



Medical History Form

Please PRINT

Today's Date: _____

Patient Name: _____ Birth Date: _____ Phone #: _____

<u>EYE HEALTH</u>			
Blurred Vision – Distance <input type="checkbox"/>	Discharge from Eyes <input type="checkbox"/>	Flashes <input type="checkbox"/>	Macular Degeneration <input type="checkbox"/>
Blurred Vision – Near <input type="checkbox"/>	Double Vision <input type="checkbox"/>	Floaters or Spots <input type="checkbox"/>	Night Vision, Poor <input type="checkbox"/>
Blurred Vision – Intermediate <input type="checkbox"/>	Droopy Eyelid(s) <input type="checkbox"/>	Glaucoma <input type="checkbox"/>	Stye, Chalazion <input type="checkbox"/>
Burning Eyes <input type="checkbox"/>	Dry Eyes <input type="checkbox"/>	Halos <input type="checkbox"/>	Twitching Eyelid(s) <input type="checkbox"/>
Bump, Lesion <input type="checkbox"/>	Eye Infection <input type="checkbox"/>	Headaches <input type="checkbox"/>	Watering Eyes <input type="checkbox"/>
Cataracts <input type="checkbox"/>	Eye Injury <input type="checkbox"/>	Itching Eyes <input type="checkbox"/>	Other: _____
Color Vision, Poor <input type="checkbox"/>	Eye Pain <input type="checkbox"/>	Light/Glare Sensitive <input type="checkbox"/>	
Crossed Eyes, Lazy <input type="checkbox"/>	Fainting, Blackouts <input type="checkbox"/>	Loss of Vision <input type="checkbox"/>	

<u>MEDICAL HISTORY</u>	
DISEASE/CONDITION	<input checked="" type="checkbox"/> <i>Fill in all that applies</i>
AIDS/HIV	<input type="checkbox"/> If yes, how many years? _____ What was your last CD4 count? _____
Asthma	<input type="checkbox"/>
Cancer	<input type="checkbox"/> If yes, when? _____ What type? _____
Diabetes (Type: _____)	<input type="checkbox"/> If yes, how many years? _____ How often do you check blood sugar? _____ What was your last HbA1C date? _____ HbA1C result: _____
Emphysema (COPD)	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/> If yes, how many years? _____ What type? _____
High Blood Pressure	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>
Migraine Headaches	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/> If yes, how many years? _____ What type? _____
Stroke	<input type="checkbox"/> If yes, when? _____
Seizure	<input type="checkbox"/>
Other illnesses (please list)	<input type="checkbox"/> _____ _____

<u>SURGICAL HISTORY</u>			
Type: _____	Date: _____	Type: _____	Date: _____
Type: _____	Date: _____	Type: _____	Date: _____
Type: _____	Date: _____	Type: _____	Date: _____
Type: _____	Date: _____	Type: _____	Date: _____



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Preferred Pharmacy: _____ Location: _____ Phone: _____

MEDICATIONS (Please List ALL) <input type="checkbox"/> See Attached List			
Medications/Vitamins/Supplements	Dose (mg, etc.)	Frequency	Reason for Medication

ALLERGIES <input type="checkbox"/> No Known Drug Allergies	
Allergy	Reaction

FAMILY HISTORY <input type="checkbox"/> No Significant Family History is Known		
DISEASE/CONDITION	<i>Please reference blood relative if marked</i> <input checked="" type="checkbox"/>	
Blindness <input type="checkbox"/>	Asthma <input type="checkbox"/>	Migraine Headaches <input type="checkbox"/>
Cataracts <input type="checkbox"/>	Cancer <input type="checkbox"/>	Thyroid Disease <input type="checkbox"/>
Crossed Eye, Lazy <input type="checkbox"/>	Diabetes <input type="checkbox"/>	Stroke <input type="checkbox"/>
Glaucoma <input type="checkbox"/>	Heart Disease <input type="checkbox"/>	Seizure <input type="checkbox"/>
Macular Degeneration <input type="checkbox"/>	High Blood Pressure <input type="checkbox"/>	Other: _____
Other Eye Diseases: _____	Kidney Disease <input type="checkbox"/>	Other: _____

SOCIAL HISTORY		
Tobacco Use	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, Tobacco type: _____
<i>Current:</i> Packs/day _____ # of Years _____		<i>Past:</i> Quit Date _____ Packs/day _____ # of Years _____
Do you drink Alcohol?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Beer <input type="checkbox"/> Wine <input type="checkbox"/> Liquor # of Drinks/week _____
Do you use Marijuana?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, how often: _____
	Consumption type: <input type="checkbox"/> Smoke <input type="checkbox"/> Edible <input type="checkbox"/> Tablet <input type="checkbox"/> Patch <input type="checkbox"/> Vape <input type="checkbox"/> Topical <input type="checkbox"/> Other: _____	
Substance Abuse	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, type: _____ How often: _____
Are you able to Drive?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes: <input type="checkbox"/> Daytime only <input type="checkbox"/> Day & Night
Occupation	<input type="checkbox"/> Retired <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Student <input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled	
Marital Status	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Partner	
Living Conditions	<input type="checkbox"/> With Family <input type="checkbox"/> Alone <input type="checkbox"/> With Caretaker <input type="checkbox"/> In Retirement Center <input type="checkbox"/> In Nursing Home	
Hospice	<input type="checkbox"/> No <input type="checkbox"/> Yes	



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REVIEW OF SYSTEMS			
CONDITIONS	<input checked="" type="checkbox"/> Check all that apply & Circle all conditions that apply to you		<input type="checkbox"/> NONE
CONSTITUTIONAL:	Fever, weight loss, fatigue, loss of appetite, chills, unexplained weight loss, fatigue, loss of appetite, night sweats		
EARS, NOSE, THROAT:	Hearing loss, sore throat, runny nose, dry mouth, jaw claudication, ear ache		
CARDIOVASCULAR:	Chest pain, shortness of breath, swelling of feet, shortness of breath when lying flat, racing pulse, irregular heartbeat, blood pressure stable		
RESPIRATORY:	Wheezing, cough, coughing up blood, severe or frequent colds, difficulty breathing		
GASTROINTESTINAL:	Abdominal pain, nausea, diarrhea, bloody stools, stomach ulcers, constipation, trouble swallowing, gastrointestinal ulcers, jaundice, or yellow skin		
GENITOURINARY:	Genital sores or ulcers, kidney failure, kidney problems, kidney stones, prostatitis, testicular pain, urinary discharge		
MUSCULOSKELETAL:	Muscle aches, joint pain, difficulty lying flat due to musculoskeletal discomfort, pain while sleeping or awakening		
NEUROLOGICAL:	Weakness, headaches, scalp tenderness, dizziness, paralysis of extremities, tremor, stroke, numbness, tingling in body, seizures or convulsions, fainting		
PSYCHIATRIC:	anxiety, depression, ADHD, Alzheimer's, Bipolar disorder, confusion, dementia		
ENDOCRINE:	Excess thirst, excessive urination, heat intolerance, hair loss, dry skin, blood sugars poorly controlled		
HEMATOLOGY/ONCOLOGY:	Easy bruising, prolonged bleeding, breast, prostate, lung, skin, colon, other		
ALLERGIC/IMMUNOLOGIC:	Autoimmune disease, seasonal allergies, unspecified		
OCULAR:	cataract, glaucoma, detached retina, blindness, lazy eye, eye injury/trauma, corneal problems, macular degeneration		
INTEGUMENTARY:	Rash, change in mole, rashes, skin sores, skin cancer, severe itching, loss of hair		
FEMALES:	Are you pregnant?	Are you nursing?	Pregnant Nursing



Acknowledgment of Notice of Privacy Practices

Southwest Eyecare Specialists reserves the right to modify the privacy practices outlined in the notice.

- I have been offered a copy of the Notice of Privacy Practices for Southwest Eyecare Specialists
- I have DECLINED a copy of the Notice of Privacy Practices for Southwest Eyecare Specialists

I authorize Southwest Eyecare Specialists to release Protected Health Information to the following Individual(s) /organization to assist me in the coordination of my care and treatment:

Person(s) to Whom Information May Be Disclosed, Authorized to Use or Disclose Information	
Name of person/organization	Telephone Number
Name of person/organization	Telephone Number

This authorization shall remain in effect until revoked.

I consent to the use or disclosure of my Protected Health Information (PHI) by Southwest Eyecare Specialists, P.C., (SWEC) for the purpose of diagnosis or treatment of any healthcare need as determined by SWEC, for the collection of payment, and for conducting healthcare operations by SWEC. Your health information will be used by our staff to send you appointment reminders. This includes mail, email, voicemail, text-messaging, telephone, and other reasonable attempts. Enrollment in the Patient Information Portal constitutes authorization for the appropriate use of information contained on the portal under privacy and security protocols for PHI. I understand that I have the right to request restriction on how my PHI is used or disclosed at the discretion of SWEC. I have the right to revoke this consent and acknowledgement. A copy of the complete HIPAA Privacy Policy describing individual rights and the duties of SWEC is available for my review. SWEC reserves the right to modify the privacy practices without notice. I have the right to request a printed copy of the current Notice of Privacy Policy. A sample copy of these policies are available in English and Spanish at the HHS website at: <http://hhs.gov/ocr/privacy/hipaa/modelnotices.html>.

Name of Patient (Print or Type)

Signature of Patient

Date

Signature of Patient Representative Relationship of Patient Representative to Patient
(Required if the patient is a minor or an adult who is unable to sign this form)

SOUTHWEST EYECARE SPECIALISTS, PC

FINANCIAL POLICY

Revised January 2021

- **INSURANCE CARDS:** Please make sure the insurance cards presented at each visit are current and accurate.
- **AUTHORIZATIONS:** Some insurance plans require a prior authorization or referral for services by specialists. If your insurance plan requires either; it is your responsibility to obtain this authorization prior to your visit.
- **PAYMENT:** Payment is due when services are rendered. If insurance is being filed you will be responsible for paying any copay, co-insurance and deductible amounts at the time of service. If you are unable to pay these amounts at the time of service your appointment may be rescheduled and/or your account may be subject to a \$20 billing fee. Balances remaining after 3 statements are also subject to billing fee.
- **NON-COVERED SERVICES/DENIED CHARGES:** Certain services may be considered non-covered services or may be denied as investigational, experimental or not medically necessary by your insurance carrier. If your physician feels these services are needed and they are performed, you are obligated to pay for these services in full should your insurance carrier deny payment. Note: Refractions are considered NON-COVERED (See REFRACTIONS below).
- **MEDICAL PLANS WITH VISION BENEFITS:** Please be advised that some medical plans do have routine vision benefits. However, sometimes these vision benefits are with a different insurance carrier. *Southwest Eyecare may participate with your medical plan but not your vision plan.* Please contact your insurance carrier to verify your benefits and whether Southwest Eyecare is a provider for your medical plan. Present all insurance cards at check-in and inform check-in if your visit is for routine vision care or to be filed to your medical insurance.
- **MEDICAID/CENTENNIAL PROGRAMS:** Southwest Eyecare participates in these programs by doctor referral only and only for medical conditions. Southwest Eyecare does not participate in the routine portion of these plans. Medicaid patients are required to see in-network optometrists for routine vision services as we are unable to provide glasses RX.
- **RETURNED CHECKS AND PAST DUE AMOUNTS:** Returned checks will be subject to collection charges, penalties and interest. All accounts are considered past due if not paid within 60 days of service. Past due accounts may result in collection turnover and may be subject to penalties and interest, and/or the refusal of future appointments until old balances have been paid in full. Southwest Eyecare does not accept postdated checks.
- **SURGERY CHARGES:** Southwest Eyecare will make every effort to determine your insurance benefits prior to any scheduled surgery. Southwest Eyecare will notify you of an approximate amount you will be responsible for paying prior to the date of surgery. Please keep in mind that this is just an estimate. You may incur other charges (in addition to the surgeons' fee) from the surgery facility, anesthesiologist, laboratory and/or radiologist.
- **CANCELLATION POLICY:** All appointments that are not cancelled within 24 hours of the appointment will be subject to a **\$30 NO SHOW fee**. The \$30 fee must be paid before we can reschedule your appointment.
- **VISION PLANS:** **Southwest Eyecare does not participate in any vision plans. We also do not fit or prescribe** contact lenses. If you are here for a routine vision exam (there are not medical concerns or chief complaint) you will be responsible for payment in full at time of service. **Routine vision exams are NOT filed to insurance and the fee of \$138 plus tax is due at checkout.**
- **REFRACTIONS:** Refraction is the process of determining if there is a need for corrective lenses. It is an essential part of an eye exam and necessary in order to write a prescription for glasses. We will file the charge for the refraction with your health insurance, we are not contracted with any vision plans. In the event the charge for the refraction is not covered by your health insurance a fee of \$55 will be applied to patient responsibility.

FINANCIAL POLICY

RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS

I have read and understand this Financial Policy. I authorize payment of the insurance benefits directly to Southwest Eyecare Specialists, PC and promise to assist in the processing of claims for benefits. I authorize any holder of medical information about me to release such information to my insurance carrier or its agents as needed to determine these benefits or the benefits payable for related services.

MEDICARE LIFETIME AUTHORIZATION (applies to Medicare patients only)

I request the payment of authorized Medicare. Medicaid/MediGap benefits to be made on my behalf to Southwest Eyecare Specialist, PC for any services provided to me by that provider of care. I authorize any holder of medical information to release to Social Security Administration, CMS and/or its agents information needed to determine these benefits payable for related services.

If you are unable to meet this policy, please speak to the Patient Account Representative in our Billing office to arrange a payment schedule that is agreeable to both parties. I acknowledge, understand, and accept the Southwest Eyecare Specialist, PC Financial Policy as indicated by my signature below.

Patients Name (Please Print): _____

Patients Signature: _____ **Date:** _____

Parent/Representative/Authority: _____ **Date:** _____

NOTE: Effective January 1, 2011 Southwest Eyecare Specialists will process all checks via desktop deposit. The system uses information from your check to make an electronic fund transfer. Funds may be withdrawn from your account as soon as the same day you make your payment, and you will not receive your cancelled check back from your bank. Please make your payment by credit card if you prefer your check not processed this way. Thank you.



REFRACTION RX Acknowledgement

Refraction is the process of determining your best corrected vision and if there is a need for corrective eyeglasses. It is an essential part of the eye exam and is necessary to write a prescription for glasses. Refraction is NOT a covered service by Medicare or most medical insurance plans. These plans consider a refraction a “vision” service not a “medical” service.

We will file the charge for the refraction with your health insurance, we are not contracted with any vision plans. If covered by health insurance copayments, co-insurance, and deductible are the responsibility of the patient and will be billed accordingly.

In the event the charge for the refraction is not covered by your health insurance a fee of \$55 will be applied to patient responsibility.

By signing below, you acknowledge you have received the Refraction RX policy.

Patients Name (Please Print): _____

Patients Signature: _____ **Date:** _____

Parent/Representative/Authority: _____ **Date:** _____