# SOUTHERN EYE SPECIALISTS, P.C.

*Date:*

**PATIENT NAME**: Last First Middle Name Called By

IF UNDER 18 YEARS OLD : Name of adult with the patient Relationship Phone Number

**1) A PICTURE IDENTIFICATION IS REQUIRED WITH A COPY OF INSURANCE CARDS.**
**2) PAYMENT WILL BE REQUIRED IN FULL TODAY IF A CURRENT COPY OF INSURANCE CARDS ARE NOT PROVIDED**
**3) ALL CO-PAYS ARE DUE AT THE SAME DAY OF TREATMENT**
4) We will file insurance, including Medicare, according to plan requirements. We will assist you in verifying your insurance coverage. However, while we are pleased to be able to provide this service to you, it is extremely difficult to know all the individual requirements of the plans. Therefore, it is your responsibility, as the patient/insured to be aware of the current terms of your insurance coverage. Please read our financial and managed care insurer policies on the back of this form.

## PATIENT INFORMATION:

Street Address Apt # City State Zip

P.O. BOX City State Zip

Home Telephone: ( ) _____ May we Leave a message for you? Y / N

Work Telephone: ( ) _____ May we Call you at work? Y / N

Email address: _____ Cell Phone: _____

Social Security No:_____ DOB: _____ Age: _____ Sex: M / F

## BILLING INFORMATION:

1) Person Responsible for Payment: Self Parent Guardian Other (Relationship)_____
2) Method of Payment: Check Cash Credit/Debit Insurance Workers Compensation
3) Please complete if the responsible person or policy holder is other than the parent:

Last Name First Middle Relationship to Patient

Street Address Apt # City State Zip

Social Security No:_____ DOB: _____Home Telephone: ( )_____

Employer: _____ Work Telephone ( )_____

Street Address: _____ City: _____ State_____ Zip_____

## EMERGENCY CONTACT:

Name Relationship Home Telephone Work Telephone

Patient Name: _____

# SOUTHERN EYE SPECIALISTS, P.C.

## FINANCIAL AND MANAGED CARE POLICIES

## PAYMENT FOR SERVICES IS DUE IN FULL TODAY

Southern Eye Specialists, P.C participate with many insurance plans as a convenience to our patients. However, we expect the patients to pay their share for our services, as specified in your benefits contract. We will help you determine these amounts.

1) Payment of coinsurance, deductibles, co-pay or private pay is due at the time of services
2) **Medicare Coverage**: I acknowledge that I may be responsible for certain charges at the time of my visit or any related claims due to either the provisions of Medicare or lack of Medicare's policy to cover these charges. I also understand Medicare MAY NOT pay for particular items and services. I am fully responsible for non-covered services and procedures.
3) **Commercial Coverage**: I acknowledge that I may be responsible for certain charges at the time of my visit or any related claims due to the provisions of my insurance or insurance policy to cover these charges. I also understand my insurance MAY NOT pay for particular items and services. I am fully responsible for non-covered services and procedures.
4) Private Pay: I understand payment is due in full at the time of service.
5) I understand I can appeal my insurance's payment decision (Commercial or Medicare)

**I understand that any financial responsibility on my behalf is to be resolved at the time of service. I also understand that I am responsible both for any fees remaining unpaid by my insurance carrier after 60 days and for collection costs and attorney fees required to collect those fees.**

Patient Signature: _____ Date: _____

## SIGNATURE AND INFORMATION UPDATE

You may sign below up to four years to acknowledge updated information. If there has been **NO** change in your home address, home phone number, work information or insurance coverages as noted in your medical file with us.

I have read the information listed on the other side of this sheet and to the best of my knowledge, all information is accurate. I acknowledge that I may be responsible for certain charges on this or any related claim due to either provisions of my insurance contract or lack of an insurance policy to cover these charges. I understand that any Financial responsibility on my behalf if to be resolved at the time of service.

1) FIRST YEAR Signature of Patient or Responsible Person:_____ Date: _____
2) SECOND YEAR Signature of Patient or Responsible Person:_____ Date: _____
3) THIRD YEAR Signature of Patient or Responsible Person:_____ Date: _____
4) FOURTH YEAR Signature of Patient or Responsible Person:_____ Date: _____

## SOUTHERN EYE SPECIALISTS, P.C.

## *MEDICAL HISTORY QUESTIONNAIRE*

Date : _____ (Valid for one year from date)

**Name** (Last, Middle, First): _____ **DOB:** _____ **AGE:**_____ **M / F**

**Referral Doctor:** _____

**Family Physician:** _____

**Past Eye History: (List all surgery/medications in the box on the right)**

**Family History:** Glaucoma Macular Degeneration Cataracts
Other: _____

**Social History:** Smoking Alcohol Blood Transfusion?

Does your Vision limit any of your daily living/activities? **Yes** **No**

Occupation: _____

**Females: ARE YOUR PREGNANT or NURSING? Yes** **No**

| **EYE SURGERY** |
|---|
| 1) |
| 2) |
| 3) |
| 4) |
| 4) |

| **EYE MEDICATIONS** (Prescribed or OTC) |
|---|
| 1) |
| 2) |
| 3) |
| 4) |
| 5) |

Do you have or have had any of the following:

**Y / N** **Endocrine** (Diabetes, Thyroid, etc)
**Y / N** **Cardiovascular** (High BP, High Cholesterol, racing pulse, etc)
Other:_____
**Y / N** **Respiratory:** (Congestion, wheezing, short of breath, asthma, emphysema, etc)
Other:_____
**Y / N** **Neurological:** (headaches/migraines/MS/stroke/paralysis/seizures)
**Y / N** **Psychiatric:** (anxiety, depression, insomnia)
**Y / N** **Blood/Lymph:** (Anemia, bleeding, hepatitis, sickle cell, HIV+ AIDS, Cholesterolemia)
**Y / N** **Muscles/Bones,** Joints: (joint pain, stiffness, swelling, arthritis, cramps, etc)
**Y / N** **Gastrointestinal:** (ulcer, hernia, stomach upset, chronic diarrhea)
**Y / N** **Allergic/Immunological:** (lupus, sarcoid, sneezing, swelling, itching, redness, etc)
**Y / N** **Kidney/Bladder/Genital:** (frequent or painful urination, yellow jaundice, etc)
**Y / N** **Skin:** (growths, rash, etc)
**Y / N** **Ear/Nose/Throat:** (hard of hearing, chronic sinus, cough, surgery)
**Y / N** **Cancer:** (What Type?_____)
Are your currently receiving Treatment? _____
**Y / N** **General Constitution:** fever, unusual weight gain/loss, tired, etc)
**Y / N** **Other Medical History or Surgery:** _____

| **OTHER MEDICATIONS** (Prescribed or OTC) |
|---|
| 1) |
| 2) |
| 3) |
| 4) |
| 5) |
| 6) |
| 7) |
| 8) |
| 9) |
| 10) |
| 11) |
| 12) |
| 13) |

| **ALLERGIES** |
|---|
| 1) |
| 2) |
| 3) |
| 4) |
| 5) |
| 6) |

**Y / N** **Allergies (Please list all allergies in the box on the right)**

**Are your currently interested in: Glasses Sunglasses Contacts LASIK**

**Patient Signature**: _____ **Date:** _____

**SOUTHERN EYE SPECIALISTS, P.C.**

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## *SUMMARY OF PRIVACY PRACTICES*

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices. Our full length Notice is posted in the reception area and a copy of the full length is available for you at the checkout desk.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY HAVE ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand that your medical information is personal to you and we are committed to protecting your 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 information is protected and kept confidential.

Please find some examples where we use or disclose your information (for more detail, please refer to the complete Notice of Privacy Practices.)

- For medical treatment
- For emergency situations
- For Workers Compensation programs
- To obtain payment for our services
- For Recalling/patient reminders
- For research
- For quality assurance
- Allow practice to flow efficiently
- In response to issues arising from legal matters
- For appointments

You, as the patient, have certain rights regarding the information we maintain about you. All requests must be made in writing, with a 48 hour notice, no exceptions. Our medical records staff/department will assist you with the written requests. These rights include:

- The right to inspect and copy your file (See rates that apply)
- The right to amend
- The right to an accounting of disclosures
- The right to a paper copy of this notice
- The right to request restrictions
- The right to request confidential communication
- The right to a paper copy of this notice

## ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Our Notice of Privacy Practices provides information about how we use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting Dr. Rohit Sharma.

You have the right to inspect that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you (or your representative) consent to our use and disclosures of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Patient Name: _____

Patient Signature: _____ Date: _____

Representative Signature:_____ Date: _____