SouthEast EyeSpecialists

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 Southeast Eye Specialists, PLLC for services furnished me by Southeast Eye Specialists, PLLC. 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. Southeast Eye Specialists, PLLC 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 Southeast Eye Specialists, PLLC, if possible or otherwise to me.

3. OTHER INSURANCE: I understand that Southeast Eye Specialists, PLLC and its 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 Southeast Eye Specialists, PLLC and its 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 Southeast Eye Specialists, PLLC to obtain necessary health care plan authorizations.

5. FINANCIAL AGREEMENT: I agree that in return for the services provided to me by Southeast Eye Specialists, PLLC I will pay my account at the time services are rendered or will make financial arrangements satisfactory to Southeast Eye Specialists, PLLC. 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 Southeast Eye Specialists, PLLC. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Southeast Eye Specialists, PLLC.

6. CONSENT TO TREATMENT: I authorize the physicians of Southeast Eye Specialists, PLLC, 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:** _____

SouthEast Eye Specialists, PLLC - Patient HIPAA Acknowledgement and 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: (_____-_____-_____)

SouthEast Eye Specialists, PLLC - Patient HIPAA Acknowledgement and Consent Form

- _____ (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#

SouthEast EyeSpecialists

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
☐Diabetes	_____	☐	☐	_____
☐Cancer	_____	☐	☐	_____
☐Heart Disease	_____	☐	☐	_____
☐High Blood Pressure (Hypertension)	_____	☐	☐	_____
☐Stroke	_____	☐	☐	_____
☐Arthritis	_____	☐	☐	_____
☐TB	_____	☐	☐	_____
☐Kidney Disease	_____	☐	☐	_____
☐Blindness	_____	☐	☐	_____
☐Cataracts	_____	☐	☐	_____
☐Glaucoma	_____	☐	☐	_____
☐Macular Degeneration	_____	☐	☐	_____
☐Retinal Disease	_____	☐	☐	_____
☐Lazy Eye	_____	☐	☐	_____
Other:_____	_____	☐	☐	_____

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

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

V1.4

Explanations:

Doctor's Signature

Review Date

SouthEast Eye Specialists

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:_____

SouthEast EyeSpecialists

Acct #: _____

PRE-SURGICAL CATARACT PATIENT QUESTIONNAIRE

VISUAL FUNCTIONING - Required

Do you have difficulty, even with glasses, with the following activities?
If YES, please circle **BOTH EYES, RIGHT EYE, OR LEFT EYE**

1. Seeing or driving at night?	BOTH	RIGHT	LEFT
2. Trouble judging distance like seeing steps, stairs, or curbs?	BOTH	RIGHT	LEFT
3. Watching TV, seeing traffic or street signs?	BOTH	RIGHT	LEFT
4. Computer work, reading menus, cooking, playing board games, seeing items on a shelf?	BOTH	RIGHT	LEFT
5. Playing sports like golf, tennis, or bowling?	BOTH	RIGHT	LEFT
6. Reading books, smart phones, tablets, sewing, woodworking, or detailed handwork?	BOTH	RIGHT	LEFT
7. Reading small print such medicine bottles or food labels?	BOTH	RIGHT	LEFT

SYMPTOMS- Required

Have you been bothered by:

1. Hazy and/or blurry vision?	BOTH	RIGHT	LEFT
2. Seeing well in poor lighting or poor night vision?	BOTH	RIGHT	LEFT
3. Glare from headlights or bright sunlight?	BOTH	RIGHT	LEFT
4. Seeing rings or halos around lights?	BOTH	RIGHT	LEFT

Required - Cataract surgery can almost always be safely postponed until you feel you need better vision. If stronger glasses will not improve your vision anymore, and if the only way to help you see better is cataract surgery, do you feel your vision problem is bad enough to consider cataract surgery now?

RIGHT EYE: YES NO

LEFT EYE: YES NO

Patient name: _____

Patient Signature: _____

Date: _____

Physician Signature: _____