HUGHES EYE GROUP

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Name (First, Middle Initial, Last):_____

Address: Street:_____ **City:**_____**State:**_____**Zip:**_____

Date of Birth:_____**Social Security #:**_____

Home Phone #:_____**Cell Phone # :**_____

Do you wish to receive appointment reminders via text message? (check one) ____Yes____No

Referring Doctor:_____**Medical Doctor:**_____

Emergency Contact Name:_____**Relation:**_____**Phone #:**_____

E-Mail Address:_____ **Employer:**_____

Patient Preferred Contact Method (check one): ____ Home Phone ____ Cell Phone ____ Email

SPOUSE / GUARDIAN / NEXT OF KIN INFORMATION

Complete if the Patient is not the Insurance Policy Holder

Spouse or Guardian (First, Middle Initial, Last):_____

Relationship to Patient:_____**Spouse**_____**Guardian**_____**Parent**_____**Other:**_____

Address: Street:_____**City:**_____**State:**_____**Zip:**_____

Date of Birth:_____**Social Security#**_____

PERMISSION TO DISCUSS INFORMATION

List names of others that have permission to discuss medical and/or appointment information on your behalf:

Name:_____**Relationship:**_____**Phone#:**_____

Name:_____**Relationship:**_____**Phone#:**_____

Name:_____**Relationship:**_____**Phone#:**_____

HUGHES EYE GROUP MEDICAL HISTORY QUESTIONNAIRE

Name: _____ **Preferred/Nickname**: _____ **Date of Birth**: _____

Primary Physician: _____ **Referring Physician:**_____

Primary Eye Doctor: _____

Pharmacy:_____ **Pharmacy Location** (City/Street):_____

Race: □ African American □ American Indian or Alaska Native □ Asian □ Caucasian
□ Native Hawaiian/Other Pacific Islander

Ethnicity: □ Hispanic □ Not Hispanic

Preferred Language: □ English □ Spanish □ Other: _____

Allergies to Medications: (List medication, type of reaction, and severity of reaction)

_____

Ocular History: (Mark all that apply)

□ Overall Healthy
□ Amblyopia (Lazy eye)
□ Aphakia
□ Astigmatism
□ Cataract
□ Contact Lens Wear
□ Diabetic Retinopathy
□ Dry Eyes
□ Glaucoma
□ Hyperopia (Far sighted)
□ Iritis
□ Keratoconus
□ Macular Degeneration
□ Myopia (Near sighted)
□ Optic Neuritis
□ Retinal Detachment
□ Trauma
Other_____

Ocular Surgeries: (Mark all that apply)

□ No ocular surgery
□ Blepharoplasty
□ Cataract Surgery
□ Corneal Transplant
□ Foreign Body Removal
□ LASIK
□ PRK
□ Punctal Plugs
□ Retinal Laser Surgery
□ RK
□ Strabismus/ Muscle Surgery
□ Trabeculectomy (Glaucoma Surgery)
□ Vitrectomy
□ Yag Capsulotomy (After Cataract Laser)
Other_____

Current Ocular Medications: (Eye Drops, Eye Ointments, Ocular Vitamins, etc)

_____

Medical History:

□ Overall Healthy
□ AIDS
□ Anemia
□ Aneurysm
□ Ankylosing Spondylitis
□ Arthritis
□ Arrhythmia
□ Asthma
□ Bleeding Disorder
□ Cancer
□ Crohn's Disease
□ Congestive Heart Failure
□ COPD
□ Diabetes (Type 1 or 2)
□ Dementia
□ Eczema
□ Fibromyalgia
□ Graves' Disease
□ Headache
□ Hearing Loss
□ Heart Attack
□ High Blood Pressure
□ High Cholesterol
□ HIV
□ Kidney Disease
□ Lung Disease
□ Liver Disease
□ Migraine
□ Multiple Sclerosis
□ Polymyalgia
□ Pregnancy (currently)
□ Psychiatric Disorder
□ Rheumatoid Arthritis
□ Sjogren's Syndrome
□ Stroke
□ Thyroid Disease
□ Ulcerative Colitis
Other:_____

Infection History:

□ Overall Healthy
□ Chicken Pox
□ Hepatitis A / B / C
□ Herpes Simplex
□ Herpes Zoster / Shingles
□ Histoplasmosis
□ HIV / AIDS
□ Meningitis
□ MRSA
□ Syphillis
□ Toxoplasmosis
□ Wound Infection
Other:_____

Previous Surgeries:

_____
_____

Current Systemic Medications: (List below or bring a copy of pharmacy list)
Aspirin or Blood Thinners? **□ No** **□ Yes, please list below**

_____
_____
_____

Have you ever had problems with Anesthesia? □ No □ Yes, reaction:_____

Have you <u>ever</u> taken prostate medicines or Alpha Blockers? □ No □ Yes, circle or list below

Flomax, Tamsulosin, Hytrin, Cardura, Saw Palmetto, Doxazosin, Terazosin, Uroxatral, Rapaflo, Other:_____

Are you interested in Laser Vision Correction? □ No □ Yes

The questions below are required by the Government:

Have you ever had the Pneumonia Vaccine? □ No □ Yes

Have you had a Fall in the past year? □ No □ Yes

(D*efined as 2 or more falls in the past year OR a fall that resulted in injury in the past year)*

Family History: (Applies to gene or "blood" relation only)

□ Unknown Family History

□ Blindness Relation:_____
□ Cancer Relation:_____
□ Diabetes Relation:_____
□ Glaucoma Relation: _____
□ Heart Disease Relation:_____
□ High Blood Pressure Relation:_____
□ Keratoconus Relation:_____
□ Macular Degeneration Relation:_____

Social History: (Mark all that apply)

Smoking: □ every day smoker □ occasional smoker □ former smoker □ never smoked

Alcohol Use: □ No □ Yes, list how much and how often?_____

Recreational Drug Use: □ No □ Yes, list type and how often?_____

Review of Systems: (Mark all that apply)

Eyes
- □ Previous Surgery
- □ Contact Lens
- □ Pain
- □ Double Vision
- □ Glaucoma
- □ Cataracts
- □ Macular Degeneration
- □ Dry Eyes
- □ Flashes
- □ Floaters

Ear, Nose, and Throat
- □ Hard of Hearing
- □ Ringing in Ears
- □ Vertigo

Cardiovascular
- □ Chest Pain
- □ Dizziness
- □ Fainting Spells
- □ Shortness of Breath
- □ Irregular Heart Beat
- □ Difficulty Lying Flat

Constitutional
- □ Fatigue / Weakness
- □ Fever
- □ Weight Gain / Loss

Respiratory
- □ Cough
- □ Congestion
- □ Wheezing
- □ Asthma

Gastrointestinal
- □ Heartburn
- □ Nausea / Vomiting
- □ Jaundice / Hepatitus

Genito-Urinary
- □ Pain / Difficulty
- □ Blood in Urine
- □ History of Kidney Stones
- □ History of STD's

Psychiatric
- □ Anxiety / Depression
- □ Mood Swings
- □ Difficulty Sleeping

Endocrine
- □ Increased Thirst
- □ Increased Hunger
- □ Increased Urination
- □ Increased Sweating
- □ Fingernail Changes

Blood / Lymphnodes
- □ Easy Bruising
- □ Gums Bleed Easy
- □ Prolonged Bleeding
- □ Heavy Aspirin Use

MusculoSkeletal
- □ Stiffness
- □ Arthritis
- □ Joint Pain / Swelling

Skin
- □ Rash / Sores
- □ Lesions
- □ Hives / Eczema

Neurological
- □ Seizures
- □ Weakness / Paralysis
- □ Numbness
- □ Tremors

Immunologic
- □ Hives
- □ Itching
- □ Runny Nose
- □ Sinus Pressure

HUGHES EYE GROUP

Financial Policy & Agreement of Responsibility

We are committed to providing you with the highest level of service and quality care. If you have medical insurance, we strive to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our financial policy. Ultimately, any and all financial liability rests with the patient and their family.

Our office participates with most major insurance plans. We provide MEDICAL and SURGICAL services to our eye care patients. We DO NOT participate in ANY "vision plan." Therefore, if you have a managed care plan that requires a referral to see a specialist, you must obtain a referral for your visit in our office to be covered under your medical insurance. If you do not have the proper referral and still wish to be seen, you will be asked to pay for your visit prior to being worked up by our technicians.

PATIENT RESPONSIBILITY: It is YOUR responsibility to:

- Contact your insurance company to obtain co-pay, coinsurance/deductible information and verify that our physicians are participating, IN-NETWORK, with your insurance
- Provide our practice with correct and current insurance information on or before the date of service
- Bring all your current insurance cards to all visits
- Obtain your insurance referrals and understand your insurance policy

Co-payments, Co-insurance and Deductibles will be collected at the time of service as REQUIRED by our contract with your insurance company. We accept cash, personal checks, Mastercard, Visa, Discover, and American Express. Copayments are charged at the "Specialist" office rate. If you arrive unprepared to pay these required fees, we will need to reschedule your appointment. We do not accept post dated checks, and we do not accept attorney letters promising payment after settlement of accident and/or injury claims.

We appreciate and expect your prompt payment in full for any outstanding balance. If you are unable to pay a balance in full, please notify our billing department immediately. Any payment made by check that does not clear your bank account will result in a $25.00 fee, which will be added to your account and must be paid before your next visit. Unpaid balances of greater than 90 days will be turned over to an outside collection agency for payment. Additional fees are accessed once an account is turned over to collections.

Credit Balances: Our office will routinely refund credit balances pending full payment from your insurance companies. Patient balances less than $25.00 will remain as a credit on your account unless a refund is requested. Despite efforts to refund credit balances, the balance will remain on the account for 3 years before adjustment.

Self-Pay patients: (Patients who have no form of medical insurance). Self-Pay patients will be required to pay fees at the time of service and prior to seeing the doctor. Fees are based on the cost of a basic exam and testing as indicated by the doctor. Full payment is required prior to surgical procedures.

Agreement of Responsibility
I understand that professional services, diagnostic tests and other medical services rendered to the patient are the financial responsibility of the patient or the patient's guarantor (the responsible party in the case of minors). I understand that I am financially responsible for all charges not covered by my insurance company.

Release of Information Assignment of Benefits
I authorize use of this form on all my insurance submissions and authorize release of information needed to process a claim to any of my insurance companies. I permit a copy of this to be used in place of the original. I authorize the provider to act as my agent in helping me obtain payment from my insurance companies. I understand the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement in disputed claims. I assign any rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand I will receive a statement for any balance due by me. I authorize Hughes Eye Group (West Tennessee Eye Associates), its agents, employees and affiliates to access my complete medical records for the purpose of billing and management functions.

Medicare Authorization (if applicable)
I request payment of authorized Medicare benefits be made on my behalf to Hughes Eye Group (West Tennessee Eye Associates), for any services furnished to me by that physician or supplier. I authorize the holder of medical information, about me, to release to Medicare and its agents any information needed to determine these benefits or the benefits payable to related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the release of the information to the insurer to the agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and any uncovered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

I understand the agreement of responsibility, authorize the release of information assignment of benefits and insurance authorization as listed in detail above.
X_____
Initials of Patient or Responsible Party

Breach Notification Act
Under the HITECH Act passed in 2009, The Hughes Eye Center will comply with Breach Notification Rule. Patients will be notified of specified breaches of unsecured protected health information. This notification will occur in a timely manner and no less than 60 days from the date of the breach.

I acknowledge that I have been made aware of this policy.
X_____
Initials of Patient or Responsible Party

Notice of Privacy Practices / HIPAA
Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you in the process of providing treatment, seeking payment or carrying out our own health care operations. This notice contains a Patient Rights section describing your rights under the law. A copy of our current policy is available for your review. Each time you receive treatment or health care services you may request a copy of our current policy.

I acknowledge that I may request a copy of Notice of Privacy Practices.

X _____ **_____**
Signature of Patient or Responsible Party Date