San Augustin Eye Foundation

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PATIENT'S INFORMATION: Please fill form out completely Today's Date: _____

_____ _____ ____ ____-____-____ _____
Last Name First Name MI Date of Birth Age

_____-_____-_____ Married/Widowed/Single/Other _____ _____
Social Security Number Circle One: Marital Status Occupation/Retired Employer

English/Spanish/_____ Mail/Phone/Email/Text Message YES/NO _____
Preferred Language: Other Contact Preference: (Circle) Would you like email updates? If so, please provide email address

Race: White / African Amer / Amer Indian / Asian / Hispanic-Latino / Decline to State Gender: Male/Female
Ethnicity : Hispanic/Latino Not Hispanic/Latino Decline to State

_____ _____ _____
Patient's Home Address City State/Zip Code

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

_____ _____ _____ (____)_____
Patient's Employers Address City State/Zip code Phone Number

_____ ____-____-____ ____-____-____ (____)_____
Spouse's Full name Spouse's SSN Spouse's DOB Spouse's Cell #

EMERGENCY CONTACT: IF UNABLE TO REACH PATIENT

_____ _____ (____)_____ (____)_____
Name Relationship Cell # Work #

IF PATIENT IS A MINOR: PLEASE COMPLETE:

_____ ____-____-____ _____ (____)_____
Parent's Full Name SSN # Date of Birth Phone Number

PHARMACY INFORMATION:

_____ _____ (____)_____
Preferred Pharmacy Street Address State/Zip Phone Number

PHYSICIANS INFORMATION:

_____ _____ (_____)_____
Primary Care Physician Street Address State/Zip Phone Number

_____ _____ (_____)_____
Referring Physician Street Address State/Zip Phone Number

Name: Date:

Please list and **MEDICAL CONDITION** for which you are **CURRENTLY BEING TREATED**, such as high blood pressure, high cholesterol, diabetes, heart disease, cancer, auto-immune disease, immune deficiency, organ transplant.	[ ]None
Please list any **MEDICAL CONDITIONS** for which you have been treated in the past.	[ ]None
Please list and **MEDICATIONS** you are currently taking.	[ ]None
Please list any **EYE PROBLEMS**, current or past.	[ ]None
Please list any **EYE DROPS** you are currently taking.	[ ]None
Please list any **PRIOR SURGERY**, including eye surgery.	[ ]None
Please list any **FOOD OR DRUG ALLERGIES**.	[ ]None
Please list **any EYE DISEASES THAT RUN IN YOUR FAMILY** such as glaucoma, macular degeneration, cataract, diabetic retinopathy.	[ ]None
Please list any **HEALTH PROBLEMS THAT RUN IN YOUR FAMILY**.	

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLING?

PLEASE CIRCLE 'Y' OR 'N' FOR EACH QUESTION

Y N CHRONIC FEVER	Y N VOMITING	Y N IRREGULAR HEAERTBEAT	Y N SWOLLEN JOINTS
Y N DIARRHEA	Y N HEADACHES	Y N SHORTNESS OF BREATH	Y N NUMBNESS
Y N FATIGUE	Y N BLOOD IN URINE	Y N ASTHMA	Y N WEAKNESS
Y N HEARING LOSS	Y N SKIN RASHES	Y N COUGHING	Y N PARALYSIS
Y N SINUS PRIOBLEMS	Y N DRY SKIN	Y N UNEXPECTED WEIGHT LOSS	Y N ANXIETY
Y N SORE THROAT	Y N MUSCLE ACHES	Y N ABDOMINAL PAIN	Y N HEARTBURN
Y N CHEST PAIN	Y N JOINT PAIN	Y N URINARY PAIN/DISCOMFORT	

Do you drink alcohol? YES/NO

Have you ever Smoked? YES/NO

San Augustin Eye Foundation

Acknowledgment of Receipt of Notice of Privacy Practices

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examinations and test results, diagnoses, treatments, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which third-party payer can verify that services billed were actually provided.
- As a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I have been provided with a **Notice of Privacy Practices** that gives a more complete description of information uses and disclosures as well as a description of my privacy rights. I understand that I can review the notice prior to signing this acknowledgment. I understand that the organization reserves the right to change their notices and practices and will provide me with a copy of any revised notice.

_____
Patient's Printed Name

_____
Signature of Patient or Legal Representative

_____
Witness

_____
Today's Date

Release of Information

[ ] I authorize the release of information including the diagnosis, records, exam results, medication dosage, and claims information to the following designated person(s).

Last, First Name	Relationship	Home #	Cell #
		(____)_____	(____)_____
		(____)_____	(____)_____

[ ] I **do not** authorize my information to be released to anyone other than myself.

_____
Patient's Printed Name

_____
Signature of Patient or Legal Representative

_____
Witness

_____
Today's Date

San Augustin Eye Foundation
FINANCIAL POLICY

We are committed to providing you with the highest level of service and quality care. If you have medical insurance, we will 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, however, any and all financial liability rests with the patient.

Our office participates with most major insurance plans. We provide **MEDICAL and SURGICAL** ophthalmologic care to our patients, as opposed to **routine eye exams**. We do not participate with **ANY** vision plans (except Superior Vision). **If you have a managed care plan that requires a referral to see a specialist, you must obtain a referral in order for your visit in our office to be covered under your medical insurance.** If you do not have the valid referral and still wish to be seen, you will be asked to pay for the visit prior to your examination. **A refractive examination is not a covered service by most insurance companies, including Medicare.**

It is the patient's/parent's/guardian's responsibility to:

- Be familiar with the benefits of your plan, including co-pays, co-insurance and deductibles.
- Bring all of your current insurance cards to all visits.
- Provide our office with current information including address, phone numbers and employer.
- In accordance with your insurance contract, you must be prepared to pay your co-pay at each visit. If you do not make your co-payment at the time of the visit, you will be charged an additional **$15 billing fee**. We accept cash, checks, Care Credit and most major credit cards.

We appreciate prompt payment in full for any outstanding balance. Any check payments that do not clear the bank will be subject to a **$35.00** returned check fee. **There is a charge for completing various forms, including your DMV form. Pre-payment is required for completing forms, or for extra written communication by the doctor. The charge is determined by the complexity of the form, letter, or communication.**

For all services rendered to minor/dependent patients, we will look to the adult accompanying the patient and/or the parent or guardian with whom the child resides for payment. In cases of separation or divorce, when presenting insurance cards for a dependent enrolled under a subscriber other than you, please be prepared to supply their name, address, phone number, date of birth and social security number. We request that you inform the subscriber that their insurance has been used.

Any patient who cancels a scheduled appointment with less than 24 hours notice of the appointment, or does not show up for the appointment, will be charged a cancellation fee of **$25.00**. Legitimate emergencies will be taken into consideration.

Any patient, who is scheduled for an elective surgery, at either the St. Augustine Surgery Center or at Flagler Hospital, is given 24 hours, **which starts at the time of scheduling**, to either cancel or reschedule. Any patient, who cancels or reschedules their surgery, more than 24 hours after scheduling, or does not show up, will be subject to a **$100** fee. Legitimate emergencies will be taken into consideration.

I have read and understand the above financial policy.

_____ _____
Signature of patient/guardian/parent Date

_____ _____
Printed name of patient Date