

EYE HEALTH PARTNERS

Teamwork in Eye Health Care

Signature on File, Assignment of Benefits, Financial Agreement, Consent to Treatment

Beneficiary Name (Please Print) _____

1. MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to Eye Health Partners of Middle Tennessee, Inc. and/or its independent contracted doctors for services furnished me by Eye Health Partners of Middle Tennessee, Inc. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on the other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Eye Health Partners of Middle Tennessee, Inc. accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductibles are based upon the charge determination of the Medicare Carrier.

2. MEDIGAP: I understand that if a Medigap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes the release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Eye Health Partners of Middle Tennessee, Inc., if possible or otherwise to me.

3. OTHER INSURANCE: I understand that Eye Health Partners of Middle Tennessee, Inc. and/or its independent contracted doctors are in network/contracted with many insurance plans. I agree that I am individually obligated to pay charges in full at time of service for all services rendered to me, if Eye Health Partners of Middle Tennessee, Inc. and/or its independent contracted doctors are not in network with my insurance plan.

4. NON-COVERED SERVICES: I accept full financial responsibility for all items or services, which are determined by my health plan not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care plan or in the benefit summary the health care plan furnishes to the patient; and treatment or tests not authorized by the health care plan. I agree to cooperate with Eye Health Partners of Middle Tennessee, Inc. to obtain necessary health care plan authorizations.

5. FINANCIAL AGREEMENT: I agree that in return for the services provided to me by Eye Health Partners of Middle Tennessee, Inc., I will pay my account at the time services are rendered or will make financial arrangements satisfactory to Eye Health Partners of Middle Tennessee, Inc. for payment. If an account is sent to a collection agency or attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury or in court action. I understand and agree that if my account is delinquent, a \$30 administrative fee may be charged to my account, and I may be charged interest at the legal rate. Any benefits, of any type under any policy, or insurance insuring the patient, or any other party liable to the patient, are hereby assigned to Eye Health Partners of Middle Tennessee, Inc. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Eye Health Partners of Middle Tennessee, Inc.

6. CONSENT TO TREATMENT: I authorize the physicians of Eye Health Partners of Middle Tennessee, Inc., their associates, technical assistants, and other health care providers under their direction to provide diagnostic evaluation and treatment. I agree to pupillary dilation for the purpose of examination and have been advised not to drive if I feel visually impaired. I understand that no guarantee has or will be made to me regarding any possible result or cure based on my examination and/or treatment.

Patient/Legal Guardian Signature: _____ **Date:** _____

Eye Health Partners – Patient HIPAA Acknowledgment & Consent Form

Patient Name: _____ Date: _____
 Date of Birth: _____ Account #: _____

Notice of Privacy Practices: I acknowledge that I have received or have been offered the Practice’s Notice of Privacy Practices. Initial **ONLY** if Notice of Privacy Practices refused by patient or patient’s representative. ____ (Patient Initials)

Release of Information: I hereby authorize this Practice to release to referring or subsequent healthcare providers, reports of my medical condition that will assist him or her in my continued medical care, and as needed, to process claims and for general healthcare operations, which may include the use of an electronic health information exchange. I further authorize this Practice to retrieve information about my current medications from third-parties in order to assist in my care and correct payment of claims.

Disclosure to Family Members and/or Friends: HIPAA allows this Practice to communicate with your family and friends who are involved in your treatment or payment for your treatment. However, you have the right to direct this Practice not to share your Protected Health Information (PHI) at all, or to specifically restrict or deny the Practice’s ability to share your PHI with individuals you may name. Please check below if you wish to OPT OUT of this Practice’s communicating with friends or family entirely- OR- complete the information below to identify those individuals with whom the Practice is NOT TO COMMUNICATE. *If both are left blank, Practice will share PHI with family and friends in accordance with privacy regulations and professional judgment.*

_____ **I DO NOT WISH** for the Practice to communicate about my treatment or payment with family or friends.

_____ The practice may communicate about my treatment to family and friends, **EXCEPT** for the following individuals:

First and Last Name	Relationship to Patient

Consent for Photographing or Other Recording for Security, Health Care Operations, and/or Education:

_____ (Pt Initials) **I Consent** OR **I do not Consent** to photographs, videotapes, digital recording, digital or analog audio recordings, and/or images of me being recorded for security purposes, Practice’s health care operations (e.g. quality improvement activities), and/or continuing medical education (CME). I understand the facility retains ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected in compliance with HIPAA. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment, or healthcare operation purposes or otherwise permitted or required by law.

Consent to email, text message or receive automated calls for appointment reminders and other healthcare communications: Patients in our Practice may be contacted via email, text message, or automated phone call to remind you of an appointment, to obtain feedback on your experience with our healthcare team and to provide general health reminders/information. **Standard text messaging rates may apply. Contact your cell service provider for details.**

Please indicate which method you prefer for appointment reminders and other health care communications. Patient’s preferences shall remain in place until changed by patient in writing.

Eye Health Partners – Patient HIPAA Acknowledgment & Consent Form

- _____ (Patient initials) **Text Message:** I authorize Practice to send text messages for appointment reminders, feedback, and general health reminders to the cell number indicated here: (____-____-____)

- _____ (Patient initials) **Email:** I authorize Practice to send appointment reminders, feedback and general health information to the email address indicated here:
Email Address: _____

- _____ (Patient initials) **Automated phone call:** I authorize Practice to place automated phone calls to the cell phone or landline phone indicated here: Phone number: (____-____-____) Is this a Cell or Landline? (Circle one)

I understand that once my PHI is disclosed to a third party, that party may disclose my information to other parties and any re-disclosure of my PHI by a third party may no longer be protected under federal or state privacy laws.

I understand that PHI may include including information relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia or HIV infection.

Patient may revoke or modify any of these consents by completing a new HIPAA Acknowledgement and Consent Form. Any disclosures made prior to the date of revocation or modification will not be affected.

Patient/Legal Guardian Signature

Date

Patient Name (Printed)

Acct#

EYE HEALTH PARTNERS

Teamwork in Eye Health Care

Medical History Questionnaire

Name: _____ Date: ___/___/___ Birth Date: ___/___/___
Last Medical Exam: ___/___/___ Name of Medical Doctor: _____ Dr.'s Phone: _____
Name of Pharmacy and Location: _____ Pharmacy Number: _____
Last Eye Exam: ___/___/___ Name of Eye Care Provider: _____

Past Eye/Medical History

Allergies: None Yes: (list) _____

Have you ever had any eye injuries? No Yes: (list) _____

Do you have any eye diseases? Please check all that apply. Macular Degeneration Cataract Glaucoma
Diabetic Retinopathy Dry Eye Syndrome Other: (list) _____

Have you ever had any eye surgeries? No Yes: (list) _____

Do you currently use any eye medications? No Yes: (list) _____

Do you have any medical conditions? Please check all that apply. Diabetes High Blood Pressure
Heart Disease High Cholesterol Thyroid Disorder Autoimmune Disease (name: _____)

Please list any additional medical conditions. _____

List all major surgeries (include dates performed): _____

List all medications (include strength and dosing): _____

Are you pregnant or nursing? No Yes

Check if you have ever been exposed to or infected with: Gonorrhea Syphilis HIV Hepatitis TB

Do you wear glasses? No Yes If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? No Yes If yes, how old is your present pair of lenses? _____

Type of contact lenses: Rigid Soft Extended Wear Other

****Please turn this form over and complete side two****

Social History:

Smoking Status: (Check one) Current every day smoker Current some day smoker Former smoker
 Never smoked Smoker, current status unknown
 Unknown if ever smoked

If smoker: How much? _____ How long? _____ When quit? _____

Alcohol Use: No Yes: Type? _____ How much? _____

Drugs: No Yes: Type? _____ How much? _____ How long? _____ When quit? _____

Family History: (Check all that apply to your blood relatives)

	Relationship	Living	Deceased	Approx Age
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Heart Disease	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> High Blood Pressure (Hypertension)	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Stroke	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Arthritis	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> TB	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Kidney Disease	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Blindness	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Cataracts	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Glaucoma	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Macular Degeneration	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Retinal Disease	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> Lazy Eye	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other: _____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Review of Systems: Please answer yes or no and comment below

<p><u>Eyes</u></p> <p>Previous Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Contact Lens Use <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Pain <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Double Vision <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cataracts <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Macular Degeneration <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Dry Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Flashes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Floater's <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><u>Ear, Nose and Throat</u></p> <p>Hard of Hearing <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Ringling in Ears <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Vertigo <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><u>Cardiovascular</u></p> <p>Chest Pain <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fainting Spells <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Shortness of Breath <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Irregular Heart Beat <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Difficulty Lying Flat <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><u>Constitutional</u></p> <p>Fatigue/Weakness <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fever <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Weight Gain/Loss <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Jaw Pain When Chewing <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Scalp Tenderness <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><u>Respiratory</u></p> <p>Cough <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Congestion <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Wheezing <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><u>Gastrointestinal</u></p> <p>Heartburn <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Nausea/Vomiting <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Jaundice/Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><u>Genito-Urinary</u></p> <p>Pain/Difficulty Urinating <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Blood in Urine <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>History of Kidney Stones <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>History of STD's <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><u>Psychiatric</u></p> <p>Anxiety/Depression <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Mood Swings <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Difficulty Sleeping <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><u>Endocrine</u></p> <p>Increased Thirst <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Increased Hunger <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Increased Urination <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Increased Sweating <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fingernail Changes <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><u>Blood/Lymphnodes</u></p> <p>Easy Bruising <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Gums Bleed Easily <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Prolonged Bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heavy Aspirin Use <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><u>MusculoSkeletal</u></p> <p>Stiffness <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Joint Pain/Swelling <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><u>Skin</u></p> <p>Rash/Sores <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Lesions <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hives/Eczema <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><u>Neurological</u></p> <p>Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Weakness/Paralysis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Numbness <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tremors <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><u>Immunologic</u></p> <p>Hives <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Itching <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Runny Nose <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sinus Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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V1.4

Explanations:

Doctor's Signature

Review Date

EYE HEALTH PARTNERS

Teamwork in Eye Health Care

PATIENT REGISTRATION

Patient Information:

Patient Name: _____ Social Security #: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: M F **Marital Status:** Married Divorced Single Widowed Other

Race/Ethnicity: Hispanic Asian Caucasian Black or African American American Indian or Alaska Native
 Native American Chinese Filipino Japanese Native Hawaiian Multi Racial
 Pacific Islander Other

Preferred Language: English Spanish Other _____

Spouse's Name: _____ Spouse's Employer: _____

Spouse's Phone Number: _____ Spouse's Employer Phone Number: _____

Nearest Relative/Relationship: _____ Their Phone number: _____

Email address: _____ Primary Care Physician: _____

Referring Physician/Optomtrist _____ Phone Number: _____

Patient Employment:

Employed Retired Student Other Occupation: _____

Employer: _____ Employer Phone Number: _____

Patient Insurance Information:

Is the insurance in your name? YES NO. If no, please provide the following information:

Insured's Name: _____ DOB: _____ Social Sec Number: _____

Please provide the front desk with current insurance cards.

Guarantor Information (person responsible for today's fees):

Same as Patient Spouse Guardian Other

Guarantor Name: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Guarantor's DOB: _____ Social Security #: _____ Driver's Lic #: _____

Guarantor's Home Phone: _____ Cell Phone: _____

Guarantor's Employer: _____ Employer Phone Number: _____

Patient Pharmacy Information:

Pharmacy Name: _____ Pharmacy Phone Number: _____

Location (City, State): _____ Pharmacy Fax Number: _____