



New Orleans Eye Specialists

A Professional Medical Corporation

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we will be glad to help you.

PATIENT INFORMATION

Date _____

SS# _____

Patient Name _____
Last Name

_____ First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex M F Age _____ Birthdate _____

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Occupation _____

Patient Employer or Guardian _____

Employer/School Address _____

Employer Phone (____) _____

Spouse's Name _____

Birthdate _____ SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date Relationship to Patient

PHONE NUMBERS

Home (____) _____ Cell (____) _____ Spouse's Work Phone (____) _____ Ext _____

Best time and place to reach you _____

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

Name _____ Relationship _____

Home (____) _____ Cell (____) _____ Work Phone (____) _____ Ext _____

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to

_____ for any services furnished to me by that provider.
Name of Doctor or Clinic

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

Signature of Beneficiary, Guardian or Personal Representative

Date

Please print name of Beneficiary, Guardian or Personal Representative

Relationship to Beneficiary



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EYE HEALTH HISTORY

Physician's Name _____

Date of last visit _____

Date of last eye exam _____

Name of doctor _____

Do you wear glasses? Yes No

All the time Occasionally
 Reading Driving TV

Do you wear contacts? Yes No

Type _____ Hours/Day _____

Describe any problems you have with your contacts _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- | | | | |
|----------------------------|--|--------------------------|--|
| Bloodshot Eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Floaters or Spots | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blurred Vision - Distance | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blurred Vision - Near | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Burning Eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Itching Eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cataracts | <input type="checkbox"/> Yes <input type="checkbox"/> No | Light Sensitive | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Color Vision, Poor | <input type="checkbox"/> Yes <input type="checkbox"/> No | Loss of Vision | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Crossed Eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraine Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Discharge from Eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Night Vision, Poor | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dizzy Spells | <input type="checkbox"/> Yes <input type="checkbox"/> No | Red Eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Double Vision | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seeing Halos | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dry Eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seeing Flashes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eye Infection | <input type="checkbox"/> Yes <input type="checkbox"/> No | Temporary Loss of Vision | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eye Injury | <input type="checkbox"/> Yes <input type="checkbox"/> No | Twitching Eyelid | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eye Strain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Vision Poor | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fainting Spells, Blackouts | <input type="checkbox"/> Yes <input type="checkbox"/> No | Watering Eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No |

HEALTH HISTORY

Physician's Name _____ Date of last visit _____

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

- | | Yourself | Family Members | | Yourself | Family Members |
|------------------------|--|--|-------------------------|--|--|
| AIDS/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis (Type _____) | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valve | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lazy Eye | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lupus | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraine Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blindness | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Poor Color Vision | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cataracts | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Retinal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shingles | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Drug Sensitivity | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Conditions | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Conditions | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eye Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Turned Eye | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hay Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you pregnant? _____ | Number of children _____ | |
| Heart Condition | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tobacco use _____ | Alcohol use _____ | |

MEDICATIONS

List any medications you are currently taking, including eye drops:

Pharmacy Name _____

Phone (_____) _____

ALLERGIES

List your allergies to medications or other substances:

NEW ORLEANS EYE SPECIALISTS

VISION PLANS

EYEMED (Humana Insight or Aetna Vision)

MARCH VISION

VSP

DAVIS VISION

VCP

ALWAYS CARE (Unum or Starmount)

SUPERIOR VISION (Medicaid ONLY)

Here at New Orleans Eye Specialists, we want to be able to provide you with the best eye care possible. It is your responsibility to know what your insurance covers and where we should file your claim. If are here for a routine visit, we will file the claim to either of the above-mentioned plans you have circled at the time of service only. We will not file with your vision plan at a later date. If you do not have one of the vision plans listed above, we will need to send your claim to your medical plan.

Signing below indicates that you have read and understand the office policy.

Signature

Date

FINANCIAL POLICIES NEW ORLEANS EYE SPECIALISTS

OUR PRACTICE MISSION

Drs. Leader, Balkan, Hendricks, and Bolton are committed to provide the most advanced, sympathetic care for your precious vision. We welcome any questions about your medical or surgical vision treatments.

OUR FINANCIAL POLICIES

While we wish that money was never a problem in medical care, it is an unfortunate reality. We feel it is better to be as clear as possible about financial matters. We want you to know about the following policies:

1. **PAYMENT** is due for your portion of any fees on the day services are rendered. We accept cash, check, Mastercard, Visa, Discover and American Express. ANY PAYMENT ARRANGEMENTS MUST BE APPROVED IN ADVANCE.
2. **BILLING** adds to the cost of medical treatment. Payments received within 10 days will be considered as paid at the time of your visit. After 10 days, your bill will be sent to a billing service and a \$5.00 billing fee will be added to your statement at that time. A \$2.50 rebilling fee will be added for each additional bill, which will be sent every 30 days for 90 days.
3. **NSF (Returned Check)** There will be a \$15.00 handling charge.
4. Your insurance is a contract between you and your insurance company. While the filling of insurance claims is a courtesy that we extend to our patients, all charges are ultimately the responsibility of the patient from the date services are rendered.
5. Not all professional services, exams or tests are covered benefits in all insurance contracts. For example, a refraction (checking of glasses) is not covered by medical insurance. We will only perform the services that are necessary. However, some insurance companies will arbitrarily select certain services that they will not cover. Professional services not covered, but which are deemed necessary for your care, will be the patient's responsibility.
6. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance.

If you have any questions about these policies, please ask. We are here to help you.

I understand these policies.

Signature: _____

OVER

NEW ORLEANS EYE SPECIALIST PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal information is protected. The Privacy Rule was also created to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal and medical records and will do all we can to secure and protect that privacy. When it is appropriate and necessary, we provide the minimum necessary information only to those we feel need your health care information.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories, insurance companies and surgical centers), for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose you give consent in this document, at some future time you may request all or part of your PHI. You may not revoke actions that have already been taken which relied on this or previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice. To request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: _____

Signature: _____ Date: _____