☐ John J. Teahan, MD
☐ Paul A. Sanchez, MD
☐ Jesse S. Swift, MD
☐ Kenneth M. Downes, MD
☐ Stacia Jacobi-Garcia, OD

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 Work Related Injuries 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? Y - N | # of children _____ | |
| Kidney disease | Yes | Yes | Tobacco use Y - N | 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 _____ | | |

Revised 12-2016

SOUTHWEST eyecare

7110 Wyoming Blvd NE, Albuquerque, NM 87109
P- 505.346.0500 F- 505.346.0164

# 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.

John J Teahan, MD
Paul A Sanchez, MD
Jesse Swift, MD
Kenneth Downes, MD
Stacia Jacobi-Garcia, OD

7110 Wyoming Blvd NE
Albuquerque, NM 87109
p. 505.346.0500
f. 505.346.0164

SOUTHWEST eyecare

# Notice of Noncovered Service

Your health insurance does not pay for the test **REFRACTION**: 92015

***You are responsible for payment at the time of service.***

| **REFRACTION** | **Reason Insurance Does Not Pay:** | **Cost** |
|---|---|---|
| Diagnostic test needed to determine Rx for eye glasses | CPT code 92015 is considered A Non-medical test. Medicare and MOST commercial insurance plans do not cover this test.<br><br>See "Vision Plan" below | **$55.00** |

(F) **Options**: Check only ONE box. We cannot choose a box for you.

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

☐ **OPTION 2.** I do NOT want the (C) **REFRACTION** listed above to determing whether or not I need an updated Rx for eyeglasses. I understand that ths servicewill not be rendered or charged and that I will not receive a prescription for glasses.

**Patient Name:** _____ DOB: _____

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

| Signature: | Date: |
|---|---|

**Southwest Eyecare is NOT a provider for any vision plans.*
Your vision plan may reimburse you for your payment of this service. We are happy to provide you with the info you need to complete your form and self file for reimbursement.