SURGICAL EYE ASSOCIATES

PATIENTS YEARLY INFORMATION

Acct. # _____ Dr. _____

Date _____ Loc. _____

PLEASE COMPLETE ALL QUESTIONS ON THIS PAGE

Patient _____ Home Phone _____

Mailing Address _____ Work Phone _____

City/State _____ Zip _____ Cell Phone _____

Social Security # _____ Date of Birth _____

Employer _____ Sex: M or F Marital Status: M S W D

Email _____ Spouse's Name _____

Emergency Contact Not Living With You _____

Relation To You: _____ Phone # _____

Please make sure that you have signed the appropriate HIPAA release for this emergency contact!

RESPONSIBLE PARTY
(Person responsible for statements)

Responsible Party: _____ Social Security # _____

Relationship to Patient if not Self: _____ Home Phone _____

Mailing Address _____ Work Phone _____

City/State _____ Zip _____ Date of Birth _____ Sex: M or F

Employer _____

INSURANCE INFORMATION

Primary Insurance

Ins. Co. _____
Insured's Name _____
Insured's Date of Birth _____
Relationship to Patient: Self Spouse Child Other
Type Plan: HMO PPO Other_____
Primary Care Physician_____

Secondary Insurance

Ins. Co. _____
Insured's Name _____
Insured's Date of Birth _____
Relationship to Patient: Self Spouse Child Other
Type Plan: HMO PPO Other_____
Primary Care Physician _____

REFERRAL INFORMATION

How did you hear about us?

_____

_____

MEDICAL INFORMATION

NAME_____ DOB: _____

EMAIL_____ **CELL NUMBER**_____

DATE_____ **REFERRED BY**_____

PHARMACY_____ **FAMILY DOCTOR**_____

1. PAST MEDICAL HISTORY: PLEASE LIST ANY PREVIOUS/CURRENT HEALTH PROBLEMS:

2. PLEASE LIST ANY PRIOR SURGERIES:

3. PLEASE LIST ANY PREVIOUS/CURRENT EYE PROBLEMS:

4. PLEASE LIST ANY PREVIOUS EYE SURGERIES:

RK/LASIK/PRK YES____ NO____ LASER SURGERIES: YES____ NO____

5. FAMILY HISTORY OF (NOT SELF): RELATIONSHIP OF FAMILY MEMBER

CATARACTS	YES___ NO___	_____
GLAUCOMA	YES___ NO___	_____
RENTINAL DETACHMENT	YES___ NO___	_____

PLEASE CONTINUE ON REVERSE SIDE

FOR OFFICE USE ONLY – PLEASE DO NOT WRITE BELOW THIS LINE
PFSH – ROS Updated

Year	Dr. Initials	Tech Initials	Year	Dr. Initials	Tech Initials
____	_____	_____	____	_____	_____
____	_____	_____	____	_____	_____
____	_____	_____	____	_____	_____

OVER

FAMILY HISTORY OF (NOT SELF): CONTINUED

EYE DISORDERS	YES___ NO___	_____
DIABETES	YES___ NO___	_____
HIGH BLOOD PRESSURE	YES___ NO___	_____
HEART DISEASE	YES___ NO___	_____
OTHER	YES___ NO___	_____

6. CURRENT MEDICATIONS: NAME AND REASON FOR USE:

7. ALLERGIES TO MEDICATIONS & TYPE OF REACTION:

8. SOCIAL HISTORY:

DO YOU USE DRUGS OTHER THAN THOSE PERSCRIBED? YES____ NO____

SMOKING STATUS: NEVER ____ FORMER____ CURRENT____

IF YOU ARE A FORMER SMOKER HOW LONG SINCE YOU STOPPED SMOKING?

YRS____ MONTHS____ WEEKS____

ALCOHOL USE: NONE____ less than one drink a day____

1-2 DRINKS A DAY____ 3+ DRINKS A DAY____

9. DRIVING STATUS:

DO NOT DRIVE ____ DAYTIME ONLY DRIVING ____ NORMAL DRIVING ____

DO YOU HAVE VISUAL DIFFICULTY WHEN DRIVING? YES____ NO____

DO YOU HAVE DIFFICULTY DRIVING AT NIGHT? YES____ NO____

10. CURRENT OCCUPATION: _____

11. PLACE OF RESIDENCE:

PERSONAL RESIDENCE: _____ ASSISTED LIVING _____

12. DO YOU HAVE AN ADVANCE DIRECTIVE OR LIVING WILL? YES_____ NO_____

DOB:_____

TO ALL SURGICAL EYE ASSOCIATES PATIENTS:

Please make sure you are aware of your insurance coverage benefits for your visit; not all plans provide a routine vision coverage benefits. Some of the following symptoms may appear to be a medical problem to a patient but may end up being related to a refractive correction problem that your carrier may not cover under your medical provisions. Some of these symptoms are:

Burning/itching eyes
Blurry vision
Certain headaches

This is not an all-inclusive list but these are some examples of symptoms that may be caused by a need for corrective eyewear and/or a prescription adjustment. Your medical insurance benefits may not cover these or other diagnosis that your carrier determines to be a routine refractive vision problem.

Your insurance carrier may not pay for the refraction component of your visit. Please be aware that you may be responsible for this service. Currently, Surgical Eye Associates charges $25.00 for a refraction.

Your signature below will indicate that you that you have read this notice and that you agree to be fully and personally responsible for any charges for services rendered are not covered by your insurance carrier.

_____

Patient name printed Date

_____

Patient signature Date

SURGICAL EYE ASSOCIATES

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT, ACKNOWLEDGEMENT OF PRIVACY PRACTICES, DISCLOSURE OF FINANCIAL INTEREST

1. **MEDICARE:** I request that payment of authorized Medicare benefits to be made on my behalf be assigned to Surgical Eye Associates, LLC for services furnished by Surgical Eye Associates, LLC and its providers. I authorize any holder of medical information about me to release to Medicare and its agents any information needed to determine these benefits or the release of medical information necessary to pay the claim. If I have other insurance coverage, my signature authorizes releasing the information to the insurer oe agency shown. Surgical Eye Associates, LLC accepts the Medicare allowable determination of the carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services.
2. **PARTICIPATING INSURANCE AND RELEASE OF INFORMATION:** I understand that Surgical Eye Associates, LLC may use and disclose medical information about me for services and procedures so they may be billed and collected from an insurance agency or other third party. Surgical Eye Associates, LLC may also tell my health plan and/or referring physician about a treatment I am going to obtain prior approval or to determine whether my plan will cover the treatment, to facilitate payment, or the like.
3. **NON-PARTICIPATING WITH PATIENT'S INSURANCE:** The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Surgical Eye Associates, LLC if I belong to a plan that Surgical Eye Associates, LLC does not participate with.
4. **NON-COVERED SERVICES:** The undersigned accepts full financial responsibility for all items and services which are determined by my insurance plan not to be covered. The undersigned agrees to cooperate with Surgical Eye Associates, LLC to obtain necessary healthcare service plan authorizations.
5. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Surgical Eye Associates, LLC, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Surgical Eye Associates, LLC for payment.
6. **FINANCE CHARGES:** I agree to pay a finance charge of 1% per month, compounded, for any balance I am responsible for which is over 60 days old. I also agree to pay for any returned check fees incurred by Surgical Eye Associates, LLC. It is the policy of Surgical Eye Associates, LLC to charge a fee no less than $25.00 for checks that are returned. It is the policy of Surgical Eye Associates, LLCto also charge a fee no less than $25.00 for each appointment you are unable to cancel or reschedule within 24 hours of your appointment. I also agree that if I am the parent/guardian bringing a child in for treatment that I am responsible for all fees incurred by the child. 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 in any court action. Any benefits of any type under any policy of insurance insuring the patient or any other party liable to the patient is hereby assigned to Surgical Eye Associates, LLC. If co-payments and/or deductibles are designed by my insurance company or health plan, I agree to pay them to Surgical Eye Associates, LLC. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.
7. **ACKNOWLEDGEMENT OF PRIVACY PRACTICES:** I hereby acknowledge that I have received a copy of the Notice of Privacy for Surgical Eye Associates, LLC. There is also a copy posted in the office. I understand that if I have questions or complaints regarding my privacy rights that I may contact the Privacy Officer.
8. **CONSENT:** I hereby authorize the doctors and staff of Surgical Eye Associates, LLC to administer or perform medical treatment including procedures or services as may deem necessary or reasonable, laboratory services and diagnostic procedures. Additionally, I authorize Surgical Eye Associates, LLC to obtain my medication history.
9. **DISCLOSURE OF FINANCIAL INTEREST:** Louisiana law requires physicians to disclose to a patient, when the physician refers the patient to another health care provider or facility, that the physician has a financial interest in that entity. The purpose of this disclosure is to notify you that Richard O. Bessent, MD has an ownership interest in Vision Care Plus, Inc. If you are referred to this entity and have any questions, please discuss this with your physician directly. You have the right to choose a different entity or choose not to receive services by letting the doctor know prior to the referral.

PATIENT SIGNATURE_____

SIGNATURE OF PATIENT'S REPRESENTATIVE_____

PATIENT NAME (PRINT)_____ DATE_____

SURGICAL EYE ASSOCIATES

COMMUNICATION WITH OTHERS

I, _____ DOB: _____
hereby authorize my doctor and his/her staff to communicate with the following people about my test results and other aspects of the care I received in the office, and I also hereby allow them to pick up presciptions or samples of my medication if authorized and approved by my doctor.

Name: _____ Relationship: _____

Phone: _____

Name: _____ Relationship: _____

Phone: _____

X _____