and ID Number _____
Name of Policy Holder _____ Date of Birth _____
Address _____
Social Security # _____ Phone # _____ Relationship to Patient _____
Secondary Insurance/Vision Plan and ID Number _____
Name of Policy Holder _____ Date of Birth _____
Address _____
Social Security # _____ Phone # _____ Relationship to Patient _____

Referred By: Friend/Relative _____ Yellow Pages _____ Newspaper _____ Other _____
Who to notify in emergency (nearest relative or friend)?
Name _____ Relationship _____ Home (____) _____
Address _____ Cell (____) _____ Work (____) _____

Financial Assignment and Agreement

- 1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, any other balance not paid for by your insurance, and any collection agency fees.
2. In order to control your cost of billings, we request that your charges for office visits be paid at the conclusion of each visit unless you are covered by Medicare.
3. I request that payment of authorized Medicare and/or insurance benefits be mad on my behalf for any services furnished me. I authorize that any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.
4. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signed (Patient or Parent if Minor) _____ Date _____

CHART # TO BE COMPLETED BY FRONT DESK PROVIDER



**Deer Eye Clinic
Medical History Questionnaire**

Name: _____ Date: _____

Date of Birth: _____ Date of last eye exam: _____

List any medications (with the dosage and frequency in which you take them) you currently take (prescription and over-the-counter): _____

Are you allergic to Latex? **YES NO**

If YES, what is your reaction to Latex? (skin reaction, breathing problems, etc.) _____

Do you have any allergies to any medications? (Circle one) **YES NO**

If YES, list the medications and your reaction to them: _____

List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.) _____

List any surgeries you have had (cataract, tonsillectomy, appendectomy, etc.) _____

PERSONAL MEDICAL HISTORY

Eyes

(CHECK ALL BOXES OF ANY SYMPTOMS THAT YOU ARE CURRENTLY EXPERIENCING)

<input type="checkbox"/>	No Complaints
<input type="checkbox"/>	Failed Vision Screening
<input type="checkbox"/>	Decrease in Vision
<input type="checkbox"/>	Decrease in Peripheral Vision
<input type="checkbox"/>	Decrease in Central Vision
<input type="checkbox"/>	Distorted Vision
<input type="checkbox"/>	Scotoma (partial vision loss/blind spot)
<input type="checkbox"/>	Fluctuating Vision
<input type="checkbox"/>	Dim Vision
<input type="checkbox"/>	Double Vision
<input type="checkbox"/>	Fuzzy Vision
<input type="checkbox"/>	Hazy/Foggy Vision
<input type="checkbox"/>	Glare
<input type="checkbox"/>	Blur
<input type="checkbox"/>	Haze
<input type="checkbox"/>	Halos
<input type="checkbox"/>	Flashes
<input type="checkbox"/>	Floater
<input type="checkbox"/>	Flashes/Floater
<input type="checkbox"/>	Black Spots
<input type="checkbox"/>	Veil/Cobwebs
<input type="checkbox"/>	Headache
<input type="checkbox"/>	Throbbing

<input type="checkbox"/>	Burning Pain
<input type="checkbox"/>	Sharp Pain
<input type="checkbox"/>	Scratchy
<input type="checkbox"/>	Foreign Body Sensation
<input type="checkbox"/>	Irritation
<input type="checkbox"/>	Dull Pain/Aching
<input type="checkbox"/>	Photophobia (light sensitivity)
<input type="checkbox"/>	Dry/Burning
<input type="checkbox"/>	Itching
<input type="checkbox"/>	Tearing
<input type="checkbox"/>	Discharge
<input type="checkbox"/>	Sticking Lids
<input type="checkbox"/>	Mattering
<input type="checkbox"/>	Redness
<input type="checkbox"/>	Puffy Eyes
<input type="checkbox"/>	Tired Feeling
<input type="checkbox"/>	Sting
<input type="checkbox"/>	Swollen
<input type="checkbox"/>	Lump
<input type="checkbox"/>	Yellow
<input type="checkbox"/>	Other:

CONTINUED ON NEXT PAGE

CHECK THE BOX IF YOU EXPERIENCE OR ARE DIAGNOSED WITH ANY OF THE FOLLOWING:

CONSTITUTIONAL	
<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	Malaise
<input type="checkbox"/>	Chills
<input type="checkbox"/>	Fever
<input type="checkbox"/>	Night Sweats
<input type="checkbox"/>	Appetite Changes
<input type="checkbox"/>	Weight Changes
<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	None of the Above

RESPIRATORY	
<input type="checkbox"/>	COPD
<input type="checkbox"/>	Wheezing
<input type="checkbox"/>	Cough
<input type="checkbox"/>	Hemoptysis
<input type="checkbox"/>	Asthma
<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Shortness of Breath
<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	None of the Above

HEAD, EARS, NOSE AND THROAT	
<input type="checkbox"/>	Head Injury
<input type="checkbox"/>	Decreased Hearing
<input type="checkbox"/>	Tinnitus
<input type="checkbox"/>	Earache
<input type="checkbox"/>	Hay Fever
<input type="checkbox"/>	Sinus Pain
<input type="checkbox"/>	Stuffiness
<input type="checkbox"/>	Discharge
<input type="checkbox"/>	Dry Mouth
<input type="checkbox"/>	Sore Throat
<input type="checkbox"/>	Dentures
<input type="checkbox"/>	Difficulty Swallowing
<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	None of the Above

Gastrointestinal	
<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	Constipation
<input type="checkbox"/>	Stool Changes
<input type="checkbox"/>	Hemorrhoids
<input type="checkbox"/>	Indigestion
<input type="checkbox"/>	Difficulty Swallowing
<input type="checkbox"/>	Nausea/Vomiting
<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	None of the Above

CARDIOVASCULAR	
<input type="checkbox"/>	Angina
<input type="checkbox"/>	Heart Attack
<input type="checkbox"/>	High Cholesterol
<input type="checkbox"/>	High BP
<input type="checkbox"/>	Low BP
<input type="checkbox"/>	Murmur
<input type="checkbox"/>	Thrombophlebitis
<input type="checkbox"/>	Varicose Veins
<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	None of the Above

GENITOURINARY	
<input type="checkbox"/>	Blood
<input type="checkbox"/>	BHP
<input type="checkbox"/>	Difficult Urination
<input type="checkbox"/>	Enlarged Prostate
<input type="checkbox"/>	Increased Frequency
<input type="checkbox"/>	Frequent UTIs
<input type="checkbox"/>	Incontinence
<input type="checkbox"/>	Kidney Stones
<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	None of the Above

DERMATOLOGICAL	
<input type="checkbox"/>	Rash
<input type="checkbox"/>	Lump
<input type="checkbox"/>	Itching
<input type="checkbox"/>	Dryness
<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	None of the Above



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RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____ have received a copy of DEER EYE CLINIC
(Patient's Name)

Clinic's Notice of Privacy Practices. (A copy can be found at www.Deereyeclinic.com, on the "Patient Forms" page select "Clinic Privacy Practices." A copy can also be requested upon your arrival at Deer Eye Clinic before/on your appointment).

Signature of Patient

Date

I elect the person(s) below as my account representatives. This will allow them access to information regarding my account and medical history.

Name _____

Name _____

Name _____

Name _____

Name _____

Name _____



DEER EYE CLINIC

Financial Policy

Welcome and thank you for choosing Deer Eye Clinic for your eye care. We are committed to providing you with the highest quality eye care possible in a cost-effective manner.

Our professional fees have been determined through careful consideration in addition to being reasonable and customary within our geographical area. We are pleased to discuss with you any question you may have concerning a bill.

Payment in full is due at the time services are rendered. Our staff check your insurance benefits and take that information into consideration when collecting for the appointment. As a courtesy to our patients, we accept cash, personal check, money order, Visa, MasterCard, Discover, American Express, and Care Credit.

In order to achieve our goal of providing you with the best care possible, we need your assistance and your understanding of our financial policy:

Cancellation and Missed Appointment Policy:

- When a patient is late for their appointment this can cause us to get behind on our schedule which can affect other patient's visits. Our policy is that if a patient is more than 15 minutes late for their appointment, the patient may be asked to reschedule their appointment, depending on the day's schedule.
- 24 hours' notice is required to cancel and/or reschedule all appointments. Failure to do so will result in a \$30.00 fee.

Refraction Service Fee:

- The refraction test is the process to determine if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and necessary to write a prescription for glasses or contacts.
- Our office fee for a refraction is \$30.00, and this fee is collected at the time of service in addition to any copayment your plan may require. Most medical insurance plans, including Medicare, do not cover routine refractions or routine eye exams.

Additional paperwork:

- Any paperwork from another institution needed to be filled out by the physician will result in an additional charge, depending on the length of the paperwork.
- A 48-hour notice is required for all paperwork or records request.

Auto accidents/workers compensation:

- Motor Vehicle Accidents (MVAs) will be filed to your auto insurance as a courtesy to you. Failure to receive payment within 30 days of the date of service may result in you becoming responsible to pay.
- Our office will send appropriate workers compensation claim forms for services rendered on your behalf as a courtesy. If a claim is denied, we will expect payment in full from you within 30 days of receipt of our bill.

Collections and outstanding balances:

- Any outstanding balance after 60 days of the date of service will be referred to an outside collection agency. Accounts referred to an outside collection agency will be subject to a collection fee of 40%, which will be added to the total balance due at the time of write off.

Refunds:

- Refunds are issued to the appropriate party.
- Patients refunds will not be processed until all active or past due charges are paid in full.
- Refunds less than \$10.00 will not be issued, unless requested, and will credit to your account at our practice.

Returned Check Fee:

- There will be a fee of \$25.00 for any returned checks to our office.

All balances are due prior to any further service provided by our office.

Signing Below Acknowledges that You have Read and Understand the Above Stated Policies.

Signature of Patient or Patient Representative

Date