515 N. State Route 291
Liberty, Missouri 64068
Office: 816.781.2900
Facsimile: 816.781.1370
www.mcknighteyecenters.com

McKnight
Eye Centers

Scott J. McKnight, MD
Dustin S. McKnight, MD
Brett J. McKnight, MD
Nicole L. West, MD
Anthony T. Brand, OD
Neal L. Eylar, OD

DATE OF YOUR APPOINTMENT	TIME OF YOUR APPOINTMENT

Office Hours:
Monday – Thursday: 7:00AM – 5:00PM
Friday: 7:00AM – NOON

YOUR APPOINTMENT WILL BE WITH:	
Scott J. McKnight, MD	
Dustin S. McKnight, MD	
Brett J. McKnight, MD	
Nicole L West, MD	
Anthony T. Brand, OD	
Neal L. Eylar, OD	

PLEASE BRING WITH YOU:	
All current Insurance Cards	
A referral if required by your insurance	
A current list of ALL MEDICATIONS	
A current POA/DPOA if needed	

Dear Patient,

Thank you for selecting McKnight Eye Centers for your eye care. We are committed to providing quality eye care. We have enclosed forms requesting the basic information for your medical record. Please complete the forms and bring them to your first visit to expedite checking-in.

Your first visit at McKnight Eye Centers will consist of a complete eye exam. The initial visit usually lasts for approximately 2 hours, however, may vary in length depending on the diagnosis made by your doctor. Your eyes may be dilated during this visit, and we recommend you bring a pair of sunglasses to protect your eyes from the sun. You may even wish to have someone drive.

Sincerely,

McKnight Eye Centers & Staff

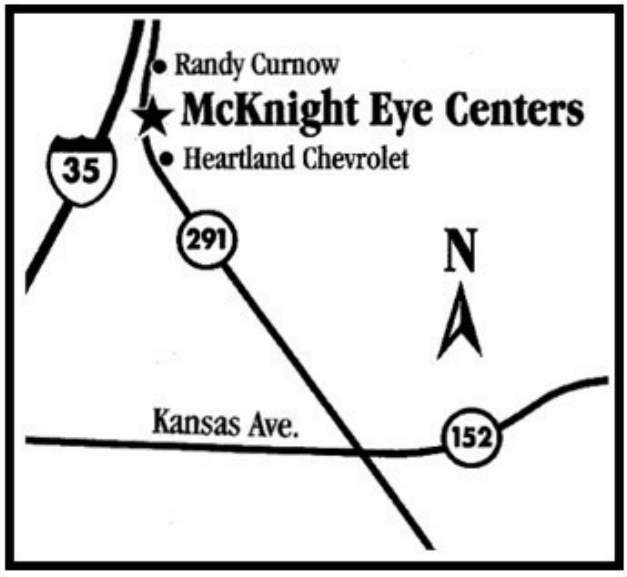
PanOptix

Trifocal IOL & Toric
Trifocal IOL

iLASIK

BOTOX® Cosmetic
Botulinum Toxin Type A

Light Adjustable Lens™
Test Drive Your Vision



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Today's Date:		Date of Birth:
Last Name:	First:	Middle Initial:

MARITAL STATUS	GENDER	RACE	ETHNICITY	PREFERRED LANGUAGE
○ Married ○ Single	○ Male ○ Female	○ Caucasian ○ African American ○ Alaskan Native ○ Asian/Pacific Islander ○ Native American	○ Hispanic/Latino ○ Not Hispanic/Latino ○ Other	○ English ○ Spanish ○ Other: _____

Street Address:		
City:	State:	Zip Code:
Home Phone:	Cell Phone:	
Last 4 digits of SSN:	Email:	

GUARDIANSHIP

Do you have a guardian? Yes___ No___

Guardian name:	Phone:

NURSING HOME

○ Not Applicable ○ Nursing Home Patient ○ Hospice Patient ○ Skilled Nursing	Facility:
	Address:
	Phone Number:

PRIMARY CARE

Primary Care Doctor:	Phone Number:
Optometrist:	Phone Number:

PRIMARY INSURANCE

Primary Insurance:	Policy Number:
Policy Holder:	Date of Birth:

SECONDARY INSURANCE

Secondary Insurance:	Policy Number:
Policy Holder:	Date of Birth:

MAIL ORDER PHARMACY

Do you have a mail order pharmacy you would like to use? Yes___No___	Pharmacy name:

REFERRAL	PATIENT SPECIAL NEEDS
○ Friend/Family ○ Patient ○ Internet ○ Yellow Pages ○ Other ○ Physician	○ Wheelchair Is patient able to transfer? Y N ○ Translator ○ Hearing Impaired ○ Oxygen Dependent ○ Other: _____

PATIENT HEALTH HISTORY

PATIENT NAME:	DATE OF BIRTH:
Primary Care Physician:	Referring Physician:

Y	N		Y	N	
		Asthma			Head Or Spinal Injuries
		Kidney Disease			Seizures, Convulsions, Or Fainting
		Tuberculosis			Extensive Confinement By Illness Or Injury
		Diabetes IDDM/Type II/No. Of Yrs _____			Latex Allergy
		Insulin Dependent			Suffering From Any Other Disease
		Migraines			Arthritis
		Psychiatric Disorder			Permanent Defect From Disease, Illness Or Injury
		Nervous Disorder			Pregnant
		Heart Disease			High Blood Pressure
		Ulcer			Stroke
		Sickle Cell Anemia			HIV
		Do You Smoke			Are Your Immunizations Current
		Do You Drink			Cancer
		Taken Illegal Substances Within The Last 12mos.			High Cholesterol

MEDICATIONS/VITAMINS (STRENGTH AND DOSAGE)	ALLERGIES/REACTIONS

Y	N	OCULAR HISTORY (OVER PAST YEAR)
		Corneal Disease
		Glaucoma
		Injury
		Cataracts
		Retina Disease
		Other Eye Disorders

SURGICAL HISTORY (Type)	DATE OF SURGERY

FAMILY HISTORY	Y	N	FAMILY MEMBER(S)	DETAILS IF NEEDED
Glaucoma				
Cataracts				
Cornea Disease				
Macular Degeneration				
Retinitis Pigmentoso				
Diabetes IDDM/Type II				
Heart				
Diabetic Retinopathy				
Retinal Detachment				
Stroke				
Cancer				
Other Eye Problems				

TECHNICIAN SIGNATURE:	DATE:

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AUTHORIZATION FORM FOR OTHER USES OF PROTECTED HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you and pursuant to our general Practice, may want to use PHI for reasons other than treatment, payment, and health care operations. This form summarizes the anticipated use of information about you for which this authorization is required. The practice provides this form to comply with Health Insurance Portability and Accountability Act of 1996 (HIPAA).

PREFERRED METHOD OF COMMUNICATION	MAY WE LEAVE A MESSAGE/TEXT AT THIS NUMBER (YES/NO)	
1.	**YES**	**NO**
2.	**YES**	**NO**

PLEASE LIST ANY OTHER PARTIES WHO YOU WOULD ALLOW US TO SHARE YOUR HEALTH INFORMATION

NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER
1.		
2.		
3.		
4.		

Do you elect to receive a digital glasses prescription and/or contact lens prescription by mail, text message or patient portal? _____ YES _____ NO

*The abovementioned protected health information may be subject to re-disclosure by the party receiving the information and may no longer be protected by the privacy rules.

*By signing this form, you authorize the Practice to use and disclose protected health information about you for the reasons mentioned above. You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Submit your revocation to the Privacy Officer or the Practice.

The authorization was signed by: _____ DOB: _____
(Printed Name of Patient or Representative) (Patient's Date of Birth)

_____ DATE: _____
(Signature)

Witness: _____ DATE: _____
(Signature)

Expiration date of authorization: _____

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McKnight Eye Centers, PC
Receipt of Notice of Privacy Practices
Written Acknowledgement Form
And
Patient Consent for Use and Disclosure of Protected Health Information

Patient (Print) Name:	Date of Birth:

PLEASE READ AND INITIAL BELOW

I have received, or have been offered, a copy of McKnight Eye Centers, PC Notice of Privacy Practices.	
I hereby give my Consent for McKnight Eye Centers, PC to use and disclose protected health information (PHI) about me to carry out treatment, payment, or health care operations as described in the Notice of Privacy Practices that I have been provided.	
I understand that I have the right to review the Notice of Privacy Practices prior to signing this Consent.	
I understand that I have the right to request that McKnight Eye Centers, PC restrict how it uses or discloses my PHI to carry out treatment, payment, or health care operations. However, the practice is not required to agree to my requested restrictions, but it is bound by this agreement.	
I understand that I may revoke my Consent in writing, except to the extent the practice has already made the disclosures in reliance upon my prior Consent. If I do not sign this Consent, or later revoke it, McKnight Eye Centers, PC may decline to provide treatment to me.	

Signature of Patient:	Today's Date:

McKnight Eye Centers, PC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

McKnight Eye Centers, PC
Attn: Compliance Director
515 North State Route 291
Liberty, Missouri 64068

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AGREEMENT OF RESPONSIBILITY

I understand that an inactive insurance card, no insurance, no insurance card, insurance we are not a participating provider for, and in-network insurers whom we are unable to communicate effectively with will/may render me responsible for payment for services. The Insured/Guardian/Patient is also advised that most carriers have a claim filing limit. Correct insurance information received greater than 60 days from the date of this document may be denied by their carrier as untimely and the insured/guardian/patient will be held responsible for any balance. We will bill your insurance for the refraction fee but request payment today for $25. **If we are unable to determine coverage of your benefits prior to your visit, you will be responsible for the charges incurred. This shall include but is not limited to procedures/injections, testing or office visits.**

CONSENT TO TREAT

I voluntarily consent to such care and treatment as prescribed by the physician as is necessary in his/her judgment.

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS

I authorize use of this form on all my insurances submissions and authorize release of information needed to process a claim to all my insurance companies. I permit a copy of this authorization to be used in place of the original. I authorize the provider to act as my agent in helping me obtain payment from my insurance companies. I understand the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement on disputed claims. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand that I will receive a monthly statement for any balance due by me.

PATIENT NAME (PRINT):	PATIENT DOB:
PATIENT SIGNATURE:	TODAY'S DATE

MEDICARE AUTHORIZATION

- I request payment of authorized Medicare benefits be made on my behalf to McKnight Eye Centers, P.C., for any services furnished to me by this physician/supplier. I authorize the holder of medical information, about me, to release Medicare and its agents any information needed to determine these benefits are payable to related services.
- I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurances" is indicated, the item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the release of the information to the insurer to the agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and the uncovered services, Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

MEDIGAP AUTHORIZATION

The following is to be filled out if you have a Medigap insurance policy for which you wish to assign benefits. A Medigap of Medicare Supplemental policy is a health insurance policy or other health plan, offered by a private company, to those entitled to Medicare benefits. It is designed to pay certain costs that Medicare does not pay. By law, this excludes a policy or plan offered by an employer to employees or former employees, as well as a policy or plan offered by a labor organization to member or former members. This agreement is in full effect until revoked in writing by the patient.

NAME OF MEDIGAP PLAN:	
PATIENT NAME (PRINT):	PATIENT DOB:
PATIENT SIGNATURE:	TODAY'S DATE