THE HAMMOND EYE CLINIC

PATIENT INFORMATION

NAME _____
First Middle Last

SPOUSE _____
First Middle Last

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME# (____)_____ WORK# (____)_____ CELL# (____)_____

EMAIL_____ REFERRED BY _____

Social Security # _____ DOB _____ AGE_____

RACE ☐ White ☐ Black ☐ Hispanic ☐ Other SEX ☐ Male ☐ Female

MARITAL STATUS ☐ Single ☐ Married ☐ Widowed OCCUPATION _____

SPECIAL INTEREST/HOBBIES_____

ORGANIZATIONS YOU BELONG TO _____

EMERGENCY CONTACT _____ PHONE (____)_____

RESPONSIBLE PARTY

NAME _____
First Middle Last

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME# (____)_____ WORK# (____)_____ CELL# (____)_____

Social Security # _____ DOB _____ Employer _____

ACKNOWLEDGEMENT: I have reviewed the above and verify that it is correct. I understand all charges are due and payable at the time of service and I will abide by this policy. I also understand that I am responsible for any unpaid balance from my insurance company. For services such as surgery, etc or if have MEDICARE, I authorize any or all insurance companies to pay benefits directly to the doctor unless I have paid them myself. In this case the benefits would come to me. I also authorize the release of medical information necessary in handling my claims.

SIGNATURE _____ DATE _____

THE HAMMOND EYE CLINIC

OFFICE POLICY, FINANCIAL ASSIGNMENT AND AGREEMENT: READ CAREFULLY AND SIGN

1. **PAYMENT IS EXPECTED AT EACH VISIT.** If we are a participating provider for your health plan we will file health insurance claims for you. 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. **You will be responsible for paying any co-payments, coinsurance, deductibles and non-covered services at the time of the visit.** Final payment responsibility will be determined upon receipt of correspondence from your insurance company.
   If we are NOT a participating provider for your health plan, you will be expected to pay in full at the time of the visit. You are responsible for filing your insurance claims.
2. To avoid any potential misunderstandings, advise the receptionist should you need to make financial arrangements.
3. Patient statements will be mailed monthly. If no payments are received on account after 3 billing cycles, collection procedures will commence.
4. There will be a $25.00 charge on all checks returned unpaid due to insufficient funds.
5. All outstanding balances due by the patient must be paid before scheduling additional visits.
6. This office is **NOT** responsible for collecting on your insurance claim nor for settling a disputed claim. Misunderstandings over insurance coverage and policy benefits are a matter to be resolved between the patient and their insurance company. We do not balance accounts according to "Reasonable and Customary" allowances established by insurance companies that we are not contracted with. Our services are coded according to the guidelines established by the AMA's Current Procedural Terminology (CPT). We will not code for reimbursement based on your insurance coverage.
7. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize 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.
8. 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.

I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THIS POLICY AND AGREEMENT.

Patient or Authorized Signature **Patient's Name Printed** **Date signed**

PATIENT CONSENT AND ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I understand that as part of the provision of healthcare services, The Hammond Eye Clinic creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and practices prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.
By signing below, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

Patient or Authorized Signature **Patient's Name Printed** **Date signed**

THE HAMMOND EYE CLINIC

NAME _____ DATE _____

PLEASE CIRCLE "YES" OR "NO" FOR THE FOLLOWING. ALSO PLEASE CIRCLE IF ANY BLOOD RELATIVES HAVE THE FOLLOWING.

	SELF	FAMILY		SELF	FAMILY
AIDS/HIV	YES NO	YES NO	HIGH BLOOD PRESS	YES NO	YES NO
ARTHRITIS	YES NO	YES NO	KIDNEY DISEASE	YES NO	YES NO
ASTHMA	YES NO	YES NO	LUPUS	YES NO	YES NO
CANCER	YES NO	YES NO	RHEUMATIC FEVER	YES NO	YES NO
DRUG USE	YES NO	YES NO	SEIZURE DISORDER	YES NO	YES NO
DIABETES	YES NO	YES NO	SHINGLES	YES NO	YES NO
EMPHYSEMA	YES NO	YES NO	SKIN CONDITION	YES NO	YES NO
GLAUCOMA	YES NO	YES NO	STROKE	YES NO	YES NO
HEART DISEASE	YES NO	YES NO	THYROID	YES NO	YES NO
HEPATITIS _____	YES NO	YES NO	TUBERCULOSIS	YES NO	YES NO
SMOKER?	YES NO		DO YOU DRINK?	YES NO	
PREGNANT?	YES NO		HOW MANY CHILDREN? _____		

PLEASE CIRCLE ANY OF THE FOLLOWING EYE PROBLEMS AS THEY RELATE TO YOURSELF.

BLINDNESS	YES NO	FAINTING SPELLS	YES NO
BLOODSHOT EYES	YES NO	FLOATERS OR SPOTS	YES NO
BLURRY DISTANCE VISION	YES NO	GLAUCOMA	YES NO
BLURRY NEAR VISION	YES NO	HEADACHES	YES NO
CATARACTS	YES NO	ITCHING OR BURNING	YES NO
POOR COLOR VISION	YES NO	LAZY EYES	YES NO
CROSSED EYES	YES NO	LIGHT SENSITIVE	YES NO
DISCHARGE FROM EYES	YES NO	MIGRAINE HEADACHES	YES NO
DIZZY SPELLS	YES NO	POOR NIGHT VISION	YES NO
DOUBLE VISION	YES NO	RETINAL DISEASE	YES NO
DRY EYES	YES NO	SEEING HALOS	YES NO
EYE INFECTION	YES NO	SEEING FLASHES	YES NO
EYE INJURY	YES NO	TEMPORARY LOSS OF VISION	YES NO
EYE SURGERY	YES NO	TWITCHING EYELID	YES NO
EYE STRAIN	YES NO	WATERING EYES	YES NO

DO YOU WEAR GLASSES? YES NO DO YOU WEAR CONTACTS? YES NO
ALL THE TIME ---- OCCASIONALLY ---- TV ---- DRIVING ----- READING

WHEN WAS YOUR LAST EYE EXAM? _____

LIST MEDICATIONS INCLUDING EYE DROPS _____

_____

_____

ANY MEDICATION ALLERGIES? _____

_____

PRIMARY CARE PHYSICIAN _____