

New / Update

____/ M / F / J / K

PATIENT NAME: (First) _____ (MI) _____ (Last) _____

MARITAL STATUS: __ Single __ Married __ Divorced __ Widowed __ Separated SEX: *Male Female*

DOB: _____ AGE: _____ SSN: _____ STUDENT STATUS: __ Full __ PT

ADDRESS

MAILING: _____ CITY _____ STATE _____ ZIP _____

PHYSICAL : _____ CITY _____ STATE _____ ZIP _____

HM:(____) _____ -- _____ CELL:(____) _____ -- _____ EMPLOYER: _____ WK:(____) _____ -- _____

SPOUSE'S NAME: _____ EMPLOYER: _____ WORK #: (____) _____ - _____

**Name of nearest relative or friend *not living with you*: _____ Phone: (____) _____ - _____

**My Family Doctor: _____ ** I was referred by: _____

MEDICAL AND VISION INSURANCE INFORMATION

◆ Are you currently being followed by Hospice Care? Y N ◆ Is this visit Worker's Compensation? Y N
◆ Will this visit be Self-pay/No Insurance? Y N ◆ Do you have prescription drug coverage? Y N _____

Spectera #: _____ ECPA (EyeMed) #: _____ Southland #: _____

Primary Ins: _____ Contract #: _____ Group #: _____

Secondary Ins: _____ Contract #: _____ Group #: _____

Tertiary Ins: _____ Contract #: _____ Group #: _____

FINANCIAL AGREEMENT / ASSIGNMENT OF BENEFITS

Responsible Party _____ HM # (____) _____ - _____ WK/CELL # (____) _____ - _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ (INDIVIDUAL *not an ins. co.*)

- MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to TUSCALOOSA OPHTHALMOLOGY, P.C. for services furnished me by TUSCALOOSA OPHTHALMOLOGY, P.C. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the Insurer or agency shown. TUSCALOOSA OPHTHALMOLOGY, P.C. accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.
- MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to TUSCALOOSA OPHTHALMOLOGY, P.C. if possible or otherwise to me.
- OTHER INSURANCE:** I understand that TUSCALOOSA OPHTHALMOLOGY, P.C. maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. And that TUSCALOOSA OPHTHALMOLOGY, P.C. has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by TUSCALOOSA OPHTHALMOLOGY, P.C. if I belong to a plan that does not appear on the aforementioned list.
- NON-COVERED SERVICES:** I understand that TUSCALOOSA OPHTHALMOLOGY, P.C.'s contracts with health care service plans (i.e. HMOs, PPOs) relate only to items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with TUSCALOOSA OPHTHALMOLOGY, P.C. to obtain necessary health care service plan authorizations.

I agree that in return for the services provided to the patient by TUSCALOOSA OPHTHALMOLOGY, P.C., I will pay my account at the time service is rendered or will make financial arrangements satisfactory to TUSCALOOSA OPHTHALMOLOGY, P.C. for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that is my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to TUSCALOOSA OPHTHALMOLOGY, P.C. If my insurance company or health plan designates copayments and/or deductibles, I agree to pay them to TUSCALOOSA OPHTHALMOLOGY, P.C. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

Authorized Signature: _____ Date: _____

HIPAA AMENDMENTS

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PERMISSION TO RELEASE/RESTRICT VERBAL/WRITTEN HEALTHCARE INFORMATION

I authorize **TUSCALOOSA OPHTHALMOLOGY, P.C.** and medical staff members to discuss my medical history, diagnosis, treatment and prognosis with *those listed by name below*. I understand this may include information regarding testing, examination and treatment for HIV, AIDS related illness, mental health and drug, alcohol or chemical abuse.

I understand that by leaving all spaces blank I am indicating my choice to be a "No Information" patient, and I do not want any information released to anyone else.

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

PATIENT'S NAME PRINTED

AUTHORIZED SIGNATURE

RELATIONSHIP TO PATIENT

DATE

PATIENT CONSENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

PATIENT NAME (PRINTED)

DATE

PATIENT/AUTHORIZED SIGNATURE

RELATIONSHIP TO PATIENT

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ **Date:** _____

Date of Birth: _____ **Date of last eye exam:** _____

List **any medications** you currently take (Rx and over-the-counter): _____

Do you have **allergies** to **any** medications? _____ If YES, please list the medications: _____

List **all major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or **injuries** (concussion, etc.): _____

List **any surgeries** you have had (cataract, appendectomy, etc.): _____

Do you *currently* have any problems in the following areas? If YES, please provide additional information.

| | YES | NO | Details |
|---|-----|----|---------|
| EYES (poor vision, pain, tearing, redness, etc.) | | | |
| GENERAL/CONSTITUTIONAL (fever, heat stroke, weight loss or gain, unusually tired, etc.) | | | |
| CARDIOVASCULAR (high BP, racing pulse, etc.) | | | |
| GASTROINTESTINAL (upset stomach, diarrhea, constipation, hernia, ulcers, etc.) | | | |
| GENITAL/KIDNEY/BLADDER (painful or frequent urination, impotence, yellow jaundice, etc.) | | | |
| FEMALES Are you pregnant? Nursing? | | | |
| MUSCLES/BONES/JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.) | | | |
| SKIN (pimples, warts, growths, rash, etc.) | | | |
| NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.) | | | |
| PSYCHIATRIC (anxiety, depression, insomnia) | | | |
| ENDOCRINE (diabetes, hypothyroid, etc.) | | | |
| BLOOD/LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.) | | | |
| ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.) | | | |

FAMILY HISTORY

MOTHER / FATHER / GRANDPARENT / SIBLING

Has any member of your family had these diseases? (Circle all that apply) YES NO UNKNOWN

Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis
Other heritable disease(s): _____

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? YES NO

Have you ever had a blood transfusion? YES NO

Do you drink alcohol? YES NO If YES, how much? _____

Do you smoke? YES NO If YES, how much? _____ How many years? _____

Date: _____

Tuscaloosa Ophthalmology, P.C.

A. George Kudirka, M.D. ♦ E. Van Johnson, M. D.

Riverside Medical Center Suite B-1 ♦ 535 Jack Warner Pkwy. NE ♦ Tuscaloosa, AL 35404
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CONTACT LENSES POLICY

It is our policy that all contact lens patients fitted by our doctors purchase one set of contacts from our optical shop to ensure that the fit of the contacts prescribed is correct. Please let the nurse know if you are interested in contact lenses prior to the exam. If there are any questions, ask the nurse at that time. There will be an additional fitting fee charged for contact lens exams, which involves the additional services and time necessary to properly fit and examine the contact lenses prescribed by our doctors. These charges include a comprehensive eye exam by a board certified medical doctor, prescription for glasses, contact lenses examination, contact lenses training by our optical technician and fit evaluation by the doctor.

- If you have insurance with vision coverage, the insurance **must** be an **approved plan** and be **verified before** you are seen.
- Contact lens patients must have an exam **every 12 months**. *These appointments should be made at least 6 weeks in advance to help insure an appointment is available before the prescription expires.*

I have read and understand this contact lenses policy. _____ (Initials)

Routine Vision Charges Review

| | <u>Established</u> | <u>New</u> |
|----------------------------|---|-----------------------------------|
| | (Fitted by our Doctors in the last 3 years) | |
| Comprehensive Exam | \$70.00 | \$70.00 |
| Refraction Fee | 20.00** (Not covered by Medicare) | 20.00** (Not covered by Medicare) |
| Contact Lenses Exam | 15.00 ** | 29.00** |

**These charges may only be covered by your insurance if you have vision coverage. Contact lenses exams are performed at the patient's request, but refractions are necessary to determine any change in prescription, whether it is for glasses or contacts.

Note: Your insurance may cover your exam even if you do not have vision coverage, but refractions and contact lenses exams are covered only on plans specifying these charges under a vision policy.

I understand that I am responsible for any charges not covered by my insurance policy the day of the visit, including co-pays, co-insurances, and non-covered services.

Signature: _____

Date: _____