SWEENEY EYE ASSOCIATES

PATIENT INFORMATION

Patient Legal Name: _____ Preferred Name: _____

Date of Birth: _____ Age: ____

☐ Male ☐Female Social Security: _____-_____-_____

Marital Status: ☐Married ☐Single ☐Divorced ☐Widow

Address: _____ City: _____ State: _____ Zip: _____

Home :(___)_____Cell: (___)_____Work: (___) _____

Employer: _____ Occupation: _____

Email Address:

Spouse or Parent Name: _____ Phone: ( ) _____

Primary Care Physician: _____ Phone ( ) __

Referring Optometrist / Physician: _____ Phone ( ) __

RESPONSIBLE PARTY

Name of person responsible for this account: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (___) _____ Work Phone: (___) _____ Cell Phone: (___)_____

INSURANCE PLEASE PRESENT COPY OF YOUR INSURANCE CARDS

Primary Insurance: _____ Insured: _____ Insured DOB: _____

Secondary Insurance: _____Insured: _____ Insured DOB: _____

PLEASE ANSWER THE FOLLOWING:

Are you currently living in a skilled nursing facility? ☐ Yes ☐ No Facility

Name: _____ Address: _____

City: _____ State: _____ Phone: _____

PREFERRED LANGUAGE: ☐ English ☐ Spanish ☐ Other

RACE: ☐ American Indian/Eskimo ☐ Asian/Pacific Islander

☐ African American ☐ White ☐ Other

ETHNICITY: Hispanic/Latino Not Hispanic/Latino

EMERGENCY CONTACT NAME:_____ Relationship: _____

Home Phone: (___)_____ Work Phone: (___)_____ Cell Phone: (___)_____

I hereby authorize the physicians and staff of Sweeney Eye Associates to perform such treatments to me as may be prescribed by any attending physician during any and all of my treatments at Sweeney Eye Associates. (If a minor) I hereby authorized the physician to treat my child as deemed medically necessary.

X _____ _____ _____

SIGNATURE / RESPONSIBLE PARTY **PRINT NAME** **DATE**

SWEENEY EYE ASSOCIATES

SWEENEY EYE ASSOCIATES MEDICAL INFORMATION Today's Date: _____

Patient Name: _____ Age: _____ Date of Birth: _____

Current visual problems _____

_____

List all eyedrops currently taking: _____

Do you wear glasses? _____ How old are they? _____

Do you wear contact lenses? _____ How long? _____ ☐ Hard ☐ Soft

Are you currently living in a skilled nursing facility? ☐ Yes ☐ No **If yes**: Name: _____
Address: _____ City: _____ State: _____ Phone: _____

FAMILY HISTORY: List family member

Cataracts _____
Glaucoma _____
Lazy Eye _____
Crossed Eye _____
Other Eye Disorder _____

Retina Disease _____
Diabetes _____
High Blood Pressure _____
Heart Disease _____
Other _____

SOCIAL HISTORY:

☐ Alcohol Drinks per day _____ ☐ Smoke How much _____

Does your vision bother your ability to: (check all that apply)

☐ Drive ☐ Read ☐ Watch TV ☐ Cook ☐ Dress ☐ See labels on medications

Do you live ☐ Alone ☐ With spouse ☐ Family member ☐ Other _____

Do you require any of the following: ☐ Walker ☐ Cane ☐ Scooter ☐ Wheelchair

What are your hobbies? _____

How would you describe your general health and well-being?

☐ Excellent ☐ Good ☐ Average ☐ Fair ☐ Poor

Do you have an interest in the following? ☐ Multifocal Lens ☐ LASIK

Previous Ocular Surgeries:

_____ Date _____
_____ Date _____
_____ Date _____
_____ Date _____

Have you previously received a Pneumonia Vaccine?

☐ **YES** ☐ **NO**

All Other Surgeries:

_____ Date _____
_____ Date _____
_____ Date _____
_____ Date _____

SWEENEY EYE ASSOCIATES

PAST HISTORY / REVIEW OF SYMPTOMS (Circle all that apply)

Patient Name:_____ **DOB:**_____

GENERAL HEALTH	**Normal**	Fever Weight Loss Cold/Flu
EYES Cataract Glaucoma Macular Degeneration Detached Retina	**Normal**	Sudden Loss or Change in Vision Double Vision Blurring at distance or near Distorted Vision Dry, Itchy, Scratchy Redness Excessive tearing or discharge Swelling of lids Other _____
EARS, NOSE, MOUTH, THROAT	**Normal**	Sinus Infection Dry Mouth Loss of Smell Hearing Loss Other _____
CARDIOVASCULAR Heart Attack When _____ Heart Surgery When _____	**Normal**	High BP Low BP Pacemaker Chest Pain Irreg Heart Beat Blood Clot Congestive Heart Failure Coronary Artery Disease Other _____
RESPIRATORY	**Normal**	Asthma Cough COPD Emphysema Bronchitis TB Oxygen Use Other _____
GASTROINTESTINAL	**Normal**	Heartburn Acid Reflux Stomach Pain Hiatal Hernia Diarrhea Constipation Hepatitis A B C Jaundice Ulcers Cirrhosis Other _____
MUSCULOSKELETAL	**Normal**	Weakness Numbness Arthritis Joint Pain Artificial Joints Other _____
INTEGUMENTARY (SKIN/BREASTS)	**Normal**	Masses Tumors Skin Rash Skin Cancer Shingles Other _____
NEUROLOGICAL	**Normal**	Seizures Headaches Stroke/TIA MS Numbness Depression Other _____
ENDOCRINE/RENAL	**Normal**	Diabetes Insulin / Pills How Long_____ Kidney Disease Dialysis Thyroid Disease
HEMATOLOGIC/LYMPHATIC	**Normal**	Anemia Bruise Easily Bleeding Problems HIV/AIDS Sickle Cell Swollen Lymph Node Prostate Other _____

******OFFICE USE ONLY******

Physician Signature: **Date:**

☐ **I have reviewed ROS and no changes noted** **Physician Signature:** **Date:**

SWEENEY EYE ASSOCIATES

Name _____ Age _____DOB _____ Date _____

Please list all current medications and supplements including over the counter

Medication Name and Dosage	Frequency	Reason for Taking

Drug Allergies: [ ] No Known Allergies
Please enter all medication allergies

_____
_____

Pharmacy _____ Mail Order_____
Address (cross streets) _____
Phone_____

Have you EVER received a pneumonia vaccination? **YES** / **NO**

I give Sweeney Eye Associates permission to upload my prescription history YES / NO

SWEENEY EYE ASSOCIATES

FINANCIAL POLICY

Thank you for choosing Sweeney Eye Associates for your eye care needs. We are committed to providing you with the highest level of service and quality care. In order to achieve these goals, we need your assistance and understanding of our financial policy. It is strongly recommended that you understand the extent of coverage that is available under your specific plan design. If you are not familiar with your insurance coverage, we suggest that you discuss the policy with your employer or insurance company before charges are incurred. Ultimately, any financial liability rests with the patient.

Insurance Notification- We ask that you provide to us a current insurance identification card. If a claim is denied due to wrong information provided, we will bill you directly for services rendered.

Examination- Not all exams are the same. Different diagnostic testing procedures may be performed based on your ocular complaints. You may be asked to return for additional testing. We will inform you during your exam if additional testing or procedures will need to be performed. The fees associated with these procedures will be discussed with you on your arrival or during your exam. If you have not been informed of additional fees, please ask our staff **prior to the procedure**. These procedures may or may not be covered by your insurance plan, or may fall under your deductible.

Refraction- A refraction is a procedure that determines if your visual complaints can be corrected with a prescription for glasses. Sometimes if glasses cannot correct your vision, then additional tests may need to be performed to determine the cause. If you are a new or established patient and have visual complaints, a refraction will be performed. The doctor is the only person that can determine if a refraction is necessary based on your visual complaints. This procedure is considered separate from your exam and **not** covered by most insurance companies.

Co-Payment/Deductible- Some ocular office visits may only require that you pay a co-payment at the time of service. Other insurance companies may apply the visit to your deductible. We will collect your co-payment and/or deductible amounts at the time of your visit based on the insurance information given to us by your insurance company. Any disputes with your insurance company must be handled by you and your insurance company or employer.

Referrals/Authorizations- Managed care plans require referral authorizations. This must be on hand the day of your visit in order for us to submit a claim and this is your responsibility to obtain. If you wish to be seen without a referral, you are responsible for payment on the day of your exam or you can reschedule once the referral is received.

Routine Eye Care or Medical Eye Care- Our office participates with most major insurance plans. We provide MEDICAL and SURGICAL ophthalmic care as well as ocular vision exams for glasses. Please note that many insurance plans do not cover vision exams when there is not a medical reason for the exam. This is what an insurance plan calls ROUTINE or ANNUAL exam for glasses. If your insurance plan does not cover ROUTINE or ANNUAL ocular exams, you are responsible for payment.

Surgical Fees- We will determine your financial responsibility due to Sweeney Eye Associates prior to your scheduled surgery. This may include any co-payments, co-insurance and/or deductible amounts quoted to us by your insurance carrier, **which will be collected at least 1 week prior to your scheduled surgery**. All surgical facility fees and anesthesia fees are separate from Sweeney Eye Associates and are collected from the Surgical Facility and the Anesthesiologist.

Outstanding Balances- Payment in full is expected for any outstanding balance. If you are unable to pay a balance in full, please notify our billing department immediately and we will be happy to work out a payment plan with you. A payment made by check that does not clear your bank will result in a $25.00 fee. This fee along with your outstanding balance must be paid by cash, credit card or cashier's check.

X_____ _____ _____

SIGNATURE / RESPONSIBLE PARTY **PRINT NAME** **DATE**

SWEENEY
EYE ASSOCIATES

PATIENT AUTHORIZATION / ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare, Medicaid, or other Commercial Insurance benefits be made on my behalf to Sweeney Eye Associates for any service furnished to me by a physician of the group. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents or other insurance any information needed to determine these benefits payable for related services. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare contractor. **I am responsible for the Medicare deductible, co-insurance or the 20% Medicare does not pay and for any non-covered services not payable and/or I am responsible for any Commercial Insurance copay, deductible or co-insurance for any non-covered services.**

MEDIGAP OR OTHER SECONDARY INSURANCE

I also request that payment of Medigap benefits or other secondary insurance be made either by me or on my behalf to Sweeney Eye Associates, or any physician of that group, for services provided to me by a physician of the group. I authorize any holder of medical information about me to release it to my Medigap insurer any information needed to determine these benefits payable for related services. **I am responsible for any deductible, copay, co-insurance for any non-covered procedures**.

This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

My signature below further verifies that I have not joined an HMO or other entity in which my Medicare Benefits have been relinquished.

X_____ _____ _____

SIGNATURE / RESPONSIBLE PARTY **PRINT NAME** **DATE**

SWEENEY EYE ASSOCIATES

NOTICE OF PRIVACY PRACTICES

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. Copies of our Privacy Practices are located on laminated pages in the front of our office and at our check in counter for your review.

I have been provided a copy of or access to the Notice of Privacy Practices.

PREFERRED METHOD OF COMMUNICATION

_____	Home	May we leave a message YES / NO
_____	Cell phone	May we leave a message YES / NO
_____	Work	May we leave a message YES / NO
_____	Text	May we send you text messages YES/NO

AUTHORIZATION TO DISCUSS MEDICAL INFORMATION

I authorize Sweeney Eye Associates' physicians and/or staff members to discuss my medical care with the individual(s) listed below:

_____ _____

Name Relationship

_____ _____

Name Relationship

X_____ _____ _____

SIGNATURE / RESPONSIBLE PARTY **PRINT NAME** **DATE**

Precaution Notice Regarding Dilating Drops

It may be necessary to dilate your eyes during the course of your eye examination or treatment. Drops are used to dilate or enlarge the pupils of the eye to allow the physician to get a better view of the inside of your eye and to diagnose your condition.

Dilating drops blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist/optometrist to predict how much your vision will be affected.

We provide disposable sunglasses that help to block the sensitivity to bright light. You will need to use caution while walking or going up or down stairs. Because driving may be difficult immediately after an examination, you may want to make arrangements for someone to drive you.

Adverse reaction, such as acute angle-closure glaucoma may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I have read and understand the precautions listed above.

X_____ _____ _____

SIGNATURE / RESPONSIBLE PARTY **PRINT NAME** **DATE**