OPHTHALMOLOGY ASSOCIATES

FOR OFFICE USE ONLY				
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Patient Registration and Financial Agreement

You must be at least 18 years old to complete and sign this form.

General Patient Information

Title: ☐ Dr ☐ Mr ☐ Mrs ☐ Miss Date: ____ / ____ / ____

First Name: ____ Middle: ____ Last Name: ____

Street Address: ____ City: ____ State: ____ Zip: ____

Age: ____ Sex: ____ Birth Date: ____ / ____ / ____ Home Phone: ____ Cell: ____

☐ Single ☐ Married ☐ Widowed ☐ Divorced Social Security Number: ____

Occupation: ____ Employer (Company): ____

Employer's Phone: ____ Referred By: ____

Spouse or Responsible Party Information:

Name: ____ Relationship: ____

Street Address: ____ City: ____ State: ____ Zip: ____

Employer (Company): ____ Phone: ____

Insurance Information:

Primary Ins.: ____ (Company) ____ (Contract No.) ____ (Group No.)

Secondary Ins.: ____ (Company) ____ (Contract No.) ____ (Group No.)

Other Insurance: ____ (Company) ____ (Contract No.) ____ (Group No.)

MEDICARE: Most insurance companies do not pay for eye refractions. If I receive an eye refraction today I agree to pay for it. The current price is **$35.00**.

ALL PATIENTS: I understand that the charges made by *Ophthalmology Associates* for professional services may not be covered in full by any insurance covering such service to the patient. The patient and the party responsible for payment of fees for services rendered to the patient agree to make payment in full to *Ophthalmology Associates* in such cases. The undersigned accepts the fee charged as lawful debt and promises to pay said fee including the cost of collection, attorney's fees, and court costs if such be necessary, waiving now and forever the right to claim exemption under the constitution and laws of the State of Alabama, or any other state.

I understand that I am required to pay for any health insurance deductibles, co-insurance, co-payments or any other charges incurred which are not paid by insurance.

I authorize release of any medical information necessary to process an insurance claim.

CO-PAYMENT IS DUE AT TIME SERVICES ARE RENDERED.

Signature of Person Responsible for Charges ____

(You must be at least 18 years old to sign this form)

OPHTHALMOLOGY ASSOCIATES

Medical History Questionnaire

Name: Date: / /

Date of Birth: / / Date of Last Eye Exam: / /

List any medications you currently take (Rx and over the counter):

Do you have any allergies to any medications? Yes No

If YES, list the medications:

List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc) or injuries (concussion, etc.):

List any surgeries you have had (cataract, appendectomy):

Do you currently have any problems in the following areas? If YES, please provide additional information.

	YES	NO	Details
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL/CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high blood pressure, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequest urination, impotence, yellow jaundice, etc.)			
FEMALES Are you pregnant? Nursing?			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia, etc.)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD/LYMPH (bleeding, cholesterolemia, anemia, problems relating to blood transfusion, etc.)			
ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			

Family History (Mother, Father, Grandparent, Sibling)

Has any member of your family had these diseases (circle all that apply)? Yes No Unknown

Blindness Cataract Glaucoma Diabetes Hypertension Heart Disease Stroke Cancer Thyroid Disease Arthritis

Other Heritable Disease:

Social History

Have you ever had a blood transfusion? Yes No

Do you drink alcohol? Yes No If YES, how much?

Do you smoke? Yes No If YES, how much? How many years?

Physician's Signature: **Date:** / /

OPHTHALMOLOGY ASSOCIATES

Consent for Use of Disclosure of Information For Purposes Requested by a Physician's Office

Randall Smith, M.D.

I hereby permit *Ophthalmology Associates, P.C.* to use my health information, and/or to disclose my health information to any third party payer, or to any party involved in my health care.

I understand that there is a Notice of Privacy Practices posted in the practice reception area available for me to read.

This consent shall be in force and effect as long as I am a Patient at this practice.

I understand that I have the right to revoke this consent, in writing, at any time by sending such notification to my physician(s) at this practice.

I understand that information used or disclosed pursuant to this consent may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I also understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights).
- Refuse to sign the consent

Signature of Patient Date: / /

Name of Patient

Family member of other person you wish to allow access to your information

OPHTHALMOLOGY ASSOCIATES

"Your Vision is Our Specialty"

Vision Plan Coverage

Randall Smith, M.D.
Comprehensive Eye Care
No-Stitch Cataract
Custom LASIK

Location:

Saint Vincent's Hospital
In the Professional Office Building III
833 Saint Vincents Drive, Suite 207
Birmingham, AL 35213
Office: 205-933-1380

If you have a **Vision Plan (i.e. VSP, EyeMed, Comp Benefits, etc.)**, please notify the front desk before your exam. Please note that Vision Plans are different than Medical Insurance and DO NOT cover Medical related Comprehensive Eye Examinations.

The type of eye exam you have is determined by the reason for your visit or your chief complaint, as well as your diagnosis. Routine vision exams that Vision Plans cover usually are for Eyeglasses and Contact Lens related exams only, without eye related complaints.

Comprehensive Medical Eye Exams must be filed under your regular medical insurance. Problems such as red eye, dry eye, blurry vision from cataracts, excessive tearing, or other such eye problems along with any medical consult request from your Primary Care Doctor must be filed with your Medical Insurance. Vision Plans will deny these visits and charge the patient for the visit since it is medically related and not covered under Vision Coverage (i.e. Glasses/ Contacts Exam).

Typically, **vision insurance policies** usually cover a Basic Eye Exam and the refraction for glasses/contacts, while **medical policies** cover the Full Comprehensive Eye Exam, but not the refraction if needed for glasses/contacts.

If you wish to use your Vision Plan for an eyeglass/contact lens exam, and you also have an eye related medical problem, you may schedule another appointment to return for those additional tests on another date where your medical insurance will be billed or if you choose to have tests performed the **same day** then your medical insurance will automatically be billed for **ALL** services performed.

Please be aware if no vision plan coverage is provided at time of service, then your medical insurance will be filed for your exam as well as any procedures performed on that date of service. It is our policy not to re-file under any Vision Plans if not presented at the time of the exam, since this dictates the type of exam the doctor performs.

Signature

/ /

Date: