COOSA EYE
associates, pc
A Family Eye Care
& Optical Center

PATIENT HISTORY FORM

Welcome to our office. Please be advised that all information in your eye health record is confidential and necessary for comprehensive and quality eye care. Please complete the information requested and read all front sections carefully.

Social Security No. _____ Ethnicity/Race _____

Patient Name_____Birthdate_____Age_____ Date_____

Address_____City_____ St____ Zip_____

Home Phone (____)_____ Work Phone (____)_____ Daytime Phone (____)_____

Cell Phone (____) _____ Email _____

Patient Occupation_____ Spouse (both parents, if child)_____

If Student: Grade_____School_____ Teacher _____

Responsible Party_____Relation to Patient_____

Employer of Responsible Party_____Work Phone (____)_____

Insurance Subscriber Name_____ Social Security No. _____ Date of Birth_____

ALL FEES FOR EXAMINATIONS AND OFFICE VISITS ARE DUE ON THE SAME DAY THE SERVICES ARE RENDERED. Credit is through Visa, MasterCard, or Discover Card only. When glasses, contact lenses or other materials are needed, a 50% deposit must be made before these materials can be ordered. The balance is due upon delivery. **THERE ARE NO EXCEPTIONS TO THIS POLICY.**

To prevent any misunderstanding, please be advised that the patient/guardian or responsible party (not the insurance company) is responsible for the fees of all professional services and materials.

If parents are separated or divorced, the parent or adult bringing the child to the office will be responsible for payment at the time of service.

We accept payment on the following insurance plans for the benefits covered under these plans (the patient must pay any non-covered services and materials as well as any deductible or co-payment.) **Refraction lense prescription determination is a non-covered service by Medicare and other major medical insurance.**

MEDICARE	**PMD (BLUE CROSS/BLUE SHIELD) (Medical only)**	**SOUTHLAND**
MEDICAID	**VISION CARE PLAN (VCP)**	**UNITED HEALTHCARE (Medical only)**

Today's method of payment: **[ ] Cash/Check** **[ ] Charge Card** **[ ]** _____

I have read and agree to the above terms regarding payment of services and materials. Should my account become delinquent and require collection services, I agree to pay all reasonable collection fees. Further, I agree that I have had made available to me the Government's required HIPAA Notice of Privacy statement as understood by this office effective April 14, 2003.

Patient or Responsible Party Signature_____ Date_____

EYEWARE GUARANTEE: "If you find the EXACT same eyewear or contact lenses advertised for less at any retail dispensary anywhere in Alabama within 30 days of purchase from our dispensary, we will refund the difference."

ONE YEAR WARRANTY – on your frames and eyeglass lenses against defects in workmanship and materials.

Name_____ Date_____

Please circle (YES) or (NO) to the following questions: **Medications**

Are you in good health?	YES	NO
Do you have a physician that you see regularly?	YES	NO
Are you taking any prescription drugs?	YES	NO
Are you taking any non-prescription (over the counter) drugs?	YES	NO
Are you taking any street drugs?	YES	NO
Do you smoke?	YES	NO
Do you drink alcohol?	YES	NO
Do you drive?	YES	NO
Do you have difficulty driving?	YES	NO
Do you have problems with your night vision?	YES	NO
Do you wear contact lenses?	YES	NO
If NO, then are you interested in wearing contact lenses?	YES	NO
Is there any blindness in your family?	YES	NO
Have you suffered an eye injury before today's visit?	YES	NO
Have you ever suffered a serious head injury?	YES	NO
Have you ever suffered a high fever?	YES	NO
Have you ever suffered from epilepsy (seizures, convulsions)?	YES	NO

FAMILY HISTORY: Please circle any of the following problems that apply to you as the patient and/or the parents, brothers/sisters or children of patient:

Blindness	Glaucoma	Cataracts	Diabetes	Macular Degeneration
Cancer	Arthritis	Gout	Lupus	Retinal Detachment
Heart Attack	Stroke	Thyroid Disease	TB	High Blood Pressure
Sjogrens Syndrome	Kidney Disease	Liver Disease		

PLEASE DO NOT WRITE BELOW THIS LINE

REVIEW OF BODY SYSTEMS:
Please check ALL categories below that patient CURRENTLY has any problems in:

- ❑ Constitutional (fever, chills, weight loss, headaches)
- ❑ Cardiovascular (heart)
- ❑ Hematopopoietic (blood disorders)
- ❑ Ears, Nose, Mouth, and/or Throat
- ❑ Gastrointestinal; (vomiting, nausea)
- ❑ Genitourinary (kidney stones, frequent urination)
- ❑ Respiratory (lungs/breathing, wheezing, disorders)
- ❑ Neck (aches-discomfort while working at computer)
- ❑ Skin (rashes, etc.)
- ❑ Bones, Joints, and/or Muscles
- ❑ Neurologic (seizures, loss of strength in a limb, numbness/tingling sensations)
- ❑ Endocrine (intolerance of cold or hot weather, drinking a lot of liquids, passing a lot of urine)
- ❑ Allergic/Immunologic

This history has been reviewed. _____ _____
Doctor's Signature Date

Who may we thank for referring you to our office? _____

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Dr. P. Duncan Roy, Jr.
Optometry

- Ocular Disease Diagnosis and Treatment
- Adult and Pediatric Eye Care
- Contacts
- Second Opinions
- Low Vision Evaluations
- Pre-evaluation for Surgery to Reduce Myopia (Nearsightedness)
- Orthokeratology

Patient Name_____ DOB_____ SS#_____

Subscriber Name _____DOB_____SS#_____

Primary Insurance Co. _____ Ins. # _____

Secondary Insurance Co. _____ Ins. # _____

***Please initial each statement.**

Insurance Assignment and Release

- I, the undersigned, certify that I (or my dependent) have insurance coverage with the above named company and assign directly to Dr. P. Duncan Roy, Jr. / or his associates all insurance benefits, if any, otherwise payable to me for services rendered. _____*
- I understand that insurance is a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. _____*
- I understand that I am financially responsible for all charges whether or not paid by insurance. Coosa Eye Associates, PC/ Dr. Roy will submit an insurance claim as a courtesy. However, if that claim is denied **for any reason**, I am responsible for payment of all applicable fees without question. _____*
- Certain ophthalmic tests like refractions are an integral part of a complete eye exam. However, many insurances such as Medicare consider this "routine eye care" and not a covered medical service. I understand that I am financially responsible for all charges for these non-covered medical services. _____*
- I authorize the use of this signature on all insurance submissions. _____*
- I hereby authorize the doctor to release all information necessary to secure the payment of benefits. _____*
- I acknowledge that I have received and signed your Patient Information Privacy Notice. _____*

Patient Signature _____ Date_____

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I, _____, give Coosa Eye Associates, PC authorization to release any of my medical information to the following person/persons.

Name_____Relationship_____DOB_____

Name_____Relationship_____DOB_____

Name_____Relationship_____DOB_____

_____
Signed

_____
Witnessed

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HIPAA NOTICE OF PRIVACY STATEMENT

This notice describes how medical and optical information may be used and disclosed, and how you can get access to this information. Please review it carefully.

This privacy statement describes how we, Coosa Eye Associates, P. C. (herein after referred to as "the practice" and/or "eye doctor") may use and disclose your protected health information to carry out treatment, payment or health care operations and for the purposes that are permitted or required by law. It also describes your rights to access and control your protected information.

Uses and Disclosures of Protected Health Care Information:
Your Protected health information may be used and disclosed by "the practice", our office staff, and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the practice, and other uses required by law.

Treatment:
We will use and disclose your protected health information to provide, coordinate, or manage your health care. This includes the coordination or management of your health care with a third party. For example, your protected health care information may be provided to another doctor to whom you have been referred to ensure the doctor has the necessary information to diagnose or treat you.

Payment:
Your protected health care information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for outpatient tests and surgery may require that your relevant protected health information may be disclosed to the health plan to obtain approval for the procedure.

Healthcare Operations:
We may use or disclose, as needed, your protected health information in order to support the business activities. We may use a sign in sheet at the registration desk where you will be asked to sign your name, and we will also call you by name in the waiting room when the staff is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to confirm your appointment or appointments you have missed, our office staff may leave a message, send post cards or other means if applicable.

We may use or disclose your protected health care information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures may be made with your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your "eye doctor" or "the practice" has taken an action in reliance on the use of disclosure indicated in the authorization.

Your Rights:
The following is a statement of your rights with respect to your protected health information.

You have the right to inspect your protected health information., at an agreed upon time and a fee may be charged for that time.

You have the right to request in writing a restriction of your protected health information. This means you may ask, in writing, us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request, in writing, that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Statement. Your request, in writing, must state the specific restriction request and to whom you want the restriction to apply.

**The practice is not required to agree with the restriction that you may request. If the practice believes it is in your best interest to permit use and disclosure of your protected health care information, your information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have the practice amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and provide you with a copy of such rebuttal.

You may have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and if possible, we will inform you accordingly.

Complaints:
If you feel your privacy rights have been violated you may file a complaint with our HIPAA COMPLIANCE OFFICER/Dr. Roy.

This notice becomes effective April 14, 2003

Patient signature: _____ Date: _____

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Thank you for choosing Coosa Eye Associates for your eye care needs!

Dr. P. Duncan Roy, Jr and his staff are looking forward to your visit. Your appointment with us is _____, _____@_____. If you are unable to keep this appointment please notify us at least 24 hours in advance.

Attached are the forms for new patients, please fill these out and bring them with you to your visit. Please arrive 15 minutes early to make sure we complete all paperwork prior to your appointment. If under the age of 19, paper work must be completed and signed by parent or legal guardian. Parent or legal guardian must accompany minor to appointment.

Please bring with you a list of all current medications, both over the counter and prescription as well as a photo I.D. (such as your driver's license), any glasses or sunglasses you have, both over the counter and prescription and all of your insurance cards to your visit. If contact lens wearer, please bring last prescription or boxes of last contact lenses worn.

If your insurance requires a referral, please make sure to bring that with you, or have it sent to our office before your visit.

All fees for examinations and office visits are due on the same day the services are rendered. We accept cash, checks or credit through Visa, MasterCard or Discovery Card only.

To prevent any misunderstanding, please be advised, the patient/guardian or responsible party (not the insurance company) is responsible for the fees of all professional services and materials.

We are looking forward to your visit. Feel free to call our office with any questions or you may e-mail us at coosaeye@bellsouth.net.

Thank you for trusting us with your eye care needs!