NEW PATIENT INFORMATION RECORD

Full Name: _____ SS#: _____

DOB: _____ Sex: _____ Marital Status: _____

Address: _____City: _____ State: ____ Zip: _____

Email: _____ Home Phone: _____ Cell: _____

Primary Care Doctor: _____

Emergency Contact: _____ Phone: _____

Relationship to patient: _____

If patient is a minor, the following information must be filled out by parent or guardian:

Parent 1: _____ Parent 2: _____

Address: _____ Address: _____

SS#: _____ DOB: _____ SS#: _____ DOB: _____

Home#: _____ Cell: _____ Home#: _____ Cell:_____

INSURANCE INFORMATION: (Insurance cards must be presented at EVERY visit)

Primary: _____ ID#: _____ Group: _____

Subscriber's Name: _____ SS#: _____ DOB: _____

Subscriber's Employer: _____

Secondary: _____ ID#: _____ Group: _____

Subscriber's Name: _____ SS#: _____ DOB: _____

Subscriber's Employer: _____

MEDICARE PATIENTS

I request that payment of authorized Medicare benefits be made to me or on my behalf to Hometown Ophthalmology for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Patient/Representative's Signature Date

MEDICARE SECONDARY INSURANCE

I request that payment of authorized Medicare benefits be made either to me or to Hometown Ophthalmology on my behalf for any services rendered to me by that provider. I authorize any holder of medical information about me to release to my secondary insurance any information to determine these benefits or the benefits payable for related services.

_____ _____

Patient/Representative's Signature Date

Hometown Ophthalmology
641 S Hebron Ave
Evansville, IN 47714
Phone 812-616-2020
Fax 812-616-1400

Responsibility, Consent and Assignment of Benefits

Medical Consent: I, the undersigned, hereafter designated as "patient" or being a person legally authorized to consent to services on behalf of the patient, do hereby consent and authorize the doctors of Hometown Ophthalmology to A) discuss, document and securely store my health information and B) provide an in-office or bedside examination of my eyes as deemed necessary by my doctor in order to appropriately arrive at diagnosis and treatment plan. I understand that preliminary information gathering and basic testing done in office is often performed by doctor's staff, as well as by the doctor herself. This work-up often includes instillation of eye drops for various reasons. This consent and authorization also extends to and includes: staff doctors, interns/students, technicians and employees of Hometown Ophthalmology. I understand that the patient is under the care of the doctor and that such doctor is responsible for determining the nature and course of treatment for the patient. After the doctor recommends treatment, the patient will have to decide whether to follow those recommendations or not. The consent given here does not extend to any oral or IV medications or any surgical procedure or injections performed. Separate consent must be obtained for any of these procedures.

HIPAA Notice: I have been given the opportunity to review a Notice of Privacy Practice, and a copy is available at my request and at all times available to view in office, disclosing how my patient health information may be used and disclosed. This also explains how I can get access to my individually identifiable health information.

Release of Information: I agree that, to the extent necessary to determine responsibility for payment and to obtain reimbursement, Hometown Ophthalmology may disclose portions of the patient's record, including their medical records, to any person or entity which is or may be responsible for all or any portion of Hometown Ophthalmology's charges, including but not limited to insurance companies, health care service plans, worker's compensation carriers, medical or utilization review organization designated by any of the foregoing, or to any other person or entity as necessary in connection with such payment or reimbursement. I authorize any holder of medical or other information about the patient to release same and copies of any medical records to Hometown Ophthalmology, the Health Care Financing Administration, its agents or carriers and my insurance carriers necessary to determine benefits and/or to process claims for this and all related claims on my behalf, now or in the future. I request my insurance company or companies honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to Hometown Ophthalmology on my behalf.

Medicare and Medicare Supplement Certification: I certify that the information given by me for payment under Title XVIII of the Social Security Act is correct. I understand that it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment (Section 1128B of the Social Security Act and 31 USC 3801-3812 provides penalties for withholding this information). I authorize the doctor who treats me to release information from my medical records to the Social Security Administrating and/or the Medicare program/it's intermediaries or carriers, or the Professional Standards Review Organizations for the processing of claims for medical benefits. I permit a copy of this authorization to be used in place of the original and I request that payment of authorized benefits be made directly Hometown Ophthalmology, on my behalf.

Medicaid: If this service is to be covered under a Medicaid Program, I understand that I must show my current Medicaid card prior to seeing the doctor, and to pay any spend down that has not been met at time of service. I agree and understand that if I am a QMB recipient, that Medicaid will extend coverage to payment of Medicare co-insurance and/or deductible only, and that I am responsible for services and supplies not covered or denied by Medicare. I further agree and understand that I am being informed, prior to receipt of service, that I may be responsible for services that the Medicaid Program in my state determines not to be a covered benefit. I agree and understand that if I do not have my current Medicaid card, that payment in full is required for this visit at the time services are rendered.

Payment Guarantee: I guarantee payment of services rendered by Hometown Ophthalmology and agree to pay the same at the time of visit, if such account is not paid by private or governmental insurance, and to pay any balance due promptly upon receipt of my first statement. I agree to comply with the terms of my insurance coverage, including payment of co-pays at time services are rendered. I understand that all accounts are the full responsibility of the patient and/or the patient's responsible party. I understand that Hometown Ophthalmology may add a finance charge to any outstanding balance. If the amounts due to Hometown Ophthalmology become delinquent and do not have agreed upon financial arrangements with Hometown Ophthalmology, these accounts may be submitted to a collection agency or attorney for collection. I agree that I will pay all attorney fees and court costs incurred by Hometown Ophthalmology in the collection of all sums due. If I provide Hometown Ophthalmology with my cell phone number, I authorize Hometown Ophthalmology to call our cell phone either manually or by auto-dialer in order to collect any amounts that I owe. I also authorized Hometown Ophthalmology to contact us via any email that I provide as my personal email.

Assignment of Benefits: In consideration of services rendered or to be rendered by Hometown Ophthalmology, I authorize request and assign payment directly to Hometown Ophthalmology covering this period of treatment and any future treatments, by all insurance carriers with whom I have coverage or from whom benefits are, or may become, payable to me, including settlements or judgments flowing from the incident for which I am receiving treatment. This assignment is a relinquishment and assignment of all legal or equitable interest which I have in any insurance benefits which exist by reason or contract or otherwise, , including but not limited to, major medical and other special coverages, and including the right to sue or make claim for said benefits. This assignment is irrevocable except upon full payment of all indebtedness, or by express written agreement between Hometown Ophthalmology and myself. This assignment does not constitute payment of indebtedness and does not relieve the undersigned from liability for unpaid balances. In the event that insurance benefits to which I am entitled are paid directly to me for services rendered to me, a member of my family, or a person for whom I am financially responsible, I agree that I will immediately deliver all such benefit received.

The undersigned certified that they have read and understand all of the above information and either is the patient named, or is duly authorized by the patient or by law to accept the terms on the patient's behalf.

Patient/Guardian Signature

Date

Patient Medical History Form

Full Name: _____ **Date of Birth:** _____

Family Physician: _____

Specialists: _____

Please check all that apply to you:

Your Medical History:

___ Diabetes – How long____
___ High Blood pressure
___ Heart Disease
___ Lung Disease
___ Stroke
___ Arthritis
___ Kidney Disease
___ Thyroid Disease
___ Headaches/migraines
___ Alzheimer's/Dementia
___ Bladder/Prostate Issues
___ Kidney Stones
___ Autoimmune Disease
___ Seasonal Allergies
___ Blood Clots
___ High Cholesterol
___ Autism
___ Depression/Anxiety
___ Cancer – Type_____

Your Eye History:

___ Glaucoma
___ Cataract
___ Retinal Disease
___ Blindness
___ Macular Degeneration
___ Retinal Detachment
___ Eye Injury
___ Double Vision
___ Blurred Vision
___ Dry Eyes
___ Itching Eyes

Family Eye History:

___ Glaucoma
___ Cataracts
___ Macular Degeneration
___ Lazy Eyes
___ Blindness
___ High Blood Pressure
___ Diabetes
___ Cancer

List any major surgeries (including eyes): _____
_____

List any medications or supplements YOU are taking: _____
_____

_____ Check here if you have **NO KNOWN MEDICATION ALLERGIES**

List any allergies to medications: _____

Preferred Pharmacy: _____

Do you smoke? ___ Yes ___ No Do you drink alcohol daily? ___ Yes ___ No

Are you planning to purchase new glasses today? ___ Yes ___ No Contact lenses? ___ Yes ___ No

Do you wear contact lenses? ___ Yes ___ No Type: ___ Soft ___ RGP Hours worn per day? _____

How often do you replace contacts? ___ Daily ___ Weekly ___ Monthly

What contact lens solution do you use? _____