☐ John J. Teahan, MD
☐ Paul A. Sanchez, MD
☐ Kenneth M. Downes, MD
☐ Kurt W. Andreason, MD
☐ Stephen J. Reigstad, 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 **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 <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 _____		

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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 2021

- 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).

- 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 insurance carrier. *Southwest Eyecare may participate with your medical plan but not your vision plan.* Please contact your insurance carrier to verify your benefits and whether Southwest Eyecare is a provider for your medical 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.

- MEDICIAD/CENTENNIAL PROGAMS: Southwest Eyecare participates in these programs by doctor referral only and only for medical conditions. Southwest Eyecare does not participate in the routine portion of these plans. Medicaid patients are required to see in-network optometrists for routine vision services as we are unable to provide glasses RX.

- 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. Southwest Eyecare does not accept postdated checks.

- SURGERY CHARGES: Southwest Eyecare will make every effort to determine your insurance benefits prior to any scheduled surgery. Southwest Eyecare 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 will be subject to a **$30 NO SHOW fee**. The $30 fee must be paid before we can reschedule your appointment.

- VISION PLANS: **Southwest Eyecare 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 not medical concerns or chief complaint) you will be responsible for payment in full at 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. We will file the charge for the refraction with your health insurance, we are not contracted with any vision plans. In the event the charge for the refraction is not covered by your health insurance a fee of $55 will be applied to patient responsibility.

Continued on Back

Pt initials_____

FINANCIAL POLICY

RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS

I have read and understand this Financial Policy. I authorize payment of the insurance benefits directly to Southwest Eyecare Specialists, PC 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 to be made on my behalf to Southwest Eyecare Specialist, PC 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 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 Southwest Eyecare Specialist, PC Financial Policy as indicated by my signature below.

Patients Name (Please Print): _____

Patients Signature: _____ **Date:** _____

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

NOTE: Effective January 1, 2011 Southwest Eyecare Specialists 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 cancelled check back from your bank. Please make your payment by credit card if you prefer your check not processed this way. Thank you.

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eyecare

REFRACTION RX Acknowledgement

Refraction is the process of determining your best corrected vision and if there is a need for corrective eyeglasses. It is an essential part of the eye exam and is necessary to write a prescription for glasses. Refraction is NOT a covered service by Medicare or most medical insurance plans. These plans consider a refraction a "vision" service not a "medical" service.

We will file the charge for the refraction with your health insurance, we are not contracted with any vision plans. If covered by health insurance copayments, co-insurance, and deductible are the responsibility of the patient and will be billed accordingly.

In the event the charge for the refraction is not covered by your health insurance a fee of $55 will be applied to patient responsibility.

By signing below, you acknowledge you have received the Refraction RX policy.

Patients Name (Please Print): _____

Patients Signature: _____ **Date:** _____

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