



**SOUTHWEST
eyecare**

Patient Name _____ Date _____

EYE HEALTH HISTORY

Please Print

Date of last eye exam _____ Optometrist _____ Ophthalmologist _____

Do you wear glasses? Yes No How often? Always Occasionally Reading Driving TV

Do you wear contacts? Yes No Type _____ Hours/Day _____

Please circle "Yes" to indicate if you **have had** any of the following.

Blurred vision - Far	Yes	Dry eyes	Yes	Light/Glare sensitive	Yes
Blurred vision - Near	Yes	Eye infection	Yes	Loss of vision	Yes
Burning eyes	Yes	Eye injury	Yes	Night vision, Poor	Yes
Cataracts	Yes	Fainting, Blackouts	Yes	Seeing halos	Yes
Color vision, Poor	Yes	Floaters or Spots	Yes	Seeing flashes	Yes
Crossed eyes (lazy)	Yes	Glaucoma	Yes	Styes, chalazion	Yes
Discharge from eyes	Yes	Headaches	Yes	Twitching eyelid	Yes
Double vision	Yes	Itching eyes	Yes	Watering eyes	Yes

HEALTH HISTORY

Please circle "Yes" to indicate if you **have had** any of the following.

Also, please circle "Yes" if a **parent, sibling or grandparent has had** any of the following.

	<u>Yourself</u>	<u>Family</u>		<u>Yourself</u>	<u>Family</u>
Arthritis	Yes	Yes	Lupus	Yes	Yes
Asthma	Yes	Yes	Macular degeneration	Yes	Yes
Bleeding	Yes	Yes	Migraine headaches	Yes	Yes
Blindness	Yes	Yes	Pacemaker	Yes	Yes
Cancer	Yes	Yes	Poor color vision	Yes	Yes
Cataracts	Yes	Yes	Retinal disease	Yes	Yes
Diabetes	Yes	Yes	Rheumatic fever	Yes	Yes
Epilepsy	Yes	Yes	Shingles	Yes	Yes
Glaucoma	Yes	Yes	Skin conditions	Yes	Yes
Hay Fever	Yes	Yes	Stroke	Yes	Yes
Heart condition	Yes	Yes	Thyroid conditions	Yes	Yes
Hepatitis (Type _____)	Yes	Yes	Tuberculosis	Yes	Yes
HIV/AIDS	Yes	Yes	Turned eye	Yes	Yes
High blood pressure	Yes	Yes	Are you pregnant? _____	Number of children _____	
Kidney disease	Yes	Yes	Tobacco use _____	Alcohol use _____	
Lazy eye	Yes	Yes	Other _____		

MEDICATIONS	SURGERIES	ALLERGIES
List medications you are currently taking, including eye drops, or attach a separate sheet:	List any surgical procedures you have had:	List any allergies to medications or other substances:
Pharmacy _____		
Phone _____		

Southwest Eye Care Payment Policy (rev. 1/11)

If you have medical insurance, we are eager to help you receive your maximum allowable benefits. Assisting in the filing of your primary and secondary insurance claims is a courtesy we extend to our patients. To do this successfully we rely on the information you provide and your understanding of our Payment Policy.
PLEASE READ & SIGN THIS PAYMENT POLICY.

PAYMENT FOR SERVICES RENDERED

All co-payments, co-insurance, deductibles and fees for non-covered services are due at the time of service.*

If you have insurance we will file your primary and any secondary insurance claims. Remember that insurance contracts are between you, (the patient) and the insurance company. If payment is not received from insurance within thirty (30) days, you will receive a statement for services and we will expect payment from you. Any account which reaches a 90-day status is in jeopardy of being turned over to a credit bureau for collection. We accept cash, checks*, MC, VISA, Discover or debit card.

REFERRALS & NETWORKS

There are countless different plans and networks. Our staff can not ensure that our providers are on your plan. It is your responsibility to know your benefits, coverage, limitations and/or network or out-of-network benefits. **As health care providers, our relationship is with you, not your insurance company. When in doubt – call your insurance!**

If a referral is required, it must be provided to the receptionist upon check in for each visit. If a patient is seen in our office without the necessary referral, that patient will be liable for the entire bill payable on the date of service.

NON COVERED SERVICES

Not all services are covered by all insurance companies. Fees for services rendered that are not covered by your medical insurance are expected to be paid on the date of service. Examples of non-covered services are ***REFRACTION** and contact lenses, refractive corrective procedures.

NOTE: Determination of refractive state (**REFRACTION**) is a diagnostic test done at your request or when indicated by your doctor. This test is necessary to determine your prescription for glasses.

The refraction is NOT covered by Medicare or most medical insurance policies.

When you are given a prescription for glasses you will be charged a Refraction Fee.

The fee for this test is \$42 and is due at the time of service.

CANCELLATIONS AND NO-SHOW FEES

Twenty Four hour (24) notice is appreciated if you are unable to keep your scheduled appointment. Charges of \$25 will be assessed to patients who miss scheduled appointments or cancel their appointment without 24 hours notice.

RELEASE OF INFORMATION & BENEFITS

I have read and understand this Payment Policy. I authorize payment of insurance benefits directly to SWEC and promise to assist in the processing of claims for benefits. I authorize any holder of medical information about me to release such information to my insurance carrier or its agents as needed to determine these benefits or the benefits payable for related services.

MEDICARE LIFETIME AUTHORIZATION (Medicare patients only)

I request the payment of authorized Medicare/Medicaid/MediGap benefits be made on my behalf to SWEC for any services provided to me by that provider of care. I authorize any holder of medical information to release to Social Security Administration, CMS and/or its agents information needed to determine these benefits or benefits payable for related services.

If you are unable to meet this policy, please speak to the Patient Account Representative in our billing office to arrange a payment schedule that is agreeable to both parties.

Patient's Name (Please Print) _____

Patient's Signature: _____ **Date:** _____

*Effective January 1, 2011, SWEC will process all checks via desktop deposit. The system uses information from your check to make an electronic fund transfer. Funds may be withdrawn from your account as soon as the same day you make your payment, and you will not receive your canceled check back from your financial institution.
Please make your payment by credit card if you prefer your check is not processed this way. Thank you.

SOUTHWEST EYE CARE SPECIALISTS, P.C.
Notice of Privacy Practices

I consent to the use or disclosure of my protected health information by SOUTHWEST EYE CARE SPECIALISTS, P.C. (SWECS) for the purpose of diagnostic or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of SWECS. I understand that diagnosis or treatment of me by any physician employed by SWECS may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. SWECS is not required to agree to the restrictions that I may request. However, if SWECS agrees to a restriction that I request, the restriction is binding on SWECS and any physician employed by SWECS.

I have the right to revoke this consent, in writing, at any time, except to the extent that SWECS has taken action in reliance on this consent.

The SWECS's complete Notice of Privacy Practices is available for my review. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of SWECS. The Notice of Privacy Practices for SWECS is also provided in the Patient Waiting Area. This Notice of Privacy Practices also describes my rights and SWECS's duties with respect to my protected health information.

SWECS reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by requesting, in writing, that a revised copy be sent in the mail or asking for one at the time of my next appointment. I acknowledge receipt of the Notice of Privacy Practices.

SWECS may call me with appointment reminders, cancellations, or regarding billing/insurance issues and may leave voice mail messages at my home or place of employment.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative (please print)

Date Signed

Description of Personal Representative's Authority