☐ John J. Teahan, MD
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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 **Gender:** ☐ Male
☐ Divorced ☐ Widowed ☐ _________ ☐ 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 ____________________

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 ____________________		

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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)

Updated: January 2015

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.

Date:______________________ **Print Patient Name:**___________________________________

If you circle YES to any of the following questions, you can have a REFRACTION -- The NON-MEDICAL diagnostic test which determines the Rx for glasses.

If your eyeglass Rx is over a year old, it has expired. Do you want a new Rx today?	**YES**	**NO**
Have you thought about changing your Rx lenses or frame for any reason?	**YES**	**NO**
Do you intend to have this service performed here today?	**YES**	**NO**

This REFRACTION fee of $55.00 is collected at the time of service and is not billable to your health insurance. Initial here ☐

A Visual Acuity Test, which IS medically necessary, is always performed during your exam and *is included* in the charge of your eye health exam, but a prescription is not a result.

Southwest Eyecare *is not* a provider for any vision plans. Your vision plan may reimburse you for your payment for this service. Please check with your plan in advance. We are happy to assist you.

I have read and I understand the information above –

SIGN HERE:____

2/1/18