SacEyeMD

Today's Date	

Please Print

PATIENT INFORMATION

Full Legal Name (First) (Middle) (Last)				Name Normally Used (Nickname)
Address	Apt. No.	City	State	Zip
E-mail	Home Phone	Work Phone	Cell Phone	
Social Security No.	Sex	Marital Status	Date of Birth	Driver's License No. / State Issued
Employer Name	Employer City	Employer State	How Did You Hear About Us?	

List anyone you authorize this office to share your medical information with (name and relationship to you)

Permitted Contact Method(s) (circle all that apply) home phone cell phone work phone mail e-mail

Ok to leave message on answering machine/voicemail? Yes___ No___

SPOUSE'S INFORMATION

Full Legal Name (First) (Middle) (Last)		Home Phone
Occupation	Employer name	Work phone / Cell Phone

INSURANCE INFORMATION

Primary Insurance Company Name	Group No.	ID/Certificate No.
Policy Holder's Name/Parent's Name (if patient a child) D.O.B.	Policy Holder's Social Security No.	
Secondary Insurance Company Name	Group No.	ID/Certificate No.
Policy Holder's Name		

EMERGENCY INFORMATION

Person to Notify in Case of Emergency	Relationship	Home Phone	Cell Phone

INFORMATION FOR THE PATIENT

1. Patients who carry standard health insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. All patients with standard health care insurance are expected to make payment as services are rendered, regardless of pending insurance, litigation, etc.
2. Patients with contract health plans should present their insurance ID card to the receptionist after completing this form. Some contract health plans (HMOs, PPOs, IPAs, etc) require a copayment at the time of service. Most contract health plans require that the claim be submitted by our office.

Patient/ Guarantor Signature:

_____Date:_____

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Patient Medical History Form

NAME: _____ AGE: _____ DATE: _____

Primary care physician:_____ _____

Other Ophthalmologists/Optometrists you have: _____

_____

PAST MEDICAL PROBLEMS (including present conditions): _____

_____

_____

_____

_____

_____

List all CURRENT PRESCRIPTION MEDICINES (include dosage, reason you take it, who prescribed it):

_____

_____

_____

List all OVER-THE-COUNTER MEDICINES, vitamins, and food supplements that you take: _____

_____

ALLERGIES TO MEDICATIONS (including reaction): _____

_____

List SURGERIES you have had (include year, surgeon, and hospital): _____

_____

_____

Describe HOSPITALIZATIONS/ILLNESSES not included above (include year, hospital): _____

_____

_____

Ethnicity (circle): Hispanic or Non-Hispanic **Race:** _____ **Preferred Language(s):** _____

Do/did you SMOKE? Yes No How much? _____ packs/day # of years _____ Year you QUIT _____

Do/did you DRINK alcohol? _____ How much? _____ drinks/week # of years _____

Do you or have you used (circle): heroin marijuana cocaine methamphetamine chewing tobacco diet pills

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Patient Family History

List any other diseases that run in your family and specify your relationship to each family member listed. _____

_____

_____

Past Ocular History

Do you have the following:

Age related macular degeneration_____ Dry eyes_____

Cataracts_____ Glasses/contacts, RGP wearer_____

Diabetic retinopathy_____ Uveitis/iritis_____

Glaucoma_____ Amblyopia_____

Strabismus_____ Myopia, hyperopia, astigmatism_____

Blind eye_____ Ocular trauma_____

Retinal detachment_____ Other ocular conditions_____

Eye medications_____

_____

_____

_____

Ocular surgeries_____

_____

_____

Laser treatments_____

_____

Injections:_____

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Confidentiality and Privacy of Medical Records

This notice describes the privacy practices of our office. PLEASE REVIEW CAREFULLY.

Our Pledge Regarding Health Information

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) was drafted, in part, to control the privacy of, access to, and maintenance of confidential information. We understand that information about you, your health, and your health care is personal. We are committed to protecting your personal health information (PHI).

We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all records of your care generated by this health care practice, whether made by your personal physician or others working in this office. This notice will tell you about the ways in which we may use and disclose your PHI. We also describe your rights to the PHI we keep about you and describe certain obligations we have regarding the use and disclosure of your PHI.

We are required by law to:

- Make sure that health information that identifies you is kept private
- Give you this notice of our legal duties and privacy practices with respect to your PHI
- Follow the terms of the notice that is currently in effect

How We May Use and Disclose Your PHI

The following categories describe different ways that we use and disclose health information.

For Treatment: We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to others involved in your healthcare treatment including other physicians, hospitals, labs, pharmacies, or other health care providers where we may have referred you.

For Payment: We may use and disclose information about treatment and services we provided to you for billing purposes. These fees may be collected from you, an insurance company, or a third party and include requests for payment/reimbursement and prior authorization for treatment.

Appointment Reminders: We may use and disclose health information to contact you as a reminder that you have an appointment or that you missed an appointment and should contact us to reschedule.

As Required by Law: We will disclose health information about you when required to do so by federal, state, military, or local law.

To Avert a Serious Threat to Health or Safety: We may use and disclose health information about you when necessary to prevent a serious threat to the health and safety of you or another individual(s).

Workers' Compensation: We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose health information about you for public health reporting purposes. These activities generally include but are not limited to the following:

- Birth, death, abuse, neglect, communicable disease prevention and/or notification, medication adverse reactions, and product recalls.

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Office Financial Policy

Thank you for choosing Sac Eye M.D. for your eye care needs. We are committed to providing outstanding medical treatment and care. We are more than willing to provide that care within your insurance plan guidelines, whenever possible. With your cooperation you should be able to receive all of the insurance benefits you are entitled to, and we will be able to focus our efforts on striving to provide you with excellent medical care. We understand that many patients find insurance coverage and financial responsibility issues complex and confusing. Due to this, we have outlined our practice's policy in detail to help you.

Regardless of insurance coverage it is your responsibility for any portion not covered by your insurance carrier. As a courtesy, we often will give an estimated cost to patients for any service rendered. Prior to seeing the ophthalmologist, you will be expected to pay for the co-pays, deductibles, co-insurance that will incur during the visit.

Once your insurance has processed your claim, they will send an Explanation of Benefits (EOB) to both you and our office showing what your total patient responsibility is. If there is any credit to your account after your insurance claim has been processed, it will be refunded back to the charged credit card.

PATIENTS WITHOUT INSURANCE (SELF PAY)
Payment will be due on the day services are rendered. A list of our fee schedule for consultations and procedures is available to patients upon request.

REFRACTION FEE
Examination for glasses is called refraction. Refractions are not covered by Medicare or most insurances including HMO and PPOs. The fee for a refraction is $40.00 and is collected at the time of service if glasses prescription is requested.

RETURNED CHECKS
A $25.00 charge will be added to your account for any returned check.

If an account is not paid in full within 90 days, a **35% collection processing fee** will be added to the outstanding balance and will be turned over to a collection company for further processing. No additional appointments will be made for delinquent accounts until they are brought current.

APPOINTMENT CANCELLATIONS & NO SHOWS
We attempt to contact every patient to remind them of their appointment; however, it is the responsibility of the patient to arrive for their appointment on time. If you are unable to keep your scheduled appointment, please call our office **at least 24 hours** before your appointment time to cancel/reschedule your appointment so we can accommodate other patients who need to be seen. Failure to do so will result in a **$50.00** fee being charged to your account.

MEDICAL RECORDS
If you need a copy of your medical records, we will need you to sign a medical release letter and please allow 5 business days to copy your records. There is no charge for the first 10 pages, but any subsequent page will be a charge of $0.25 per page.

CREDIT CARD ON FILE
This is an optional service that we recommend established patients to provide a credit card on file with our office. Your credit card will be stored with our merchant service provider, Payline, for future transactions. For your protection, only the last 4 digits of your card will show in our system.

Credit cards on file will be used to pay any remaining patient balance after the medical claims has been processed by the insurance company. Any credit from excess charge will be refund back to the charged card.

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Credit Card on File Authorization

I agree to place my credit card on file to be charged by Sac Eye M.D. for any outstanding bills for medical services rendered. I authorize their staff and/or billing service to utilize my credit card for the purposes stated above.

Signature: _____ Date: _____

I hereby authorize the physician to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company and/or Medicare; and thereby authorize payment of the insurance benefits directly to the physician for any services rendered that are not paid for directly by myself.

BY SIGNING BELOW, I ACKNOWLEDGE I HAVE READ AND UNDERSTAND THE FOLLOWING POLICIES. I ACCEPT THE RIGHTS AND RESPONSIBILITIES OUTLINED WITHIN THEM:

- **Patient Financial Responsibility including deductible, copay, coinsurance, no show policy, collections**
- **Confidentiality and Privacy of Medical Records**

_____ _____

Patient Signature Date

_____

Patient Printed Name