Patient Name:

Chart#:

Date:

---

New *I* Update *|MI* F

PATIENTNAME: (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#: L_)_____ -___ _

"""Name of nearest relative or triend *not living with you:*____________________ **Phone:** L_) ________________

**My Family Doctor:___________________________ **EMAIL ADDRESS:**__________________________

**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: _ EyeMed: _ Southland: _ Superior Vision: _ Davis Vision: Subscriber DOB:__________

**Primary Ins:** ___. _____. Contract#: ___________ Gronp #: ____________________

**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)*

---

L MEDICARE: I request that payment of authorized Medicare benefit be made on my behalf to TUSCALOOSA OPHTHALMOLOGY, P.C. for services furmished 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 benifits or the benefits payable for related services. I understand my signatnre 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 fo1m or elsewhere on other approved claim forms, my signature authority 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 detennination of the Medi:are carrier.

2. MEDIGAP: l 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 font1!1, my signature authoriz.es release of the information to the insurer or agency shown 1request that payment of authorized secondary insurance benefits be made on my behalf to TUSCALOOSA OPHTHALMOLOGY, P.C. if possible or otherwise to me

3. OTHER INSURANCE: I understand that TUSCALOOSA OPHTHALMOLOGY, P.C. maintains a list of health. Care serrvice plans with which it contracts. A!is t 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.

4 NON-COVERED SERVICES: I understand that TUSCALOOSA OPHTIIAIMOLOGY, P.C. 's contrncts with health care servioe 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 cooperrate with TUSCALOOSA OPHTHALMOLOGY, P.C to obtain necessary health care se1Yice 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 md/or deductibles, I agree to pay them to TUSCALOOSA OPHTIIALMOLOGY, P.C. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

Services NOT COVERED by Medicare include the refraction fee ($40) and contact lenses fitting fee(s) ($35/$25).

---

**Authorized Signature:**________________________________________**Date:**_____ _

Patient Name:

Chart#:

Date:

## *HIPAA AMENDMENTS*

### PERMISSION TO RELEASE/RESTRICT VERBAL/WRITTEN HEALTHCARE INFORMATION

I authorize the physicians of Tuscaloosa Ophthalmology 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.

______________________ **PHONE#:** ______________________

**Name & Relationship**

______________________ **PHONE#:** ______________________

**Name & Relationship**

______________________ **PHONE#:** ______________________

**Name & Relationship**

______________________ X ______________________

**PATIENT'S NAME PRINTED** **AUTHORIZED SIGNATURE**

______________________ ______________________

**RELATIONSHIP TO PATIENT** **DATE**

## PATIENT CONSENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 and the 2013 HIPAA Omnibus Final Rule, I have certain rights to privacy regarding my Protected Health Infom1ation (PHI). 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 agree that *Tuscaloosa Ophthalmology, PC* may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my Personal Health Information (PHI). I have been given the right to review such *Notice of Privacy Practices (HIPM)* 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 1nay 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'S NAME PRINTED** DATE

X ______________________ ______________________

**PATIENT/AUTHORIZED SIGNATURE** **RELATIONSHIP TO PATIENT**

Patient Name:

Chart#:

Date:

## REVIEW OF SYSTEMS / MEDICAL HISTORY

| **Date of Birth:** **Gender:** M / F<br>Current **MEDICATIONS:** ***Please List*** | **Current Height** **Current Weight**___ lbs<br>**ALLERGIES:** |
|---|---|
| | List Previous Surgeries: |
| | |
| | |

### DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING?

*Please circle any conditions*

| | |
|---|---|
| **EYES:** poor vision, tearing pain, redness, etc. | Y N |
| **HEART:** High BP, heart attack, racing pulse, angina, etc. | Y N |
| **LUNG:** asthma, emphysema, COPD | Y N |
| **NEUROLOGICAL:** stroke, numbness, seizures, black out spells, multiple sclerosis, migraines, etc. | Y N |
| **GENERAL:** weight loss/gam, fever, tat1gue, etc. | Y N |
| **ENDOCRINE: diabetes**, thyroid, etc. | |
| **GASTROINTESTINAL:** ulcer, hiatal hernia, etc. | Y N |
| **BLOOD/LYMPH:** Cancer, cholesterol, hepatitis, liver disease, sickle cell anemia, anemia, bleeding disorder, etc. | Y N |
| **BONE/JOINT/MUSCLE:** arthritis (Rheumatoid, etc.),joint pain | Y N |
| **ALLERGIC/IMMUNOLOGIC:** Lupus, itching, swelling, hives, etc. | Y N |
| **KIDNEY/(GENITAL:** enlarged prostate, kidney failure/disease, on dialysis, etc. | Y N |
| **PSYCHIATRIC: anxiety , depression, etc.** | Y N |
| **FEMALES:** Are you pregnant or nursing? | Y N |

### SOCIAL HISTORY

*Please circle Yes or No*

| | |
|---|---|
| Do you smoke? | Y N |
| Do you drink alcohol? | Y N |
| Do you take drugs? | Y N |
| Have you ever had a blood transfusion? | Y N |

**Any FAMILY HISTORY of:**

| | |
|---|---|
| Glaucoma/Blindness | Y N |
| Diabetes | Y N |
| Hypertension | Y N |
| Heart Disease | Y N |
| Cancer | Y N |
| Stroke | Y N |
| Sickle Cell | Y N |
| Migraines | y N |
| Thyroid | y N |
| TB | Y N |

### PHYSICAL EXAM

*to be completed by PHYSICIAN only*

| | |
|---|---|
| **General appearance:** Well-developed Other<br>**Mental Status:** Alert & Oriented Other<br>**Heart:** RRR<br>**Lungs:** Clear<br>**Abdomen:** Soft<br>**Neurological:** No Focal Defects<br>**Extremities:** Normal<br>**HEENT:** Normal | Patient taking Flomax or related medication? **Y N**<br>**BP** ___ **Pulse** ___ **Respirations** ____<br>Any previous reaction to anesthesia? **Y N**<br>Planned anesthesia: □ **MAC** □ **Local**<br>Patient's physical condition appropriate for planned anesthesia? **Y N** |

***Reviewed & Updated Physician's Signature(s)***

**1) MD Sig**______________________ **Date:**__________ **2) MD Sig**______________________ **Date:**__________

**3) MD Sig**______________________ **Date:** __________ **4) MD Sig**______________________ **Date:** __________

TUSCALOOSA OPHTHALMOLOGY

# Appointment Reminder Consent Form

Please complete the information below to receive appointment reminders by text to your cell phone or by email. We will send you an appointment reminder 2 days prior to your appointment date.

**Patient Name:** (please print),___________________________________________________________

**Date of Birth:**____________________________

**Parent/ Guardian** if patient is a minor under 18:_______________________________________________

● My Email I authorize to be used for appointment reminders is:

_______________________________@ ___________________

• My Cell phone number I authorize to receive text reminders is:

__________ __________ ____________________

( I am aware that my cell service provider may charge me additional fees if I do not have a text messaging feature on my phone plan.)

**CELL PHONE CARRIER** (please circle one):

AT&T VERIZON T-MOBILE NEXTEL SPRINT PCS US CELLULAR ALLTEL Other:_______________

I (the patient or guardian) consent to receive appointment reminder emails and/or text messages to my cell phone from Tuscaloosa Ophthalmology. I understand this request to receive messages will apply to all future appointment reminders unless I request a change in writing.

I (the patient or guardian) am aware that Tuscaloosa Ophthalmology will not respond to any text messages or emails that I might send in response. This service is provided to inform me of upcoming appointments. The text service and/or email service is not a method of further communication. If I have any questions, I will call Tuscaloosa Ophthalmology during regular business hours.

_________________________________ _________________________________

**Signature** of Patient or Guardian Date

(It is the responsibility of the patient, parent or guardian to notify our office of any change in the email or cell phone number **provided, or if you choose to stop any or all forms of appointment reminders.)**

FOR OFFICE USE ONLY

☐ I hereby revoke my request to receive any future appointment reminders by email. **DATE:**_______________

☐ I hereby revoke my request to receive any future appointment reminders by text. **Date:**_______________