

Name: _____ Date of Birth: _____ Age: _____ Date: _____

Language: English Spanish Other _____ Gender Male Female

Race: _____ Ethnic Group: _____ Marital Status: _____

<input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Other race <input type="checkbox"/> Declined to specify	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Declined to specify	<input type="checkbox"/> Married <input type="checkbox"/> Widow <input type="checkbox"/> Single <input type="checkbox"/> Divorced
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Is it OK to leave a detailed message? _____ Who referred you to us: _____

Home: Yes No Cell: Yes No Your Primary Care Dr.: _____

Preferred Pharmacy: _____ Your Optometrist: _____

Local Pharmacy	Address	Phone Number
Mail Order Pharmacy	Address	Fax Number

Select any of the following medical conditions that you currently have:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> COPD | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Blood Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Lung Cancer |
| <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Depression | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> Enlarged Prostate | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> GERD | <input type="checkbox"/> Seizures | | |
| <input type="checkbox"/> Other: (please list) _____ | | | |

List any surgeries you have had: (Non Eye)

Select any of the following eye conditions that you have:

- | | | | |
|--|---|---|---------------------------------------|
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Diabetic Retinopathy | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Retinal Tear |
| <input type="checkbox"/> Blepharitis | <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Narrow Angles | <input type="checkbox"/> Crossed Eyes |
| <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> Glasses/Contact Lens | <input type="checkbox"/> Ocular Hypertension | <input type="checkbox"/> Lazy Eye |
| <input type="checkbox"/> Corneal Dystrophy | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Ophthalmic Migraine | <input type="checkbox"/> Floaters |
| <input type="checkbox"/> Steriod Responder | <input type="checkbox"/> Other: (please list) _____ | | |

Select any of the following eye surgeries that you have had:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Blepharoplasty | <input type="checkbox"/> Eye Muscle Surgery | <input type="checkbox"/> Ptosis Repair | <input type="checkbox"/> Laser Capsulotomy after
Cataract Surgery |
| <input type="checkbox"/> Cataract Surgery Right | <input type="checkbox"/> Intravitreal Injections | <input type="checkbox"/> Punctal Plugs | <input type="checkbox"/> Glaucoma Laser or Surgery |
| <input type="checkbox"/> Cataract Surgery Left | <input type="checkbox"/> LASIK/ PRK/RK | <input type="checkbox"/> Retinal Laser or
Surgery | <input type="checkbox"/> Corneal Transplant |
| <input type="checkbox"/> Other: (please list) _____ | | | |

List all Prescriptions and Over the Counter medications you are taking: (Including Eye Drops)
If you have a list, please give it to our receptionist to copy in lieu of filling out form:

General Medications	Dosage	Taken how often?	Route
		PRN= when needed	
		___ Times a day OR <input type="checkbox"/> PRN	<input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Injection
		___ Times a day OR <input type="checkbox"/> PRN	<input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Injection
		___ Times a day OR <input type="checkbox"/> PRN	<input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Injection
		___ Times a day OR <input type="checkbox"/> PRN	<input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Injection
		___ Times a day OR <input type="checkbox"/> PRN	<input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Injection

Eye Medications	Dosage	Taken how often?	Route
		PRN= when needed	
		___ Times a day OR <input type="checkbox"/> PRN	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> by mouth
		___ Times a day OR <input type="checkbox"/> PRN	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> by mouth
		___ Times a day OR <input type="checkbox"/> PRN	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> by mouth
		___ Times a day OR <input type="checkbox"/> PRN	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> by mouth
		___ Times a day OR <input type="checkbox"/> PRN	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> by mouth

LIST ANY DRUG ALLERGIES:

SOCIAL HISTORY:

Do you use Tobacco? Never Every Day Smoker Some day Smoker Former Smoker

DO YOU HAVE ANY OF THE FOLLOWING TODAY?

- | | | | |
|---|---|--|-------------------------------------|
| <input type="checkbox"/> Blood sugar not under control | <input type="checkbox"/> Unexplained weight loss | <input type="checkbox"/> Decrease Vision | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Blood pressure not under control | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Joint Pain |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Jaw Pain, Difficulty Chewing | <input type="checkbox"/> Anemia | |

FAMILY HISTORY: Has any member of your immediate family (blood relatives) have/had these diseases?

Disease/Condition	Family Member				Disease/Condition	Family Member							
Lazy Eye	yes	no	Mother	Father	Sibling	Child/Children	Diabetes	yes	no	Mother	Father	Sibling	Child/Children
Macular Degeneration	yes	no	Mother	Father	Sibling	Child/Children	Hypertension	yes	no	Mother	Father	Sibling	Child/Children
Blindness	yes	no	Mother	Father	Sibling	Child/Children	Stroke	yes	no	Mother	Father	Sibling	Child/Children
Retinal Disorders	yes	no	Mother	Father	Sibling	Child/Children	Thyroid Disease	yes	no	Mother	Father	Sibling	Child/Children
Cancer	yes	no	Mother	Father	Sibling	Child/Children	Arthritis	yes	no	Mother	Father	Sibling	Child/Children
Glaucoma	yes	no	Mother	Father	Sibling	Child/Children		yes	no	Mother	Father	Sibling	Child/Children

FINANCIAL POLICY

The fees charged in our office are directly related to the complexity of your problem and the resources devoted to your diagnosis and treatment. Our doctors are participating providers with Medicare and many commercial insurance carriers. Medicare assignment is accepted for all covered services. Due to the many changes in insurance policies, we cannot be responsible for interpreting each & every policy. We will verify that you have a current & active insurance policy only. Therefore, we urge you to please check with your insurance company regarding the specifics of your individual coverage, including co-insurance, copays, and deductibles, as well as who is an authorized provider for your plan. We request payment of the 20% Medicare co-insurance and any deductibles or co-pays at the time of your visit.

Refractive surgery and cosmetic procedures are usually not covered by Medicare and most insurance companies. Please ask our financial counselors about payment options for these procedures.

Referrals & Non-Participating Provider Policy

If you need a referral from your insurance company or from your primary care physician to be seen in our office, we must have the referral at the time of your visit. You are responsible for obtaining the referral. If you do not have a referral you will need to reschedule your visit. If we are not providers for your insurance company, we will need to collect the fee for the visit at the time of service.

Medicare

We accept assignment but you must understand that you are still responsible for the yearly deductible as well as the 20% co-insurance. There are also a number of non-covered Medicare services (i.e. refractions) that you will be responsible for. Make sure you understand your insurance and Medicare coverage limits.

PPO/POS

Your co-pay must be paid at the time of service.

We accept Cash, Checks, MasterCard, Visa, American Express and Discover.

A fee of \$50.00 will be charged for any returned check.

THANK YOU FOR UNDERSTANDING OUR FINANCIAL POLICY. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS.

I have read the Financial Policy & I agree to it.

Patient Signature_____ Date_____

Printed Name_____

PRIVACY NOTICE CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.
- The Practice Utilizes a number of methods to contact or communicate with our patients. We use the telephone, posted mail, e-mail, facsimile transmission (fax), TTY relay operators and translators. If you do not want the Practice to communicate with you by any of the methods listed above, you must so state.
 - Any of the above communication methods are acceptable
 - Please do not use the following methods to contact me:

This Consent was signed by: _____
Sign and print name

Relationship to Patient (if other than patient): _____

Date: ___ / ___ / ___

In front of _____
Sign and print name

SUMMARY OF PRIVACY PRACTICES

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices. You may request the detailed Notice from our office staff.

Date of Last Revision: Feb 25, 2016
Effective Date: Immediately

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.

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your protected health information is kept private.

How will we use or disclose your information? Here are a few examples (for more detail please refer to the Notice of Privacy Practices document):

- For medical treatment
- To obtain payment for our services
- In emergency situations
- For appointment and patient recall reminders
- To run our Practice more efficiently and ensure all our patients receive quality care
- For research
- To avert a serious threat to health or safety
- For organ and tissue donation
- For workers' compensation programs
- In response to certain requests arising out of lawsuits or other disputes

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our office manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You have certain rights regarding the information we maintain about you. These rights include:

- The right to inspect and copy
- The right to amend
- The right to an accounting of disclosures
- The right to request restrictions
- The right to a paper copy of this notice
- The right to request confidential communications

For more information about these rights, please request the detailed Notice of Privacy Practices document from our office staff.

24 HOUR CANCELLATION & "NO SHOW" OFFICE FEE POLICY

Every time a patient misses a scheduled appointment without providing proper notice to the office, another patient is prevented from receiving the care they require. Therefore the physicians at Ophthalmology Consultants reserve the right to charge a fee of \$50.00 for all missed Appointments/No Shows etc which are not cancelled with the courtesy of a 24-hour notification.

Thank you for your understanding and full cooperation as we strive to best serve the needs of all our of patients.

By signing below you acknowledge that you have received this notice & understand this policy.

Printed Name

Date

Signature

ABOUT YOUR REFRACTION

The refraction is an important part of your medical eye exam because it helps determine if eye diseases, such as cataracts or macular degeneration, are affecting your vision. The refraction portion of your eye exam also determines if eyeglasses or a change in your present lenses are needed to optimize your vision.

The charge for your refraction is \$75.00. Most medical insurances consider the refraction a non-covered service and therefore, will not pay for it. You will be responsible for this payment plus any co-payments and deductibles on the day of your exam.

If you have questions regarding refractions, their importance to your exam, or insurance policy concerning coverage of refractive services, please ask our office staff or call your carrier at the toll free number listed on your insurance card.

Ophthalmology Consultants