PATIENT INFORMATION

Patient's Last Name _____ First _____ M.I._____

Home Phone _____ Work Phone _____ Cell Phone_____

Home Address _____ City _____ State _____ Zip_____

E-Mail Address_____

Social Security # _____ Sex _____ Marital Status _____

Patient's Date of Birth _____ Age _____ Spouse's First Name _____

Patient's Occupation _____ Employer _____

Employer's Address _____ City _____ State _____ Zip _____

IN CASE OF AN EMERGENCY, CONTACT (Please specify someone who does not live in your household.)

Name _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip_____

Home Phone _____ Work Phone _____

WHOM MAY WE THANK FOR REFERRING YOU?

Physician or Optometrist – (name) _____ (city)_____

Family/Friend – (name) _____

(address) _____

Newspaper – (specify) _____ TV (specify) _____

Radio – (specify) _____ Yellow Pages _____

Health on Site _____ Other (specify) _____

PARTY RESPONSIBLE FOR BILL IF DIFFERENT FROM PATIENT

Name _____ Relation _____

Address _____ City _____ State _____ Zip _____

Social Security # _____ Date of Birth _____ Phone _____

Employer _____ Work Phone _____

Driver's License #/State _____

PATIENT HEALTH HISTORY

Date:_____

Name:_____**Age:**_____**Weight:**_____**Height:**_____

Drug Allergies:_____

_____

Current Medications:_____

_____

_____

Have you had any surgeries in the past? _____Yes _____ No

Have you had problems with any anesthetics in the past?_____Yes _____No

Please circle "Yes" or "No" to indicate if you have or have had any of the following. Also circle "Yes" or "No" to indicate if a blood relative has or has had any of the following. Thank you for helping us plan your individualized care.

	Yourself		**Family Members**			**Yourself**		**Family Members**	
AIDS/HIV	Yes	No	Yes	No	Hepatitis (Type ____)	Yes	No	Yes	No
Arthritis	Yes	No	Yes	No	High Blood Pressure	Yes	No	Yes	No
Artificial Heart Valve	Yes	No	Yes	No	Kidney Disease	Yes	No	Yes	No
Asthma	Yes	No	Yes	No	Lupus	Yes	No	Yes	No
Bleeding	Yes	No	Yes	No	Migraine Headaches	Yes	No	Yes	No
Blood Transfusion	Yes	No	Yes	No	Pacemaker	Yes	No	Yes	No
Breathing Problems	Yes	No	Yes	No	Paralysis	Yes	No	Yes	No
Cancer	Yes	No	Yes	No	Rheumatic Fever	Yes	No	Yes	No
Chemical Dependency	Yes	No	Yes	No	Seizures	Yes	No	Yes	No
Diabetes	Yes	No	Yes	No	Shingles	Yes	No	Yes	No
Drug Sensitivity	Yes	No	Yes	No	Shortness of Breath	Yes	No	Yes	No
Emphysema	Yes	No	Yes	No	Skin Conditions	Yes	No	Yes	No
Epilepsy	Yes	No	Yes	No	Stomach Ulcers	Yes	No	Yes	No
False Teeth	Yes	No	Yes	No	Stroke	Yes	No	Yes	No
Hard of Hearing	Yes	No	Yes	No	Thyroid Conditions	Yes	No	Yes	No
Hay Fever	Yes	No	Yes	No	Tuberculosis	Yes	No	Yes	No
Heart Attack	Yes	No	Yes	No	Females: Are you pregnant? _____				
Heart Condition	Yes	No	Yes	No	Are you nursing a baby?_____				

Do you smoke?_____ Packs per day?_____How many years?____

EYE HEALTH HISTORY

Name:_____ **Date:**_____

Thank you for choosing Wallace Eye Surgery for your eye care needs. For us to better serve you, please answer the following questions:

Date of last eye exam:_____

1. Have you ever had an eye injury? Please describe _____

_____

2. Have you ever had eye surgery? Please list type, which eye and approximate dates:_____

_____

3. Are you currently using any eye medications? Please list name and how often used:_____

_____

Place circle "Yes" or "No" to indicate if you have or have had any of the following. Also circle "Yes" or "No" to indicate if a blood relative has or has had any of the following.

	Yourself	**Family Members**			**Yourself**	**Family Members**	
Bloodshot Eyes	Yes No			Glaucoma	Yes No	Yes No	
Blurred Vision – Distance	Yes No			Headaches	Yes No	Yes No	
Blurred Vision-Near	Yes No			Itching Eyes	Yes No		
Burning Eyes	Yes No			Light Sensitive	Yes No	Yes No	
Cataracts	Yes No	Yes No		Loss of Vision	Yes No	Yes No	
Crossed Eyes	Yes No	Yes No		Macular Degeneration	Yes No	Yes No	
Discharge from eyes	Yes No			Migraine Headaches	Yes No	Yes No	
Dizzy Spells	Yes No			Poor Night Vision	Yes No	Yes No	
Double Vision	Yes No	Yes No		Red Eyes	Yes No		
Dry Eyes	Yes No	Yes No		Retinal Disease	Yes No	Yes No	
Eye Infection	Yes No	Yes No		Seeing Halos	Yes No		
Eye Injury	Yes No			Seeing Flashes	Yes No		
Eye Strain	Yes No			Temporary Vision Loss	Yes No		
Fainting Spells, Blackouts	Yes No	Yes No		Twitching Eyelid	Yes No		
Floater or Spots	Yes No			Watering Eyes	Yes No		

Please circle any of the following that you would like more information about:
Cataract Surgery Conductive Keratoplasty (CK) Diabetic Eye Disease Glaucoma

LASIK PRELEX Other:_____

Visual Needs Questionnaire

Your answers to the following questions will help us determine the solution that best meets your visual neesds.

1. How many hours per week do you spend driving after dark? _____
2. How many hours per week do you spend working on a computer? _____
3. How many hours per week do you spend reading small print materials for extended periods (e.g. magazine, newspaper, paperback book)? _____
4. Do you wear contact lenses? ☐ Yes ☐ No
5. What type of glasses do you presently wear?
   ☐ Bifocal ☐ Progressive (lineless) Bifocal ☐ Trifocal
   ☐ Reading only ☐ Distance only ☐ None
6. Do you currently wear glasses full time for both distance and reading? ☐ Yes ☐ No
7. If not, what percentage of time do you wear your glasses? _____
8. If you sometimes read without your glasses, what percentage of your reading s done with your glasses? _____ without glasses? _____
9. If you had to choose just one of the following, which type of focus do you feel that you would prefer to have without glasses?
   ☐ Reading fine print ☐ Social reading (e.g. restaurant menu)
   ☐ Computer ☐ TV ☐ Driving
10. How important would reducing the need for glasses be for you after cataract/lens surgery?
    ☐ Extremely ☐ Very ☐ Somewhat ☐ Minimally
11. How many ours per week do you spend at outdoor activities (e.g. golf, or other athletics, aviation)? _____
12. Please list any other activities, hobbies or sports that you consider an important part of your life: _

_____

_____

_____ _____

Patient Signature Date

Medical History
Review of Systems

Patient Name:_____ **Date:**_____ **Physician initials**_____

Are you currently experiencing problems with any of the following?

		If yes, please explain
Sudden weight gain or loss	☐Yes ☐No	
Chronic fever or chronic fatigue	☐Yes ☐No	
Heart (example: chest pain, angina, irregular heart beat)	☐Yes ☐No	
Respiratory (example: coughing, wheezing, shortness ☐of breath, asthma)	☐Yes ☐No	
Ear/Nose/Throat (example: sore throat, sinus problem, earache, hearing loss)	☐Yes ☐No	
Gastrointestinal (example: abdominal pain, heartburn, bowel problems, vomiting)	☐Yes ☐No	
Urinary (example: pain when urinating, blood in urine	☐Yes ☐No	
Hematologic/ Lymphatic (example: blood disorders, bruising, cuts heal slowly, enlarged glands)	☐Yes ☐No	
Endocrine (example: thyroid problems)	☐Yes ☐No	
Integumentary (example: rashes, dry skin	☐Yes ☐No	
Musculoskeletal (example: joint pain, stiffness or swelling, muscle pain or weakness)	☐Yes ☐No	
Neurological (example: numbness, headache, seizures, paralysis)	☐Yes ☐No	
Psychiatric (example: depression, anxiety, insomnia, confusion)	☐Yes ☐No	
Allegic/Immunologic (example: reaction to food or drugs, allergies, hay fever)	☐Yes ☐No	

Social History:

Marital status	☐Single	☐Married	☐Separated	☐Divorced	☐Widowed
Use of alcohol	☐Never	☐Rarely	☐Moderate	☐Daily	How much? _____
Use of tobacco	☐Never	☐Previously, but not in past _____years		☐Yes _____ packs/day	

Family Medical History:

	Age	Medial/Eye Disease	If deceased, cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____

AUTHORIZATION TO RECEIVE/RELEASE HEALTH INFORMATION

Due to the **HIPAA Compliance Privacy Laws of the Federal Government,** it is mandatory that we ask you to review and answer the following questions listed below.

Name: _____

May we leave messages/detailed medical information on voicemail at either of these phone numbers?

□ Yes □ No Home Phone: _____ □ Yes □ No Cell Phone: _____

May we contact you at your place of employment? □ Yes □ No
If so, may we leave a message? □ Yes □ No

If yes: Work Phone: _____ Extension: _____

Do you have any particular person or family members that you authorize to receive and discuss information regarding your personal health information (general information, surgical and billing)?

□ Yes □ No If yes, please provide:

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____
Is this person your Power of Attorney for medical purposes? □ Yes □ No

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____

I hereby authorize Wallace Eye Associates to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, laboratories, radiology facilities or other institutions. **This authorization remains in effect until revoked.**

I have reviewed the aforementioned information and provide my consent regarding any and all the issues as stated above.

I have reviewed Wallace Eye Associates' Notice of HIPAA Privacy Policy. A copy of this policy will be provided to me upon request.

Patient Signature: _____ Date: _____

WITNESSED BY: _____ Date: _____

Lifetime Signature on File, Assignment of Benefits, Financial Agreement

Beneficiary Name (print) _____ Medicare Number _____

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Wallace Eye Surgery, for services furnished me by Wallace Eye Surgery. 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 HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Wallace Eye Surgery accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered 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 Wallace Eye Surgery, if possible or otherwise to me.

3. **RELEASE OF INFORMATION:** Wallace Eye Surgery 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 Wallace Eye Surgery for reimbursement for services rendered, and (2) any health care provider for continued patient care. Wallace Eye Surgery 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 Wallace Eye Surgery 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 Wallace Eye Surgery 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 Wallace Eye Surgery if I belong to a plan that does not appear on the above-mentioned list.

5. **NON-COVERED SERVICES:** I understand that Wallace Eye Surgery's contracts with health care service plans (i.e., HMOs, PPOs) relate 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 furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Wallace Eye Surgery to obtain necessary health care service plan authorizations.

6. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Wallace Eye Surgery, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Wallace Eye Surgery for payment. 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 Wallace Eye Surgery. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Wallace Eye Surgery. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

Beneficiary Signature or Authorized Party _____ Date _____

NOTICE OF PRIVACY PRACTICES

WALLACE EYE ASSOCIATES **This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

Patient Health Information
Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing and insurance information. Your information may be stored electronically and if so is subject to electronic disclosure.

How We Use Your Patient Health Information
Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.
Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment or disclose your information to payors to determine whether you are enrolled or eligible for benefits. We will submit bills and maintain records of payments from your health plan.
Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, arranging for legal services and to assess the care and outcomes of your case and others like it.

Special Uses and Disclosures

Following a procedure, we will disclose your discharge instructions and information related to your care to the individual who is driving you home from the center or who is otherwise identified as assisting in your post-procedure care. We may also disclose relevant health information to a family member, friend or others involved in your care or payment for your care and disclose information to those assisting in disaster relief efforts.

Other Uses and Disclosures
We may be required or permitted to use or disclose the information even without your permission as described below:
Required by Law: We may be required by law to disclose your information, such as to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
Research: We may use or disclose information for approved medical research.
Public Health Activities: We may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
Health oversight: We may disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
Judicial and administrative proceedings: We may disclose information in response to an appropriate subpoena, discovery request or court order.
Law enforcement purposes: We may disclose information needed or requested by law enforcement officials or to report a crime on your premises.
Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.
Business Associates: We may also disclose your health information to business associates (individuals or entities that perform functions on our behalf) provided they agree to safeguard the information.
Messages: We may contact you to provide appointment reminders or for billing or collections and may leave messages on your answering machine, voice mail or through other methods.

In any other situation, we will ask for your written authorization before using or disclosing identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. Subject to compliance with limited exceptions, we will not use or disclose psychotherapy notes, use or disclose your health information for marketing purposes or sell your health information, unless you have signed an authorization.

Individual Rights
You have the following rights with regard to your health information. Please contact the Contact Person listed below to obtain the appropriate form for exercising these rights.

❑ You may request restrictions on certain uses and disclosures. We are not required to agree to a requested restrictions, except for requests to limit disclosures to your health plan for purposes of payment or health care operations when you have paid in full, out-of-pocket, for the item or service covered by the request and when the uses or disclosures are not required by law.

❑ You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.

❑ In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.

❑ You have the right to request that we amend your information.

❑ You may request a list of disclosures of information about you for reasons other than treatment, payment, or health care operations.

❑ You have the right to obtain a paper copy of the current version of this Notice upon request, even if you have previously agreed to receive it electronically.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect. We are required to notify affected individuals in the event of a breach involving unsecured protected health information.

Changes in Privacy Practices
We may change this Notice at any time and make new terms effective for all health information we hold. The effective date of this Notice is listed at the bottom of the page. If we change our Notice, we will post the new Notice in the waiting area. For more information about our privacy practices, contact the person listed below.

Complaints
If you are concerned that we have violated your privacy rights, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person
If you have any questions, requests, or complaints, please contact:

Anna Johnson or Debra Moore
(318) 448-4488

I, _____
hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed:_____ Date:_____

If not signed, reason why acknowledgement was not obtained: _____

Staff Witness seeking acknowledgement

_____ Date:_____

Please complete the following information for e-prescribing purposes:

Patient Name:_____

Date of Birth:_____

Mailing Address:_____

City:_____ State:_____

Pharmacy:_____

Location:_____

Prescription Drug Insurance Plan:_____

_____

Drug Allergies:_____