Welcome to Shelby Eye Centers. In order to serve you better, we ask that you complete the following information and answer all questions to the best of your ability.

Patient Information

Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed Sex: ☐ Male ☐ Female ☐ Other

Last Name	First Name	Middle Name
DOB Age Email address:	Home # Cell#	SS#
Address	State	Zip Code

We will leave reminder calls at the preferred method of contact:

☐ cell ☐ home ☐ work ☐ other _____

Employer: _____ Occupation: _____

Business address: _____ Work Phone: _____

Spouse: _____ Spouse's Cell: _____

Employer: _____ Work Phone: _____

Person Responsible for Payment: _____ Relationship: _____

Address: _____ City/State/Zip: _____ Phone: _____

Emergency Contact: _____Relationship: _____ Phone: _____

Referred by: _____

Patient Authorization for Disclosure of Protected Health Information via Alternative Means

Form 7.34

Purpose of Authorization – It is the policy of this practice to provide communication with patients, as stated in our Notice of Privacy Practices, *"by phone or other means designated by you to provide results from exams and tests and to provide information that describes or recommends alternatives regarding your care."* The practice requires the following authorization for release of protected health information (PHI) via alternative means (other than to the primary home phone number that you have provided).

I authorize the practice to disclose or provide PHI to me as described below. I understand that it is my responsibility to notify the practice of any change in this manner of communication and that any disclosure made to the designated address or number, indicated by me, is subject to the redisclosure statement within this authorization.

☐ cell phone: ☐ email address: ☐ US Mail: ☐ fax number: ☐ phone:

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

I, _____understand that Shelby Eye Centers P.A. maintains paper and/or electronic medical records of my health history, medications, examination, test results, diagnoses, treatment, and any plans for future care. I understand that this information is used for planning treatments, communication with other providers, third party payor verification, and billing purposes.

I understand that as part of this organization's treatment, payment or plan of care, 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. I consent to the disclosure of my protected health information to the following individuals:

Name	Relationship	DOB	Phone Number

_____ _____

Patient Name (Print) DOB

_____ _____

Patient signature Date

Financial Policy

We are pleased that you have chosen Shelby Eye Centers 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.

Out of Network Benefits: If you have an insurance that we are not under contract to file, you will need to file the appropriate paper work with your insurance company to be reimbursed. We will provide you with the paperwork before you leave.

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 you have Medicare, our office is happy to file your Medicare and secondary insurance. If you have Medicare only, you are responsible for your yearly deductible and the 20% charge that is not covered by Medicare.

Medicaid: If you have Medicaid, you must present your card and pay the necessary co-payment at the time of service. If your insurance requires a referral, we cannot provide services without a referral from your primary care physician.

HMO and PPO plans: If we participate with your HMO or PPIO 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 the deductible is met. Please refer to your handbook, as all services are not covered by all HMO and PPO plans.

Vision Plan: If you have a vision plan, please provide us with the name of your insurance carrier at the time of your visit. This will allow us to obtain the necessary authorization for your visit.

Additional charges: Refractions are not covered by medical insurance, if you are tested for new glasses and you do not have routine eye coverage, $35 will be collected at the time of your visit. A contact lens fitting is also a non-covered service with medical insurance, but may be covered under your vision plan.

Returned checks will be subject to a $25 non-sufficient fund fee.
Broken appointments without at least 24-hour notice will be subject to a $25 charge

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: _____ Date: _____

Signature: _____

Patient Name: _____ DOB: _____

Insurance Information

Name of Insured: _____ Relationship to Patient: _____

Date of Birth: _____ SS#: _____ Phone Number: _____

Name of Employer: _____

Insurance Company: _____ Group #: _____ Policy#: _____

Insurance Company Address: _____ Phone #: _____

Do you have additional medical coverage or a vision plan? Yes ☐ No ☐ If yes, please complete the following

Name of Employer: _____

Insurance Company: _____ Group #: _____ Policy#: _____

Insurance Company Address: _____ Phone #: _____

SHELBY EYE CENTERS

WRITTENT ACKNOWLEGEMENT OF PRIVACY PRACTICES

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

Name (print): _____

Signature: _____ Date: _____

Or

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

Relationship to the patient: _____Parent ____ Legal Guardian_____ Healthcare Proxy

Name (please print): _____

Signature: _____ Date: _____

Medical History

Patient Name: _____ Date of Birth: _____

Primary Care Physician: _____ Date of Last Eye Exam: _____

Do you have any of the following eye conditions?

☐ cataracts	☐ glaucoma	☐ seasonal allergies
☐ crossed Eyes	☐ macular degeneration	☐ history of eye surgery _____
☐ dry Eyes	☐ retinal Disease	☐ other_____

Have you ever had an injury to your eyes or head? If yes, please explain _____
Have you ever been treated for a drug addiction? If yes, when? _____
Do you currently wear glasses? If yes, how old are they? _____
Do you wear contact lenses? If yes, what is the prescription and brand? _____

Do you have any of the following health problems?

☐ Diabetes: How many years? _____ Current A1C _____ Current blood sugar reading _____			
☐ Anemia/Leukemia	☐ High Blood Pressure	☐ Liver Disease/Hepatitis	☐ Thyroid Disease
☐ Arthritis/Lupus	☐ Heart Disease	☐ Mental Illness	☐ TB
☐ Asthma	☐ Kidney Disease	☐ Skin condition	☐ other_____
☐ Cancer	☐ Lung disease/ Emphysema	☐ Stroke _____ (yr)	

Family Health History: (please write the relation on the line provided; mother, father, sibling, grandparent)

☐ Anemia/Leukemia _____	☐ Crossed Eyes _____	☐ High Blood Pressure _____	☐ Mental Illness _____
☐ Arthritis/Lupus _____	☐ Diabetes _____	☐ Heart Disease _____	☐ Stroke _____
☐ Asthma _____	☐ Dry Eyes _____	☐ Kidney Disease _____	☐ Thyroid Disease _____
☐ Cancer _____	☐ Emphysema _____	☐ Lung disease _____	☐ Retinal Disease _____
☐ Cataracts _____	☐ Glaucoma _____	☐ Macular Degeneration _____	☐ other _____

Patient Name: _____ DOB: _____

Surgical Procedures

PROCEDURE	YEAR

Medications

(please list your medications or provide us with a list)

MEDICATION	DOSAGE	REASON FOR USE

Drug Allergies

MEDICATION	REACTION

Tobacco/Alcohol Use

Do you smoke? Yes ☐ No ☐
If yes how much do you smoke per day? _____ How many years? _____
If you are a previous smoker, when did you quit? _____
Do you use any other tobacco products? Yes ☐ No ☐ If yes, what? _____
Do you drink alcohol? Yes ☐ No ☐ If yes, how much weekly? _____

Life Style questionnaire

Do you have any of the following problems?	
Driving/ Driving at night / Glare	Yes ☐ No ☐
Sports /Hobbies	Yes ☐ No ☐
Reading / Watching TV	Yes ☐ No ☐