Patient Demographic Form

Please PRINT

Today's Date: _____

Last Name: _____ **First Name:** _____ **MI:** _____

Address: _____ **City:** _____ **State:** _____

_____ **Zip:** _____

Preferred Phone Number: _____

☐Home ☐Cell ☐Work ☐Other: _____

Alternate Phone Number: _____

☐Home ☐Cell ☐Work ☐Other: _____

We are committed to providing quality services. Therefore, you may be contacted periodically by the business to confirm upcoming appointments and provide feedback regarding your experience. This contact may come via text or email; you can opt out anytime.

E-Mail Address: _____ ☐**Private**

Social Security Number: _____

Birth Date: _____ **Age:** _____

Marital Status: ☐Single ☐Married ☐Life Partner

☐Divorced ☐Widowed ☐Other: _____

Gender: ☐Female ☐Male ☐Additional category (please specify): _____

☐Decline to answer

<u>Emergency Contact</u>

Name: _____

Relationship: _____

Preferred Phone Number: _____

☐Home ☐Cell ☐Work ☐Other: _____

<u>Primary Care Physician</u>

Name: _____

Address: _____

City: _____ **State:** _____

Zip: _____ **Phone:** _____

Note: The below information and categories are requested as part of the Healthcare Reform Act

Race: ☐African American ☐American Indian ☐Asian ☐Caucasian ☐Hispanic ☐Pacific Islander

☐Other: _____ ☐Decline to answer

Ethnicity: ☐Hispanic, Latino or Spanish origin ☐Not Hispanic or Latino ☐Other: _____

☐Decline to answer

Language: ☐English ☐Spanish ☐Other: _____

How Did You Hear About Us?

☐Billboard ☐Drive By ☐Social Media ☐Radio

☐Friend/Patient ☐Internet Search ☐Television

☐Word of Mouth ☐Insurance ☐Urgent Care/ER

☐Other: _____

☐Referring Physician

Name: _____

Address: _____

City: _____ **State:** _____

Zip: _____ **Phone:** _____

Medical History Form

Please PRINT

Today's Date: _____

Patient Name: _____ Birth Date: _____ Phone #: _____

EYE HEALTH			
Blurred Vision – Distance ☐	Discharge from Eyes ☐	Flashes ☐	Macular Degeneration ☐
Blurred Vision – Near ☐	Double Vision ☐	Floaters or Spots ☐	Night Vision, Poor ☐
Blurred Vision – Intermediate ☐	Droopy Eyelid(s) ☐	Glaucoma ☐	Stye, Chalazion ☐
Burning Eyes ☐	Dry Eyes ☐	Halos ☐	Twitching Eyelid(s) ☐
Bump, Lesion ☐	Eye Infection ☐	Headaches ☐	Watering Eyes ☐
Cataracts ☐	Eye Injury ☐	Itching Eyes ☐	Other:
Color Vision, Poor ☐	Eye Pain ☐	Light/Glare Sensitive ☐	
Crossed Eyes, Lazy ☐	Fainting, Blackouts ☐	Loss of Vision ☐	

MEDICAL HISTORY		
DISEASE/CONDITION	☒ ***Fill in all that applies***	
AIDS/HIV	☐	If yes, how many years? _____ What was your last CD4 count? _____
Asthma	☐	
Cancer	☐	If yes, when? _____ What type? _____
Diabetes (Type: _____)	☐	If yes, how many years? _____ How often do you check blood sugar? _____ What was your last HbA1C date? _____ HbA1C result: _____
Emphysema (COPD)	☐	
Heart Disease	☐	If yes, how many years? _____ What type? _____
High Blood Pressure	☐	
Kidney Disease	☐	
Migraine Headaches	☐	
Thyroid Disease	☐	If yes, how many years? _____ What type? _____
Stroke	☐	If yes, when? _____
Seizure	☐	
Other illnesses (please list)	☐	_____ _____

SURGICAL HISTORY			
Type: _____	Date: _____	Type: _____	Date: _____
Type: _____	Date: _____	Type: _____	Date: _____
Type: _____	Date: _____	Type: _____	Date: _____
Type: _____	Date: _____	Type: _____	Date: _____

Medical History Form

Please PRINT

Today's Date: _____

Preferred Pharmacy: _____ Location: _____ Phone: _____

MEDICATIONS (*Please List ALL*) ☐See Attached List			
Medications/Vitamins/Supplements	**Dose (mg, etc.)**	**Frequency**	**Reason for Medication**

ALLERGIES ☐No Known Drug Allergies	
Allergy	**Reaction**

FAMILY HISTORY ☐No Significant Family History is Known		
DISEASE/CONDITION	***Please reference blood relative if marked*** ☒	
Blindness ☐	Asthma ☐	Migraine Headaches☐
Cataracts ☐	Cancer☐	Thyroid Disease☐
Crossed Eye, Lazy ☐	Diabetes☐	Stroke☐
Glaucoma ☐	Heart Disease☐	Seizure☐
Macular Degeneration ☐	High Blood Pressure☐	Other:
Other Eye Diseases:	Kidney Disease☐	Other:

SOCIAL HISTORY		
Tobacco Use	☐No ☐Yes	If yes, Tobacco type:
Current: Packs/day _____ # of Years _____		*Past*: Quit Date _____ Packs/day _____ # of Years _____
Do you drink Alcohol?	☐No ☐Yes	☐Beer ☐Wine ☐Liquor # of Drinks/week _____
Do you use Marijuana?	☐No ☐Yes	If yes, how often:
Consumption type: ☐Smoke ☐Edible ☐Tablet ☐Patch ☐Vape ☐Topical ☐Other: _____		
Substance Abuse	☐No ☐Yes	If yes, type: _____ How often: _____
Are you able to Drive?	☐No ☐Yes	If yes: ☐Daytime only ☐Day & Night
Occupation	☐Retired ☐Full Time ☐Part Time ☐Student ☐Unemployed ☐Disabled	
Marital Status	☐Married ☐Single ☐Divorced ☐Widowed ☐Separated ☐Partner	
Living Conditions	☐With Family ☐Alone ☐With Caretaker ☐In Retirement Center ☐In Nursing Home	
Hospice	☐No ☐Yes	

Medical History Form

Please PRINT

Today's Date: _____

Patient Name: _____ Birth Date: _____ Phone #: _____

REVIEW OF SYSTEMS		
CONDITIONS	✓ **Check all that apply & Circle all conditions that apply to you**	☐ **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 lying 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 lying 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?	

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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.

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:**_____