Account #: _____ Name: _____ D.O.B.: _____

SOUTHERN EYE CONSULTANTS
EYECARE PARTNERS.

- Bret Fisher, MD
- Donald McCurdy, MD
- Max Musharoff, MD
- Kimberly Sanders, OD

1406 McFarland Blvd N
Suite 1-B
Tuscaloosa AL 35406
Phone: 205-752-5551
Fax: 205-831-8370

Name _____ Date of Birth: _____

SSN: _____

Address: _____

_____

Cell Phone: _____ Home Phone: _____

Email: _____

Medical Insurance Type & Plan Number: _____

_____

_____

Vision Insurance Type & Plan Number: _____

_____

_____

Emergency Contact Name, Relationship, & Phone Number: _____

_____

PLEASE SIGN HERE STATING THE ABOVE INFORMATION IS ACCURATE

_____

_____

*** PLEASE READ AND SIGN NEXT PAGE ***

Account #: _____ Name: _____ D.O.B.: _____

Please read and sign the below agreement:

I understand that the charges made by Southern Eye Consultants for professional services may not be covered in full by any insurance covering such services to the patient. The patient and/or responsible party for payment of fees for services rendered to the patient agrees to make in full to Southern Eye Consultants in such cases. The undersigned accepts the fees charged as lawful debt and promises to pay said fee including up to 35% of the debt for the cost of collection, in addition to any attorney fees, and court costs if necessary, waiving now and forever the right to claim exemption under the constitution and laws of the state of Alabama or any other state. I understand that I am required to pay any health insurance deductibles, co-insurance, co-payments, or any other charges incurred which are not paid by insurance. I understand that Blue Cross and other insurances may or MAY NOT cover refractions, after hours services or other services that the doctor feels necessary for the treatment of my condition and/or maintenance of good health. If I receive a refraction, receive care after hours or other non-covered service by my insurance today and future visits, I agree to pay for these services in full. I authorize the release of any medical information necessary to process an insurance claim and wish to receive updates in medical information via email.

ALL PAYMENTS ARE DUE AT THE TIME OF SERVICES RENDERED.

◯ YES ◯ NO - SOUTHERN EYE CONSULTANTS HAS MY PERMISSION TO KEEP MY CREDIT CARD ON FILE FOR REFUNDS ONLY.

SIGN HERE:

_____

*** PLEASE READ AND SIGN NEXT PAGES ***

Account #: _____ **Name:** _____ **D.O.B.:** _____

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

Request to Receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby authorize the Practice to communicate with me by the alternative means that I have listed below.

PLEASE CHECK ALL THAT APPLY

Home Phone Number: _____

◯ OK to leave message with detailed information
◯ Leave message with call back numbers only
◯ OK to send reminders/follow up to the numbers listed above

Cell Number: _____

◯ OK to leave message with detailed information
◯ OK to Text at the number listed above
◯ Leave message with call back numbers only

E-mail me at: _____

◯ OK to send email and/or text correspondence regarding appointments, reminders or other office related business using communication methods listed.

I understand and acknowledge that communications sent via unencrypted email over an open network are inherently insecure, and there is no assurance of confidentiality of information communicated in this manner. Nevertheless, I consent to allow EyeCare Partners LLC or its affiliates to use unsecure email to communicate with me regarding my health information.

How did you hear about us?

◯ Friend ◯ Family ◯ Newspaper ◯ Magazine ◯ Internet search ◯ Facebook ◯ Event ◯ Insurance

◯ Other _____

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

Acknowledgement of Practices Notice of Privacy Practices:

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

Signature of Patient/Parent/Guardian _____ Date _____

Name of Patient _____ Date of Birth _____

Designation of Certain Relatives, Close Friends, and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain of my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my health care. In that case, the Physician Practice will disclose only information that is directly relevant to the persons involvement with my health care or payment relating to my health care.

Print Name: _____ Relationship: _____

Print Name: _____ Relationship: _____

Print Name: _____ Relationship: _____

Account #: _____ **Name:** _____ **D.O.B.:** _____

MEDICAL CONDITIONS (Please check any that apply.)

CARDIOVASCULAR:
- ◯ Abnormal Valve
- ◯ Heart Attack
- ◯ High Blood Pressure
- ◯ High Cholesterol
- ◯ Heart Murmur

ENDOCRINE:
- ◯ Diabetes Type I
- ◯ Diabetes Type II
- ◯ Thyroid Disease

ENT:
- ◯ Allergies
- ◯ Deafness
- ◯ Sinus Problems

EYES:
- ◯ Blurred Vision
- ◯ Cataracts
- ◯ Double Vision
- ◯ Dryness
- ◯ Flashes of Light
- ◯ Floaters
- ◯ Glaucoma
- ◯ Injury
- ◯ Itching
- ◯ Poor Night Vision
- ◯ Redness
- ◯ Tearing

GENERAL:
- ◯ Fatigue
- ◯ Fever
- ◯ Loss of Appetite
- ◯ Weight Gain

GASTROINTESTINAL:
- ◯ Acid Reflux
- ◯ Hepatitis
- ◯ Hernia
- ◯ Ulcer
- ◯ Vertig

GENITOURINARY:
- ◯ Cancer
- ◯ Kidney Disease
- ◯ Kidney Stones
- ◯ Prostate Disease

HEMATOLOGY:
- ◯ AIDS
- ◯ Anemia
- ◯ Bleeding Disorder
- ◯ HIV

MUSCULOSKELETAL:
- ◯ Arthritis
- ◯ Lupus
- ◯ Muscle Aches
- ◯ Rheumatic Disease

NEUROLOGICAL:
- ◯ Headache
- ◯ Migraine
- ◯ Seizure
- ◯ Stroke

PSYCHIATRIC:
- ◯ Anxiety
- ◯ Depression

RESPIRATORY:
- ◯ Asthma
- ◯ Sleep Apnea
- ◯ Shortness of Breath

SKIN:
- ◯ Itching
- ◯ Rash
- ◯ Redness
- ◯ Shingles
- ◯ Infection

MEDICAL HISTORY

Primary Care Physician: _____ Phone #: _____

Pharmacy Name/City: _____ Phone #: _____

Drug Allergies: _____

Use of Alcohol: ◯ Yes ◯ No Use of Tobacco: ◯ Yes ◯ No

Prior Surgeries: _____

Family History (check and indicate family member):

◯ Cancer Family Member _____

◯ Eye Disease Family Member _____

◯ Diabetes Family Member _____

◯ Heart Disease Family Member _____

Medication/Dosage: (attach list if applicable) _____

_____

Vaccinations:

Pneumonia Vaccination ◯ Yes ◯ No Influenza Vaccination ◯ Yes ◯ No

Print Name: _____

Sign Here: _____ Date: _____