

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

E-mail _____ Spouse's Name _____

Emergency Contact not living with you: _____

Relation to you: _____ Phone #: _____

Please make sure that you've signed the appropriate HIPPA 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 _____ Cell Phone _____

Employer _____ Date of Birth _____ Sex: M or F

INSURANCE INFORMATION

Primary Insurance

Ins. Co. _____

Insured's Name _____

Insured's Date of Birth _____

Relationship to patient: Self Spouse Child Other

Primary Care Physician _____

Secondary Insurance

Ins. Co. _____

Insured's Name _____

Insured's Date of Birth _____

Relationship to patient: Self Spouse Child Other

Primary Care Physician _____

HOW DID YOU HEAR ABOUT US? _____

MEDICAL INFORMATION

NAME _____

D.O.B _____

E-MAIL _____

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(S)

CATARACTS YES ___ NO ___

GLAUCOMA YES ___ NO ___

RETINAL DETACHMENT YES ___ NO ___

EYE DISORDERS YES ___ NO ___

DIABETES YES ___ NO ___

HIGH BLOOD PRESSURE YES ___ NO ___

HEART DISEASE YES ___ NO ___

OTHER YES ___ NO ___



FOR OFFICE USE ONLY
PLEASE DO NOT WRITE BELOW THIS LINE

YEAR

DR. INITIALS

TECH INITIALS

YEAR

DR. INITIALS

TECH INITIALS

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 PRESCRIBED?

YES ____ NO ____

SMOKING STATUS:

NEVER ____ FORMER ____ CURRENT ____

IF YOU ARE A FORMER SMOKER, HOW LONG SINCE YOU'VE STOPPED SMOKING:

YEARS ____ 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 ADVANCED DIRECTIVE OR LIVING WILL?

YES ____ NO ____

CONT.

D.O.B. _____

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 eye wear 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 charge \$25.00 for a refraction.

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

Patient Name Printed

Date

Patient Signature

Date

SURGICAL EYE ASSOCIATES

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT, ACKNOWLEDGMENT 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 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 or 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 and insurance agency or 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 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. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

7. ACKNOWLEDGMENT 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 prescriptions or samples of my medication
if authorized and approved by my doctor.

Name: _____ **Relationship:** _____

Phone: _____

Name: _____ **Relationship:** _____

Phone: _____

PATIENT SIGNATURE _____ **DATE** _____