PAUL A. SANCHEZ, MD
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JOHN J. TEAHAN, MD
DAVID T. TRUONG, MD

SOUTHWEST eyecare

7110 WYOMING BLVD. NE
ALBUQUERQUE, NM 87109
505 – 346 – 0500
FAX 505 – 346 – 0164

PATIENT INFORMATION – PLEASE PRINT CLEARLY AND FIRMLY	TODAY'S DATE:
LAST NAME:	FIRST NAME: MI:
ADDRESS:	CITY: STATE: ZIP:
PREFERRED PHONE NUMBER:	WORK PHONE:
ALTERNATE PHONE:	EMPLOYMENT/OCCUPATION:
E-MAIL:	SSN #:
BIRTHDATE: AGE:	REFERRED BY DR.:
EMERGENCY CONTACT PHONE # & RELATION	PRIMARY CARE PHYSCIAN AND PHONE #:
HOW DID YOU HEAR ABOUT US? ☐ PROVIDER LIST ☐ REFERRAL ☐ FRIEND_____ ☐ TELEVISION ☐ BILLBOARDS ☐ WEBSITE/ONLINE ☐ OTHER_____	**MARITAL STATUS:** ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐_____ **GENDER:** ☐ MALE ☐ FEMALE **RACE:** ☐ CAUCASION ☐ ASIAN ☐ AFRICAN AMERICAN ☐ NATIVE AMERICAN ☐ PACIFIC ISLANDER ☐ DECLINED **ETHNICITY:** ☐ HISPANIC ☐ NON - HISPANIC ☐ DECLINED **LANGUAGE:** ☐ ENGLISH ☐ SPANISH ☐ OTHER NOTE: THE ABOVE INFORMATION AND CATAGORIES ARE REQUESTED AS PART OF THE HEALTHCARE REFORM ACT.

PERSON RESPONSIBLE FOR MEDICAL EXPENSES IF SELF GO TO INSURANCE INFORMATION SECTION ☐ SPOUSE ☐ PARENT		
NAME:	BIRTH DATE:	SS#
ADDRESS:	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: _____ NAME OF POLICY HOLDER (IF NOT SELF): _____ BIRTHDATE: _____ RELATION TO PATIENT: _____	SECONDARY INSURANCE: _____ PATIENT ID #: _____ GROUP NUMBER: _____ NAME OF POLICY HOLDER (IF NOT SELF): _____ BIRTHDATE: _____ RELATION TO PATIENT: _____
PREFERRED PHARMACY PHARMACY: _____ PHONE: _____ LOCATION: _____	FOR **WORK RELATED INJURIES** COMPLETE THE FOLLOWING EMPLOYER: _____ SUPERVISOR PHONE: _____ ADDRESS: _____

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CONDITIONS:	Circle any and all conditions that apply to you or check none.	NONE
CONSTITUTIONAL:	Fever, weight loss, fatigue, loss of appetite, chills, unexplained weight loss, fatigue, loss of appetite, night sweats	
EARS, NOSE, THROAT:	Hearing loss, sore throat, runny nose, dry mouth, jaw claudication, ear ache	
CARDIOVASCULAR:	Chest pain, shortness of breath, swelling of feet, shortness of breath when laying flat, racing pulse, irregular heartbeat, blood pressure stable	
RESPIRATORY:	Wheezing, cough, coughing up blood, severe or frequent colds, difficulty breathing	
GASTROINTESTINAL:	Abdominal pain, nausea, diarrhea, bloody stools, stomach ulcers, constipation, trouble swallowing, gastrointestinal ulcers, jaundice or yellow skin	
GENITOURINARY:	Genital sores or ulcers, kidney failure, kidney problems, kidney stones, prostatitis, testicular pain, urinary discharge	
MUSCULOSKELETAL:	Muscle aches, joint pain, difficulty laying flat due to musculoskeletal discomfort, pain while sleeping or awakening	
NEUROLOGICAL:	Weakness, headaches, scalp tenderness, dizziness, paralysis of extremities, tremor, stroke, numbness, tingling in body, seizures or convulsions, fainting	
PSYCHIATRIC:	anxiety, depression, ADHD, Alzheimer's, Bipolar disorder, confusion, dementia	
ENDOCRINE:	Excess thirst, excessive urination, heat intolerance, hair loss, dry skin, blood sugars poorly controlled	
HEMATOLOGY/ONCOLOGY	Easy bruising, prolonged bleeding, breast, prostate, lung, skin, colon, other	
ALLERGIC/IMMUNOLOGIC:	Autoimmune disease, seasonal allergies, unspecified	
OCULAR:	cataract, glaucoma, detached retina, blindness, lazy eye, eye injury/trauma, corneal problems, macular degeneration	
INTEGUMENTARY:	Rash, change in mole, rashes, skin sores, skin cancer, severe itching, loss of hair	
FEMALES:	Are you pregnant? Are you nursing?	

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

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HAVE YOU HAD ANY PROCEDURES ON YOUR EYES? YES PLEASE DESCRIBE:

HEALTH HISTORY & FAMILY 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

Disease/Condition	Yourself	Family	Disease/Condition	Yourself	Family
ARTHRITIS, JOINT PAIN, ETC	YES	YES	LUPUS	YES	YES
ASTHMA, SMOKING, COPD, SLEEP APNEA	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, ENDOCRINE DISORDERS	YES	YES	RHEUMATIC FEVER	YES	YES
EPILEPSY	YES	YES	SHINGLES	YES	YES
GLAUCOMA	YES	YES	SKIN CONDITIONS, OPEN WOUNDS, HISTORY OF MRSA, OR STAPH INFECTION	YES	YES
HAY FEVER	YES	YES	STROKE	YES	YES
HEART CONDITON	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, STOMACH, URINARY, PROSTATE, BOWL	YES	YES			
LAZY EYE	YES	YES			

SOCIAL HISTORY:

(Circle:) Student Homemaker Employed Retired **(Circle:)** Single Married Separated Divorced Widowed

Do you use Tobacco? Yes / No Cigarettes / Smokeless _____ # Packs/Times a Day _____# of Years

Have you ever smoked? Yes / No If Yes when:_____

Do you use Alcohol? Yes / No Rarely Daily Weekly 1-2 drinks 2-4 drinks Other _____

Substance Abuse? Yes / No Rarely Daily Weekly _____

Do you still drive? Yes / No Day Night or Both (Circle One)

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List all Prescriptions and Over the Counter medications you are taking: (Including Eye Drops)

If you have a list, please give to receptionist to copy in lieu of filling out form:

Medication Name	Dosage	SURGERIES	ALLERGIES
LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING, INCLUDING EYE DROPS, OR ATTACH A SEPARATE SHEET OF PAPER.		LIST ANY SURGICAL PROCEDURES YOU HAVE HAD:	LIST ANY ALLERGIES TO MEDICATIONS OR OTHER SUBSTANCES
PREFERRED PHARMACY & PHONE #:			

When was the last time you had a wellness check and/or physical?

- If it has been less than 1 year, please have your provider send your last wellness exam and labs.
- If you answered more than 1 year, please call your primary provider for a wellness check.

Do you have any heart conditions, heart murmurs, irregular heart beat and/ or procedures? ☐ Yes ☐ No

If yes please describe:

Have you had any heart surgeries or procedures (STENT placement/Ablation/CABG/Pacemaker) ☐Yes ☐No

If yes please describe:

Do you take any blood thinners, or any blood conditions we should know about? ☐ Yes ☐ No

Do you see a Cardiologist and/ or Vascular provider? ☐ Yes ☐ No Provider Name:

Clinic: Date of last exam:

Do you see a specialist for other medical history not listed above? Yes No Please Describe:

Provider Name: Clinic: Date of last exam:

Can you lay flat on your back with out shortness of breath? ☐Yes ☐ No

Do you take any diabetes medications ex: metformin, glipizide, etc.? ☐ Yes ☐ No

Do you have any history or claustrophobia, anxiety, depression, PTSD? ☐ Yes ☐ No

If Yes Please describe:

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 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.

SOUTHWEST
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:**_____