Patient Information

Identification

Legal First Name:_____ Middle Initial: _____ Last:_____

Gender: Male / Female / Other / Prefer Not to Say Date of Birth:_____

Age: _____ SSN#:_____

Address

Address:_____ City:_____ State:_____

Zip:_____ Country: _____ Okay to send Mailings? ☐ Yes ☐ No

Contact Information

Home Phone: _____ Okay to leave voicemail? ☐ Yes ☐ No

Mobile Phone:_____ Okay to leave voicemail? ☐ Yes ☐ No

Email: _____

Primary contact Method: ☐ Home ☐ Mobile ☐ Email Backup Method: ☐ Home ☐ Mobile ☐ Email

Demographics

Race: ☐ White ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Other Race ☐ Prefer not to say

Marital Status (Circle): Single / Married / Widow / Widower

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to say

Language: ☐ English ☐ Spanish ☐ Other:_____

Smoking Status: ☐ Smoker ☐ Non-Smoker

Emergency Contact

First Name : _____ Last Name:_____ Relationship:_____

Primary Phone: _____ Secondary Phone: _____

Employment

Employment Status:_____ Patient's Employer:_____

Occupation: _____ Wk. Phone (ext.):_____

Guarantor Information

Name:_____ Employer:_____
Date of Birth: _____ SSN#: _____

Insurance Information

Primary Medical Insurance: _____ Effective Date: _____
Policyholder's Name: _____ Policy No: _____
Employer's Name: _____ Relationship to Policyholder: _____
Policyholder's DOB: _____

Secondary Medical Insurance: _____ Effective Date: _____
Policyholder's Name: _____ Policy No: _____
Employer's Name: _____ Relationship to Policyholder: _____
Policyholder's DOB: _____

Primary Vision Insurance: _____ Effective Date: _____
Policyholder's Name: _____ Policy No: _____
Employer's Name: _____ Relationship to Policyholder: _____
Policyholder's DOB: _____

Secondary Vision Insurance: _____ Effective Date: _____
Policyholder's Name: _____ Policy No: _____
Employer's Name: _____ Relationship to Policyholder: _____
Policyholder's DOB: _____

*****PLEASE PRESENT INSURANCE CARDS TO THE FRONT DESK ASSOCIATE OR RECEPTIONIST*****

Patient Consent

- I hereby authorize and request the medical treatment necessary for the care of the above patient.
- I authorize EyeSouth Partners to use and disclose protected health information to complete the treatment, payment, and healthcare operations for the above patient. I understand this may include the release of all medical records to the referring and family physicians and to my insurance company. If necessary, I will allow the fax transmittal of my medical records.
- I acknowledge full financial responsibility for services rendered at EyeSouth Partners. I understand payment is due at the time of service unless other definite financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of a default of payment of my charges.
- I further authorize and request that insurance payments be made directly to EyeSouth Partners if they elect such an arrangement.
- I acknowledge my primary contact method may be used solely to relay information regarding appointments, non-critical test results, or other general information.
- I certify that the information I have provided is true and accurate, and I understand and agree to all the patient responsibilities previously outlined.
- I hereby understand that I may be contacted via email, phone, mail to be provided a Good Faith Estimate.

I have read and fully understand the above consent for treatment, for the release of protected health information, for financial responsibility, and for insurance authorization.

_____ _____

Patient / Parent or Guardian Signature Date

Authorization for Use or Disclosure of Protected Health Information

I have been offered and reviewed a copy of the Eyecare Associates Notice of Privacy Practices. By completing this form, I authorize my physician and/or administrative staff of Eyecare Associates to disclose general medical information and other protected health information to the following person(s) and/or entities listed below. If no one is listed below, protected health information will not be disclosed except in those situations described in the Notice of Privacy Practices.

Name and relation of person(s) to whom you elect to allow access—for example, your spouse, child, parents, neighbor, caretaker, close friend:

Name of Person or Entity	Relationship

This authorization to use and disclose the protected health information is being submitted by my request and shall be in force and effect until revoked in writing by me, or, if the purpose of the disclosure is related to research, at the end of the research study.

I understand that information used or disclosed pursuant to this authorization may be disclosed by Eyecare Associates and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Practice's Privacy contact at 4324 Veterans Blvd, Metairie, LA 70006. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was given as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

My physician will not condition my treatment, payment or enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except: (1) If my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

Authorization for Use and Disclosure of Financial Information

Upon signing this form, I, _____, am authorizing EyeSouth Partners to release personal financial information to:

Name	**Relationship**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

This authorization is valid as of _____ / _____ / _____, the date I signed below. This remains in effect until I give notification to discontinue or for the remainder of the calendar year.

_____
Patient Name

_____
Patient Signature

_____ _____
Parent or Guardian Signature Relationship
(if patient is a minor)

_____
Date

Missed Appointment Policy

We want to thank you for choosing us as your eye care provider. To give you and all our patients the best possible care, we request that you review our policy regarding missed appointments. We understand that circumstances occasionally arise that do not allow you to keep your appointment but **failing to arrive at your allotted appointment time without sending a cancellation notice at least 24 hours in advance will cause a missed appointment to go on your record.**

Refraction Fee

The refraction process determines the prescription for your lenses and aids in the diagnosis and treatment of many eye diseases. Refraction does not include any screening or examination. Federal guidelines require that refraction must be billed separately for all patients. **Medicare does not cover refraction.** Since Medicare considers this a non-covered service, your supplemental insurance will deny payment as well. While some insurance plans may recognize and pay for refractions, most do not. Refraction is performed on almost all complete eye exams and payment will be expected at the time of service unless coverage and eligibility is verified.

Contact Lense Fitting Fees

A contact lens fitting determines if the contact lenses safely fit on your eyes and which lenses provide the best vision, comfort, and health for your eyes. The process includes the measurement of the eyes; the design and selection of lenses; and follow-up visits. After wearing contacts for a period of time, your doctor will require a reexamination at least once a year to verify that your contact lens prescription is still appropriate and healthy for your eyes. Most of the time, medical insurances do not pay for these services though some vision plans do provide partial coverage for contact lens services. Check with your insurance carrier to verify what coverage you have for contact lens services. Our fitting fees for contact lenses range from **$100-$350** depending on specific needs/complicity. Renewal and refitting fees for contact lenses range from **$60-$150**. Contact lens fitting fees are due at the time of service. No contact lenses will be dispensed prior to the payment of these fees.

I have read and understand the policies listed above.

Print Patient Name: _____

Patient / Parent or Guardian Signature: _____

Date: _____

Medical History

Name:_____ DOB:_____ Date:_____

Pharmacy Name:_____ Phone:_____ PCP:_____

MEDICAL HISTORY – Check if applicable:

- ☐ Arthritis
  Date of Onset: _____
- ☐ Cancer
  Date of Onset: _____
- ☐ Kidney Stones
  Date of Onset: _____

SURGICAL HISTORY – Check if applicable:

- ☐ None
- ☐ Appendectomy
- ☐ Gallbladder Removal
- ☐ Heart Bypass
- ☐ Heart Stent
- ☐ Heart Surgery
- ☐ Hysterectomy
- ☐ Mastectomy
- ☐ Knee Replacement
- ☐ Shoulder Surgery
- ☐ Tonsillectomy
- ☐ Thyroidectomy
- ☐ Other_____

COMMON DRUG ALLERGY – Check if applicable:

- ☐ No Known Drug Allergies
- ☐ Amoxicillin
- ☐ Augmentin
- ☐ Betadine
- ☐ Codeine
- ☐ Ibuprofen
- ☐ Penicillin
- ☐ Statins
- ☐ Sulfa

ALLERGY TO SUBSTANCE – Check if applicable:

- ☐ Adhesive Tape
- ☐ Iodine
- ☐ Latex

FAMILY HISTORY – Check if applicable:

- ☐ Adopted/Unknown
- ☐ Hypertension

- ☐ Both Parents Alive and Healthy
- ☐ Arthritis or Rheumatism
- ☐ Asthma
- ☐ Cataract
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Kidney Disease
- ☐ Lazy Eye
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ None

ALCOHOL – Check if applicable:

- ☐ None
- ☐ Occasional/Social
- ☐ Daily
- ☐ Heavy

DRIVING – Check if applicable:

- ☐ No Difficulty Driving
- ☐ Difficulty Driving
- ☐ Daytime Only

SUBSTANCE ABUSE – Check if applicable:

- ☐ None
- ☐ Cocaine
- ☐ Heroin

ALLERGY/IMMUNOLOGY – Check if applicable:

- ☐ Negative
- ☐ Allergies
- ☐ Autoimmune Disease
- ☐ Itching
- ☐ Redness
- ☐ Hives

CARDIOVASCULAR – Check if applicable:

- ☐ Negative
- ☐ Chest Pain
- ☐ Irregular Heartbeat
- ☐ Hear Attack
- ☐ High Blood Pressure

Patient Consent Form and Financial Operations

Use and Disclosure of Protected Health Information

With my consent, EyeSouth Partners and its affiliates (also referred to as "the Practice" within this form) may use and disclose protected health information (PHI) or individually identifiable health information (IIHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to the Practice's Notice of Privacy Practices for a more complete description of such users and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent.

With my consent, EyeSouth Partners and its affiliates may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care.

With my consent, EyeSouth Partners and its affiliates may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

Consent for Treatment

By signing this form, I am giving my permission to the providers and staff of EyeSouth Partners and its affiliates to treat me, including the performance of testing and/or procedures, as deemed necessary in the exercise of their professional judgment.

Medicare or Medicaid Consent

I certify that the information given by me in applying for payment under Title SVIII and /or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services. I understand that I am responsible for my health insurance deductibles and coinsurance.

Payment for Service

I understand I am responsible for paying the full amount for all services on the day of service, unless the physician or Practice has an agreement with my insurance carrier. If I am insured, I authorize the Practice to release all information necessary to secure payment. I further understand my share of the cost of the services, e.g., co-payments, co-insurance, and deductibles, will be collected upon time of service.

Insurance Claims

As a courtesy, the Practice will file insurance claims with your insurance carrier. Your insurance company, in lieu of reimbursing you directly, will pay to the physician or Practice any benefits for services rendered. Your medical insurance carrier may pay less than the actual bill for services, so you may be responsible for payment of all services rendered. You are responsible for making available complete insurance information for accurate filing of claims. To meet this end, we will request your current insurance card at each visit. Reduction or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred. It is your responsibility to know and understand your medical insurance coverage. Not all services are a covered benefit in all contracts. Additionally, some services we provide will be billed separately for the office visit and may require a separate co-pay or be applied to your co-insurance/deductible. Please call your insurance company to verify your benefits. You will be responsible for all fees not paid by your insurance company.

Referrals and Authorizations

As a specialist, managed care payers require that prior to any visit you must obtain a referral from your primary care physician. It is your responsibility to know if this is required by your insurance and, if so, to obtain the referral. If this is not done by the day of your appointment, you will be asked to either reschedule your appointment or pay the full amount for all services on the day of service. If your insurance company rejects a claim because a valid authorization or referral was not in place, the full cost of the visit may be your responsibility.

Workers' Compensation

Our providers do not accept workers' compensation.

Scheduling Fees

If you are unable to keep your scheduled appointment, please contact our office at least 24 hours in advance. We reserve the right to charge for any appointment which is not cancelled with proper notice.

Unpaid Account Balances

If you fail to make payments for services rendered, your account may be turned over to a collection agency. You will be responsible for paying the collection agency's fees that may be incurred in the collection of any outstanding balance. If a credit card payment is cancelled and a Chargeback fee is applied to your account, the fee may be applied to your out-of-pocket expense and not covered by your insurance.

Agreement: I have read the above form and policies and agree to the terms stated.

_____
Name (printed)

_____ _____
Signature Date

If the Patient is a Minor

I hereby give my consent for the minor patient named above to receive medical evaluation and treatment as deemed necessary by the healthcare provider(s). This may include, but is not limited to, diagnostic procedures, examinations, routine medical care, and any emergency treatment required to protect the minor's health and well-being.

I further understand and agree that I am financially responsible for all charges related to the treatment of the minor patient, including but not limited to co-pays, deductibles, non-covered services, or any other out-of-pocket expenses not covered by insurance.

Parent/Guardian Signature: _____ Date: _____