Welcome to Shelby Eye Centers

In order to serve you better we ask that you print the following information and answer to the best of your ability. (All information will be kept confidential)

Patient information

Name____
Last First Middle

Address____State____Zip___________

Mailing address if different from physical
Address____State____Zip___________

Date of Birth__________________Age_______________SS#_____________________
(this information is required for filing some insurances)

Email Address____
Phone (please check preferred method of contact)
[ ] Cell________________________
[ ] Home_______________________
[ ] Work_______________________ Ext_______
We will leave reminders of appointments at the preferred number

Sex: []Male [] Female

Please Check Appropriate Box
[]Minor[]Single[]Married[]Separated[]Divorced[]Widowed

Employer_______________________________Occupation________________________
Business Address____Phone_________

Spouse _____________________Employer ____________________ Phone_____________

Person Responsible for Payment__________________ Relationship_________________
Address___________________________________City/State__________Zip____________

Emergency Contact
Name_______________________________ Relation ________________Phone__________

Referred by Name____Phone__________
Address_______________________________City/State____________Zip____________

Responsible Party

Name of Insured ______________________Relation to patient______________________
Address____Phone_________________
Employer____Phone_________________
Is person currently a patient at this office []Yes []No

Insurance Information

Name of Insured____________________________ Relationship to Patient____________
Date of Birth___________________________________SS#_________________________
Name of employer____Phone___________
Address of Employer____
Insurance Company____
Group #__________________________________Policy#___________________________
Insurance Company Address______________________________ Phone_____________

Do you have additional Insurance []Yes []No (If yes complete the following)

Name of employer____Phone___________
Address of Employer____
Insurance Company____
Group #______________________________Policy#_______________________________
Insurance Company Address______________________________ Phone_____________

I understand and agree that (regardless of insurance coverage), I am ultimately responsible for payment of my account for professional services rendered. I certify that information above is true and correct to the best of my knowledge.

Signature_______________________________________Date______________________
Parent if Minor__________________________________Date______________________

Shelby Eye Centers

Financial Policy

We are pleased that you have chosen Shelby Eye Center as your eye care provider. We are committed to providing you with the best possible medical, optical and surgical eye care. If you have medical health insurance, we are here to help you receive your maximum allowable benefits. However, we need your help and we want you to fully understand our financial policy.

Payment is expected at the time of service rendered

For our non-covered patients we except Cash, Checks and all major Credit Cards

If you have an insurance that we are not under contract to file, you will be provided with papers to file the claim as you leave the office so that you may be reimbursed.

If you have Medicare, Medicaid or private insurance we ask that you pay any unpaid deductibles or co-payments required by your health insurance plan. Your insurance is a contract between you and your insurance company. Any balances or denied services your insurance does not pay will automatically become your responsibility.

If we participate with your HMO or PPO plan, we will file your insurance after the copayment has been paid. If your insurance has a deductible, you will be asked to pay the patient responsibility after that deductible is met. Please refer to your handbook, as all services are not covered by all HMO and PPO plans.

If you are a Medicare patient, our office is happy to file your Medicare and secondary insurance. If you have Medicare only, you are responsible for paying the (Medicare deductible) in each calendar year and then your responsibility will be 20% of the charges. If you are a Medicare patient and you have a secondary insurance that covers your deductible you will have no payment responsibility unless Medicare denies a service.

If you are a Medicaid patient you MUST present you Medicaid card and pay your $3.00($3.30 South Carolina) copayment before the doctor sees you. Without your card and copayment we cannot perform services for you under the Medicaid program.

Additional Charges
Returned Checks- will be subject to a $25.00 non-sufficient fund fee.
Broken Appoints- a charge of $25.00 will be imposed if not notified at least 24 hours in advance.

Acknowledgement
I have read the Shelby Eye Centers financial policy. I understand and agree that regardless of my health insurance coverage I am ultimately responsible for payment of my account for services rendered.

Print Name______________________________________SS#_________________________

Signature_______________________________________Date________________________

Medical History

Please provide the following information to the best of your knowledge

Name____DOB___________________________

Ocular
Have you been told that you have any of the following eye conditions :
[ ] Cataracts [ ] Glaucoma [ ] Macular Degeneration
[ ] Retinal Disease [ ] Crossed Eyes [ ] Chronic eyelid disease or infections
[ ] Seasonal Allergies [ ] Droopy Eyelids
[ ] Other

Have you ever had an injury to your head or eyes? [ ]Yes [ ] No
If yes please explain____

Do you currently wear contact lenses or glasses? [ ] Yes [ ] No
If yes how long have you had your prescription?________ Years

Tobacco/Alcohol Use
Do you smoke [ ] Yes [ ]No If yes how much do you smoke per day____________________
and for ________________years
If you have been a previous smoker date quit________/____________/____________
Do you use any other tobacco products? [ ] Yes [ ] No
If yes What?__________________________________ Number of years__________________
Do you drink alcohol [ ] Yes [ ] No How much weekly_______________________________

Systemic History (Please Check any of the following that you have or have had):

Are you a Diabetic? [ ] Yes [ ] No
If Yes how many years____________________ Average BS Level____________________
Treating Physician____

[ ]Heart Disease [ ] Ulcers
[ ] Strokes______yr [ ] Colitis/Diverticulitis
[ ] High Blood Pressure [ ] Bladder Problem
[ ] Thyroid Disease [ ]Kidney
[ ] Cancer-Type_________ [ ] Arthritis/Lupus
[ ] Anemia/Leukemia [ ]HIV
[ ] Tuberculosis [ ]Neurological
[ ] Sexual transmitted disease [] Psychological/Mental
[ ] Lung disease/asthma/emphysema [ ] Skin disease
[ ] Liver Disease/Hepatitis [ ] Bleeding or Bruising
[ ] Other____
Have you ever had any injuries?____
Have you ever been treated for drug addiction? [ ] Yes [ ] No if yes _____________________________

Surgical History

Procedure	Year

Family History
Please note any of the following by adding relation of blood relative that had the condition

Condition	Relative
Diabetes	
High Blood Pressure	
Heart Disease	
Anemia/Leukemia	
Thyroid Disease	
Tuberculosis	
Cancer	
Stroke	
Neurological	
Psychological	
Cataracts	
Glaucoma	
Macular Degeneration	
Crossed Eyes	
Other	

Has any family member ever had a drug addiction? [ ] Yes[ ]No
If Yes____

Drug Allergies
Please list any medications which have caused sensitivity or allergic reactions:

/reaction	/reaction
/reaction	/reaction
/reaction	/reaction
/reaction	/reaction

Medications

Medication	Dosage/Use	Reason for Use

Primary Care Physician___________________________
Facility____________________________________
Phone____________________________________Fax_______________________________________

Lifestyle Questionnaire

Do you have anyproblems :

	Yes	No
Driving/Driving at Night		
Glare		
Reading		
Watching TV		
Sports		
Hobbies		
Any Daily Activities		

Describe____
____
____

Patient Consent for the Use and Disclosure of Health Information, Treatment, Payment, Communication or Healthcare Operations.

I,____ understand that Shelby Eye Centers P.A. originates and maintains paper and/or electronic records describing my health history,symptoms, examination and test results, diagnoses, treatment,and any plans for future care and treatment. I understand that this information is used for planning my care and treatment, communication with other providers, third party payorverification, correct coding, billing, and as a tool for routine healthcare operations.

I understand, and have been given, the opportunity to read and review a Notice of Information Practices that provides description of information uses and disclosures.

I understand that as part of this organization's treatment, payment or health care operation, it may become necessary to disclose my protected health information to another entity (*including family members and individuals listed below*) and I consent to such disclosure for these permitted uses, including disclosure via fax.

Name	Relationship	Verification (DOB)

I fully understand and accept the terms of this consent

Print Full Name   Date of Birth

Signature   Date

Print Full Name (Legal Guardian)   Date of Birth

Signature Guardian or legal Power of Attorney   Date

Witness Signature and Title   Date

Shelby Eye Centers
Written Acknowledgement Form

I hereby acknowledge receipt of Shelby Eye Centers Notice of Privacy Practices

Name (please print):____

Signature: ____

Date:____

or

I am a legal guardian of___________________________(patient name). I hereby acknowledge receipt of Shelby Eye Centers Notice of Privacy Practices with respect to the patient.

Name (please print):____
Relationship to the Patient:_____Parent______Legal Guardian

Signature:
______________________________________Date:_________________________