☐ John J. Teahan, MD
☐ Paul A. Sanchez, MD
☐ Jesse S Swift, MD
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SOUTHWEST eyecare

7110 Wyoming Blvd. NE
Albuquerque, NM 87109
505.346.0500
Fax 505.346.0164
www.southwesteyecare.com

PATIENT INFORMATION — *Please print clearly and firmly*

Last Name _____

First Name _____ MI _____

Address _____

Apt # _____

City _____

State _____ Zip _____

Preferred Phone _____

Work Phone _____

Alternate Phone _____

Employer/Occupation _____

E-mail _____

Birth Date _____ Age _____

Today's Date _____

Patient's SS# _____ - _____ - _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Sex:** ☐ Male ☐ Female

Race: ☐ Caucasian ☐ Asian ☐ African American ☐ Native American/Alaskan ☐ Pacific Islander ☐ Declined

Ethnicity: ☐ Hispanic ☐ Non Hispanic ☐ Declined

Language: ☐ English ☐ Spanish ☐Other _____

NOTE: The above information and categories are requested as part of the Healthcare Reform Act.

Referred by Dr. _____

☐Primary Care Physician _____

PCP Phone _____

Emergency Contact _____

Phone _____ Relation _____

How did you hear about us? ☐ Radio ☐ Yellow pages ☐ Newspaper ☐ Provider List ☐ Friend _____

PERSON RESPONSIBLE FOR MEDICAL EXPENSES ☐ self , *if self go to Insurance Information section* ☐spouse ☐ parent

Name _____ Birth Date: _____ SS # _____ - _____ - _____

Address *(if different than patient)* _____

Phone _____ Alternate Phone _____ Employer _____

INSURANCE INFORMATION — *Please present insurance cards at each visit. Courtesy filing of Primary and Secondary MEDICAL insurance only.*

Primary Insurance _____

Patient ID # _____

Group Number _____ Effective Date _____

Name of Policy Holder (if not self) _____

Birth Date: _____ Relation to patient _____

Secondary Insurance _____

Patient ID # _____

Group Number _____ Effective Date _____

Name of Policy Holder (if not self) _____

Birth Date: _____ Relation to patient _____

Preferred PHARMACY

Pharmacy _____

Phone # _____

Location _____

For <u>Work Related Injuries</u> complete the following:

Employer _____

Supervisor Phone # _____

Address _____

SOUTHWEST eyecare

Today's Date:_____

Patient Name _____ Birthdate _____

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.

	Yourself	Family		Yourself	Family
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 Eyecare Specialist

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations: Your health information may be used as necessary to support the day-to-day activities and management of Southwest Eyecare Specialists. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department. Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purposes other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes when financial remuneration is involved. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

Additional Uses of Information

Appointment Reminders: Your health information will be used by our staff to send you appointment reminders. This includes mail, email, text, telephone, or other reasonable attempts. You authorize voice mail messaging unless you specifically opt out of this reminder method.

Information About Treatments: Your health information may be used to send you information on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Fundraising: Southwest Eyecare does not utilize patient PHI to fundraise. If the practice determines that such fund-raising was needed, each patient may request to not participate in such efforts by notifying us in writing.

Education & Marketing: Unless you request us not to, there are some education and marketing activities for which we may use your name and address, to provide you with information about services and treatments available at our practice. If you'd rather not receive educational and marketing communication from our practice please notify us in writing.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your PHI has been disclosed
- The right to receive a printed copy of this notice

Southwest Eyecare Specialists Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices outlined in this notice. In the event of a breach of unsecured protected health information, if your information has been compromised it is our duty to notify you.

Right to Revise Privacy Practices[1]

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the receptionist or the Privacy Official. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to: Privacy Official or Chief Executive Officer Southwest Eyecare Specialist

7110 Wyoming Blvd, NE Albuquerque, NM 87109

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

This notice is effective on or after January 1st, 2015.[1]

In February 2014, the Department of Health and Human Services (HHS) posted to its website new models of the notice of privacy practices in an effort to make the Notice of Privacy Practices (NPP) less cumbersome, and to improve patient's experience and understanding of their rights and how their PHI is managed,. These notices are written in clear, user-friendly language and reflect regulatory changes to HIPAA. There are two sets of notices available, one specific for health plans and one for health care providers. Sample are provided in English and Spanish and available at the HHS website at: http://www.hhs.gov/ocr/privacy/hipaa/modelnotices.html.

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Acknowledgment of Notice of Privacy Practices

Southwest Eyecare Specialists reserves the right to modify the privacy practices outlined in the notice.

☐ I have been offered a copy of the Notice of Privacy Practices for Southwest Eyecare Specialists
☐ I have DECLINED a copy of the Notice of Privacy Practices for Southwest Eyecare Specialists

☐ I authorize Southwest Eyecare Specialists to release Protected Health Information to the following Individual(s) /organization to assist me in the coordination of my care and treatment:

Person(s) to Whom Information May Be Disclosed, Authorized to Use or Disclose Information

Name of person/organization	Telephone Number
Name of person/organization	Telephone Number

This authorization shall remain in effect until revoked.

I consent to the use or disclosure of my Protected Health Information (PHI) by Southwest Eyecare Specialists, P.C., (SWEC) for the purpose of diagnosis or treatment of any healthcare need as determined by SWEC, for the collection of payment, and for conducting healthcare operations by SWEC. Your health information will be used by our staff to send you appointment reminders. This includes mail, email, voicemail, text-messaging, telephone, and other reasonable attempts. Enrollment in the Patient Information Portal constitutes authorization for the appropriate use of information contained on the portal under privacy and security protocols for PHI. I understand that I have the right to request restriction on how my PHI is used or disclosed at the discretion of SWEC. I have the right to revoke this consent and acknowledgement. A copy of the complete HIPAA Privacy Policy describing individual rights and the duties of SWEC is available for my review. SWEC reserves the right to modify the privacy practices without notice. I have the right to request a printed copy of the current Notice of Privacy Policy. A sample copy of these policies are available in English and Spanish at the HHS website at: http://hhs.gov/ocr/privacy/hipaa/modelnotices.html.

Name of Patient (Print or Type)

Signature of Patient

Date

Signature of Patient Representative Relationship of Patient Representative to Patient
(Required if the patient is a minor or an adult who is unable to sign this form)

SOUTHWEST EYECARE SPECIALISTS, PC

FINANCIAL POLICY

Revised January 2015

- INSURANCE CARDS: Please make sure the insurance cards presented at each visit are current and accurate.

- AUTHORIZATIONS: Some insurance plans require a prior authorization or referral for services by specialists. If your insurance plan requires either it is your responsibility to obtain this authorization prior to your visit.

- PAYMENT: Payment is due when services are rendered. If insurance is being filed you will be responsible for paying any copay, co-insurance and deductible amounts at the time of service. If you are unable to pay these amounts at the time of service your appointment may be rescheduled and/or your account may be subject to a $20 billing fee. Balances remaining after 3 statements are also subject to billing fee.

- NON-COVERED SERVICES / DENIED CHARGES: Certain services may be considered non-covered services or may be denied as investigational, experimental or not medically necessary by your insurance carrier. If your physician feels these services are needed and they are performed, you are obligated to pay for these services in full should your insurance carrier deny payment. NOTE: Refractions are considered NON-COVERED (see REFRACTIONS below). This charge for refraction will be deducted from the purchase price of a complete pair of glasses when purchased at Southwest Eyewear Optical Shop.

- MEDICAL PLANS WITH VISION BENEFITS: Please be advised that some medical plans do have routine vision benefits. However, sometimes these vision benefits are with a different carrier. *SWEC may participate with your medical plan but not your vision plan*. Please contact your carrier to verify your benefits and whether SWEC is a provider for both your medical and vision plan. Present all insurance cards at check-in and inform check-in if your visit is for routine vision care or to be filed to your medical insurance.

- MEDICAID / SALUD PROGRAMS: SWEC participates in these programs by doctor referral only and only for medical conditions. SWEC does not participate in the routine vision portion of these plans. Medicaid patients are required to see in-network optometrists for routine vision services.

- RETURNED CHECKS AND PAST DUE AMOUNTS: Returned checks will be subject to collection charges, penalties and interest. All accounts are considered past due if not paid within 60 days of service. Past due accounts may result in collection turnover and may be subject to penalties and interest, and/or the refusal of future appointments until old balances have been paid in full. SWEC does not accept post dated checks.

- SURGERY CHARGES: SWEC will make every effort to determine your insurance benefits prior to any scheduled surgery. SWEC will notify you of an approximate amount you will be responsible for paying prior to the date of surgery. Please keep in mind that this is just an estimate. You may incur other charges (in addition to the surgeons' fee) from the surgery facility, anesthesiologist, laboratory and /or radiologist.

- CANCELLATION POLICY: All appointments that are not cancelled within 24 hours of the appointment are subject to a **$30 NO SHOW fee.** The $30 fee must be paid before we can reschedule your appointment.

- VISION PLANS: SWEC does not participate in any vision plans. We also **do not fit or prescribe** contact lenses. If you are here for a routine vision exam (there are no medical concerns or chief complaint) you will be responsible for payment in full at the time of service. Routine vision exams are NOT filed to insurance and the fee of **$138 plus tax** is due at checkout.

- REFRACTIONS: Refraction is the process of determining if there is a need for corrective lenses. It is an essential part of an eye exam and necessary in order to write a prescription for glasses. Medicare, Medicare Advantage Plans and most medical insurance carriers do not cover the fee for refractions. You are responsible for the **$55 refraction fee** and it is payable at the time of service. We can, at your request, file your refraction charge with your medical insurance plan. If your insurance policy pays this refraction fee, we will issue a refund. This charge for refraction will be deducted from the purchase price of a complete pair of glasses when purchased at Southwest Eyewear Optical Shop.

FINANCIAL POLICY

RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS

I have read and understand this Financial 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 (applies to 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. I acknowledge, understand, and accept the SWEC Financial Policy as indicated by my signature below.

Patient's Name (Please Print) _____

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

Parent/Representative/ Authority: _____ **Date:** _____

NOTE: 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 bank. Please make your payment by credit card if you prefer your check is not processed this way. Thank you.

SOUTHWEST eyecare

(A) Notifiers: John J Teahan, MD
Paul A Sanchez, MD
Jesse S Swift, MD
Stephen J Saxe, MD FACS
Stacia Jacobi-Garcia, OD

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(B) Patient_____ DOB_____

Notice Of Noncoverage

Your health insurance does not pay for the test: (D) REFRACTION.
You are responsible for payment at the time of service.

(D)	(E) Reason Insurance Does Not Pay:	(F) Cost
Refraction: Diagnostic Test to determine Rx for Glasses.	A Non-medical test: **CPT code 92015** Insurance considers this a non-covered service. Since Medicare doesn't cover it, commercial insurance companies usually follow suit. See *Vision Plan, below.	$55.00

(G) Options: **Check only one box. We cannot choose a box for you.**

☐ **OPTION 1.** I want the (D) REFRACTION listed above to determine whether or not I need an updated Rx for glasses. I will pay at the end of my visit today. (F) $55.00

☐ **OPTION 2.** I don't want the (D) REFRACTION test which will result in an RX for glasses, as listed above. I understand this service ***will not*** be rendered or charged and I **will not receive** an Rx for glasses.

Signing below means that you have received and understand your options.

Signature:	Date:

*Southwest Eyecare ***is not a provider*** for vision plans - Your plan may reimburse you for your payment of this diagnostic service. We will assist you with signatures, copies, etc., for you to self-file for this service.

Update 10/2016