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 service s 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.

- _________ (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#

Pediatric Ophthalmology and Strabismus – New Patient Questionnaire
Page 1: Background information

<table>
<tr><td>Date of first exam:</td><td rowspan="2">This section for pediatric patients only.
Family Status: ☐ patient living with parents
☐ living with relative, guardian or foster-parent
parents are:☐ married ☐ separated ☐ divorced

Full name of father (or other guardian)

Occupation:

Daytime phone:

Full name of mother (or other guardian)

Occupation:

Daytime phone</td></tr>
<tr><td>Patient's name:

Mailing address:

Social security:
Occupation or school grade(if applicable)

Home phone:

Daytime phone(adults only):

Birthdate:</td></tr>
<tr><td>Family physician or pediatrician:

Address:

Phone:</td><td>Other phone numbers to reach parents or emergency family contact:

Name and ages of brothers and sisters:</td></tr>
<tr><td>Other physicains who should receive a report:
(please provide specialty, address and phone)

Referred by:___________________________________</td><td></td></tr>
</table>

Reason for today's visit? ____

I request that payment of authorized Medicare and insurance benefits to be made to Irene H. Ludwig, MD, PC for any services furnished me by the provider. I authorize the release to Health Care Financing Administration and its agents any medical information needed to determine these benefits or the benefits payable for related services. I request that payment of authorized Medigap benefits be made on my behalf to Irene H. Ludwig, MD, PC for services furnished me by that provider. I authorize any holder of medical information about me to release to __________________________________ to determine these benefits.

Patient Signature ____ Date _____________________

PLEASE ANSWER THE QUESTIONS ON THE OTHER SIDE OF THIS PAGE ⇨

Pediatric Ophthalmology and Strabismus – New Patient Questionnaire
Page 2: Medical and Family History

Please check either yes or no for each of the following questions:

FAMILY HISTORY: Which of the patient's relatives have had any of the following?

yes	no		yes	no	
☐	☐	Blindness	☐	☐	Cataracts in childhood
☐	☐	Amblyopia (lazy eye)	☐	☐	Glaucoma in childhood
☐	☐	Patching treatment	☐	☐	Other serious eye disease
☐	☐	Strabismus (crossed eye)	☐	☐	Complications from anesthesia
☐	☐	Eye muscle surgery	☐	☐	Genetic disease (runs in family)
☐	☐	Glasses before age 6	☐	☐	Other serious disease
☐	☐	Are both parents alive and in good health?			

History of eye problems: Has the patient had any of the following?

yes	no		age	yes	no		age
☐	☐	Eye exam	________	☐	☐	Eye injury	________
☐	☐	Glasses	________	☐	☐	Eye surgery	________
☐	☐	Patching	________	☐	☐	Other eye problems?	_________

Recent symptoms:

yes	no		How long?	yes	no		How Long?
☐	☐	Crossed or wandering eye	_________	☐	☐	Frequent headaches	________
☐	☐	Excessive squinting	_________	☐	☐	Tired eyes when reading	________
☐	☐	Double vision	_________	☐	☐	Weakness or numbness	________
☐	☐	Excessive eye rubbing	_________	☐	☐	Bumping into things	________
☐	☐	Frequent tearing or discharge	_________	☐	☐	Can't make normal eye contact	________
☐	☐	Blurred vision	_________	☐	☐	Change in performance work/school	_____
☐	☐	Light sensitivity	_________	☐	☐	Other symptoms not mentioned	

____

Other medical problems (medical history and review of systems)

yes	no		yes	no	
☐	☐	Fever or weight loss	☐	☐	Skin rash
☐	☐	Frequent ear infections	☐	☐	Neurologic problems
☐	☐	Other ear, nose & throat problems	☐	☐	Mental illness
☐	☐	Heart problems	☐	☐	Sickle cell disease
☐	☐	Lung problems	☐	☐	Allergy to medications___________
☐	☐	Kidney or urinary problems	☐	☐	Other allergies__________________
☐	☐	Arthritis	☐	☐	Missing immunizations

List any previous surgery, hospitalizations, major illness or injuries (other than eye problems)

List any medications the patient is taking, including eye drops.

Birth History (Pediatric patients only)

Birth weight:_______lbs._______ozs.

yes	no	(if "yes" please explain)	yes	no	(if "yes" please explain)
☐	☐	Problems during pregnancy	☐	☐	Delivered more than 2 weeks early or late
☐	☐	Problems during delivery/forceps	☐	☐	Baby kept in hospital due to illness
☐	☐	Cesarean section	☐	☐	Delayed development

Reviewed by ______________________________

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/Ethinicity:[ ]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/Optometrist________________________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:_______________________________