WILLIAMSON
EYE CENTER

PATIENT INFORMATION

If for any reason you have a problem filling out this form, please feel free to ask for help.

(PLEASE PRINT)

Patient Name ______________________________
First Middle Last Maiden

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Sex __________

Age ______ Birthdate ______________ SS No. ______________ Driver's License No. ______________

Home Address ______________________________
Street

____
City State Zip

Phone No. ______________ Cell No. ______________ E-mail ______________

Employer ______________________________ Phone No. ______________
Company Name

____
Street City State Zip

In case of emergency, name of person other than spouse we should notify:

Name ______________ Relation ______________ Phone No. ______________

Were you referred by a doctor? ______________ If so, whom? ______________

Do you have a regular optometrist? ______________ If so, whom? ______________

Who referred you to our office? ☐ friend ☐ relative ☐ TV ☐ newspaper ☐ yellow pages ☐ radio ☐ other ______________

☐ I AM INTERESTED IN LASIK LASER VISION CORRECTION.

Responsible Party* ______________ Relationship ______________ D.O.B. ______________

Address ______________________________

Phone ______________ SS No. ______________ Driver's License No. ______________

Place of Employment of Responsible Party ______________ Phone ______________

***(In case of child whose parents are divorced, the person bringing in child for treatment is the responsible party.)**

Medicare No. ______________ Medicaid No. ______________

Private ______________ Policy No. ______________ Group No. ______________

Is this workman's compensation? ☐ Yes ☐ No

(We respectfully request that you allow us to make copies of your cards.)

OVER — PLEASE READ AND SIGN THE BACK OF THIS PAGE — OVER

Signature on File, Assignment of Benefits

Beneficiary Name (print) ____________________ Medicare Number ____________________

1. MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to Williamson Eye Center for services furnished me by Williamson Eye Center. 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 other approved claim forms; my signature authorizes releasing the information to the insurer or agency shown. Williamson Eye Center accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible 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 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 Williamson Eye Center, if possible, or otherwise to me.

3. RELEASE OF INFORMATION: Williamson Eye Center may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Williamson Eye Center for reimbursement for services rendered, and (2) any health care provider for continued patient care. Williamson Eye Center may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

4. OTHER INSURANCE: I understand that Williamson Eye Center maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. And that Williamson Eye Center has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Williamson Eye Center if I belong to a plan that does not appear on the above mentioned list.

5. NON-COVERED SERVICES: I understand that Williamson Eye Center's contract with health care service plans (i.e., HMOs, PPOs) relates only to items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans 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 service plan or in the benefit summary the health care service plan furnished to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Williamson Eye Center to obtain necessary health care service plan authorizations.

Beneficiary Signature or Authorized Party ____________________ Date ____________________

NOTICE OF PRIVACY PRACTICES PATIENT CONSENT

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosure we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and the patient has the opportunity to review this notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

This Consent was signed by:____________________________________
Signature - Patient or Representative

Relationship to Patient:____________________________________
(If other than patient)

Witness:____
Practice Representative (PRINT)

FINANCIAL POLICY ACKNOWLEDGEMENT

The Williamson Nelson Eye Center financial policy requires that you read, understand, and sign acknowledgement prior to treatment. A full version of the Williamson Nelson Eye Center Financial Policy has been provided to you. The following is a statement of our Financial Policy.

- All patients must complete our Information and Insurance form before seeing the doctor. We verify your insurance information at each visit, so please **bring your insurance card(s) with you to every appointment**. In order for us to bill your insurance company we need complete, current and accurate information, including a copy of your card. It is your responsibility to inform the front desk personnel when the cause for treatment has resulted from an injury that should be billed to worker's compensation.
- If you currently have no insurance, all services provided are to be paid in full at the time of service. All co-payments, deductibles, and co-insurance are due at the time of service. All Medicare patients will be required to pay their yearly deductible, and the 20 % coinsurance based upon the current Medicare Fee Schedule at the time of services, unless proof of secondary policy is evident.
- Payments may be made with cash, personal check, VISA, MasterCard, or Discover.

I acknowledge receipt and have read, understand and agree to the provision of this Financial Policy.

____________________	____________________
Patient Name (PRINT)	Patient Signature
____________________	____________________
Legal Custodian (PRINT)	Legal Custodian Signature

Date:________________________

WILLIAMSON

____

Patient Name (PRINT)

I request that payment of authorized Medicare benefits be made on my behalf to The Williamson Eye Center for any services furnished me by that provider. I authorize the holder of medical information to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

*** PLEASE NOTE ***

MEDICARE, MEDICAID, and most other insurance carriers WILL NOT pay for REFRACTIONS (checkup for glasses) or ROUTINE EYE EXAMS (exams for blurred vision, headaches, or yearly exam not related to medical diseases).

MEDICAID WILL NOT COVER eye examinations for patients over age 21 and does NOT COVER examination and/or fitting of contact lenses under any circumstances and must be paid at the time of service.

The fee for REFRACTION (testing for glasses prescriptions) is $25. This fee plus any co-insurance or deductible is due at the time of service.

I have read and understand the above information regarding fees for service.

____________________________________ ____________________

Signature of Patient **Date Signed**

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PATIENT HISTORY QUESTIONNAIRE

Name:______________________________ Date of Birth:______________

Primary Care Physician:______________________________

Were you referred? ☐ Yes ☐ No If Yes, by whom?______________________________

Insulin: ☐ Yes ☐ No If Yes, dosage:______________________________

Current eye medication:______________________________

____

Current systemic medication:______________________________

____

Allergies to medication or food:______________________________

OCULAR HISTORY: **(please check yes or no and explain all that apply)**

	Yes	No	
Blurred vision	☐	☐	________
Distorted vision	☐	☐	________
Double vision	☐	☐	________
Loss of vision	☐	☐	________
Loss of side vision	☐	☐	________
Fluctuation of vision	☐	☐	________
Mucous discharge	☐	☐	________
Floaters / Flashes	☐	☐	________
Pain / soreness	☐	☐	________
Chronic infection	☐	☐	________
Eye surgery	☐	☐	________
Other	☐	☐	________

Review of Systems: **(please check yes or no and explain all that apply)**

	Yes	No	
Constitutional Systems:			
Fever, weight loss, other	☐	☐	________
Ears, Nose, Mouth, Throat:			
Hearing or sinus problems	☐	☐	________
Cardiovascular System:			
High blood pressure	☐	☐	________
Heart disease/heart attack	☐	☐	________
Heart surgery / Other	☐	☐	________
Respiratory Systems: (lungs, breathing)			
Asthma, emphysema, TB	☐	☐	________
Short of breath	☐	☐	________
Gastrointestinal: (stomach, intestine)			
Jaundice, hepatitis, ulcers	☐	☐	________
Hernia, reflux, GI bleeding	☐	☐	________
Genitourinary: (genital, kidney, bladder)			
Kidney disease, pain	☐	☐	________
Frequent urination	☐	☐	________
Integumentary: (skin and/or breast)			
Skin disease, skin cancer	☐	☐	________
Musculo-skeletal	Yes	No	
Degenerative arthritis	☐	☐	________
Rheumatoid arthritis	☐	☐	________
Lupus / other	☐	☐	________

CONTINUED ON PAGE

Neurological			
Fainting, dizziness	❑	❑	
Migraines, seizures	❑	❑	
Stroke, paralysis	❑	❑	
Psychiatric			
Depression	❑	❑	
Schizophrenia / other	❑	❑	
Hematologic / Lymphatic			
Anemia, sickle cell	❑	❑	
Bleeding disorder	❑	❑	
Leukemia / other	❑	❑	
Allergic / Immunologic			
Seasonal allergies	❑	❑	
Immune disorder	❑	❑	
Hay fever / other	❑	❑	
Endocrine			
Diabetes, thyroid	❑	❑	
Hormone replacement	❑	❑	
Cancer (if Yes - please describe)	❑	❑	
HIV / AIDS:	❑	❑	

List past surgeries:

Date:	Type:	Date:	Type:

Describe any other problems, illnesses, or conditions that were not previously mentioned:

FAMILY HISTORY: Do you have a family history of:

	Yes	No	Family member:
Diabetes	❑	❑	
Glaucoma	❑	❑	
Macular degeneration	❑	❑	
Retinal detachment	❑	❑	
Other eye disease	❑	❑	

Social History:	Yes	No	Please explain:
Do you drink alcohol?	❑	❑	
Do you smoke?	❑	❑	
Have you used recreational or illegal drugs?	❑	❑	

Print Name

Signature

Date

Physician Signature