Name: Age:

Chart: DOB:

Date:

HAIK HUMBLE EYE CENTER

Patient Information

last name	first name	middle	maiden name	home phone
Test	**Test**			

street address/p.o. box/route	city	state	zip	social security number	date of birth	age	sex
							☐ M ☐ F

Race: ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Asian ☐ White ☐ Black or African American ☐ Other _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

cellular phone	email address	Primary Language: ☐ English ☐ Other _____	employer name and occupation

employer address	city	state	work phone	workman's compensation? ☐ yes ☐ no

marital status	spouse's name	spouse's social security #	spouse's birthdate	spouse's work phone

spouse's employer and occupation	spouse's employer address	city	state	zip

Payment / Insurance Information

How will you pay for today's visit?

☐ Medicare ☐ Medical Insurance ☐ Vision Insurance ☐ Self-Pay ☐ Worker's Comp

medicare number	medicaid number	medicare supplement	policy number

insurance company	policy number	group number	name of insured

Guarantor Information (for children)

last name (father)	first name	middle	phone

billing address/p.o. box/route	city	state	zip	social security number	date of birth

employer	occupation	work phone number

last name (mother)	first name	middle	maiden name	phone number

billing address/p.o. box/route	city	state	zip	social security number	date of birth

employer	occupation	work phone number

Emergency Contact (not in same household)

name	relationship to patient

address	city	state	zip	phone number

Referred By: Please indicate who referred you so we may thank them.

☐ Family/Friend ☐ Radio ☐ Newspaper ☐ Yellow Pages ☐ TV ☐ Billboard ☐ Website/Internet ☐ Direct Mail

☐ Doctor _____ ☐ Nurse Practitioner _____ ☐ Other _____

referring person or doctor's name	Has any member of your family ever been treated by our clinic?
	☐ yes ☐ no ☐ don't know name(s): _____

Please read the following statements and sign:

I authorize release of medical information. I consent to photography. This authorization shall be binding indefinitely from the date of signature. A copy of this release will be as legal and binding as the original.

I understand all office visits are to be paid at the time services are rendered. I also realize that I am responsible for payment before filing my insurance. For any services rendered I request that payment of authorized Medicare, Medicaid, or insurance benefits be made to Eye Associates of Northeast Louisiana and Surgery Center of West Monroe. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration, insurance company and its agents any information needed to determine these benefits or benefits for related services.

A monthly interest charge of 1 1/2% per month (18% annually) may be added to all past due accounts (over 60 days). Any account with a pending balance over 90 days may be referred for collection.

Due to danger to myself and others, I realize I should not drive while my eye is dilated, medicated, or patched.

Signature of patient or guardian: _____ Date: _____

Name: Age:

Chart: DOB:

Date: Referring Dr:

Any past eye problem? _____

Describe the reason for your visit today: _____

_____

Family Doctor _____ **Pharmacy/Street Address** _____

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? ☐ **Yes** ☐ **No**

Have you been treated for any of the following?

Yes	No	*(please mark yes or no)*
☐	☐	HIV / AIDS
☐	☐	Allergies (Hay Fever, Skin Rash)
☐	☐	Arthritis
☐	☐	Cancer (including skin cancer)
☐	☐	Cardiovascular (Heart, Vessels)
☐	☐	Cataract
☐	☐	Cholesterol (High / Low)
☐	☐	Crossed Eyes
☐	☐	Diabetes
☐	☐	Ear/Nose/Throat (Sinus, Infection)
☐	☐	Glaucoma
☐	☐	Hepatitis
☐	☐	High Blood Pressure
☐	☐	Lungs (Asthma/Emphysema)
☐	☐	Retinal Detachment
☐	☐	Stroke
☐	☐	Thyroid
☐	☐	Tuberculosis (TB)

OTHER:_____

Family History

Yes	No	*(please mark yes or no)*
☐	☐	Arthritis
☐	☐	Blindness
☐	☐	Cancer
☐	☐	Cataracts
☐	☐	Diabetes
☐	☐	Glaucoma
☐	☐	Heart Disease
☐	☐	Hypertension
☐	☐	Macular Degeneration
☐	☐	Retina Disease
☐	☐	Stroke
☐	☐	Thyroid Disease

Alcohol

☐ Never
☐ Once a month or less
☐ 2 to 4 times a month
☐ 2 to 3 times a week
☐ 4 or more times a week

Living Conditions:

☐ Single ☐ Married
☐ Widowed ☐ Nursing Home

Smoking

☐ Never smoker
☐ Current every day smoker
☐ Current some day smoker
☐ Heavy tobacco smoker
☐ Light tobacco smoker
☐ Former smoker

Hobbies / Activities

☐ Golf ☐ Hunting / Fishing
☐ Water Sports ☐ Computer Work
☐ Tennis ☐ Needlepoint
☐ Reading ☐ Other _____

List any past surgeries (including any past eye surgeries)

☐ No Past Surgeries

_____
_____
_____

List current Rx & over-the counter medications, including eyedrops

☐ No Active Medications

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

List Medication Allergies:

☐ No Known Drug Allergies

_____
_____
_____
_____
_____
_____
_____
_____
_____

What additional services would you like to learn about? Please check all that apply.

☐ Seeing without glasses or contacts
☐ Computer Eyewear
☐ Colored Contact Lens
☐ Drooping brow or eyelid
☐ Botox Cosmetic
☐ Cosmetic Filler (Juvederm)
☐ Facial fine lines/wrinkles
☐ Facial veins/redness/blotchy skin
☐ Brown spots/Age spots/Freckles
☐ Laser hair removal
☐ Scar revision
☐ Body contouring

I agree that Haik Humble Eye Center may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

Signature of patient or guardian: _____ Date: _____

Name: Age:
Chart: DOB:
Date:

EYE ASSOCIATES OF NORTHEAST LOUISIANA •• SURGERY CENTER OF WEST MONROE

NOTICE OF PRIVACY PRACTICES

This is only a summary of our Notice of Privacy Practices. We encourage you to read the full Notice posted in our lobby. If you would like a paper copy, please ask the receptionist.

HOW WE USE AND DISCLOSE YOUR INFORMATION

We will obtain your written authorization for any uses and disclosures of protected health information "PHI" not described in the Notice of Privacy Practices.

Treatment, Payment, and Health Care Operations. We may use your PHI in order to provide your medical care; to bill for our services and to collect payment from you or your insurance company; and for the general operation of our business.

Marketing, Fundraising, and Sale of PHI. We will obtain your prior written authorization before sending you certain marketing communications. We may use or disclose your demographic information in order to contact you for our fundraising activities, but you have the right to opt out of such communications. If you do not wish to be contacted, please contact our Privacy Officer. We will not sell your health information or otherwise use or disclose your medical information for marketing purposes without your prior written authorization.

We may use your PHI as otherwise authorized or required by law for such purposes as:

- public health reporting and oversight activities
- judicial, administrative, or law enforcement proceedings
- complying with workers' compensation laws
- communicating with your family or caregivers
- sending appointment reminders

YOU HAVE THE RIGHT TO:

- Request certain restrictions on our use and disclosure of your PHI.
- Request communications from us by specific means or locations.
- Receive an accounting of disclosures of your PHI by our practice.
- Inspect and copy your medical record.
- Ask us to correct the information in your medical record.
- Be notified in the case of a breach of unsecured PHI.

CONTACT US

Contact our Privacy Officer with any questions, comments, or complaints or to exercise any of your rights:

Kasey Smalling, Administrator
1804 N 7th Street • West Monroe, LA 71291 | Ph: (318) 325-2610

By signing this form, you acknowledge that you have been informed that Eye Associates of Northeast Louisiana and Surgery Center of West Monroe provide information about how we may use and disclose your protected health information.

Eye Associates of Northeast Louisiana and Surgery Center of West Monroe may use the following methods of communicaiton regarding information related to my personal health, treatment or payment for treatment. I acknowledge I am responsible for updating this information as necessary. This request supersedes any prior request for methods of communication I may have made.

☐ Contact me by phone at home_____ ☐ Work_____ ☐ Cell_____
☐ May leave a message on my voice mail/answering machine ☐ Email_____
☐ May speak to anyone who answers the phone
☐ May only speak to_____
☐ May leave a message for me at my work phone number.

Signature:_____ Date:_____
(Patient / Parent / Conservator / Guardian)

Practice Representative:_____

EYE ASSOCIATES OF NORTHEAST LOUISIANA

SURGERY CENTER OF WEST MONROE

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

Beneficiary Name	HIC Identification Number	DOB	Chart ID:

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Eye Associates of Northeast Louisiana and Surgery Center of West Monroe for any services furnished to me by Eye Associates of Northeast Louisiana and Surgery Center of West Monroe. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payble for related services. I understand my signature requests that payment be made and authorizes releases of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Eye Associates of Northeast Louisiana and Surgery Center of West Monroe accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2. **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Eye Associates of Northeast Louisiana and Surgery Center of West Monroe, if possible or otherwise to me.

3. **RELEASE OF INFORMATION:** Eye Associates of Northeast Louisiana and Surgery Center of West Monroe may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Eye Associates of Northeast Louisiana and Surgery Center of West Monroe for reimbursement for services rendered, and (2) any health care provider for continued patient care. Eye Associates of Northeast Louisiana and Surgery Center of West Monroe may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

4. **OTHER INSURANCE:** I understand that Eye Associates of Northeast Louisiana and Surgery Center of West Monroe maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office and that Eye Associates of Northeast Louisiana and Surgery Center of West Monroe has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Eye Associates of Northeast Louisiana and Surgery Center of West Monroe if I belong to a plan that does not appear on the above mentioned list.

5. **NON-COVERED SERVICES:** I understand that Eye Associates of Northeast Louisiana and Surgery Center of West Monroe's contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient and treatment or tests not authorized by the health care to obtain necessary health care service plan authorizations.

6. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Eye Associates of Northeast Louisiana and Surgery Center of West Monroe), I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Eye Associates of Northeast Louisiana and Surgery Center of West Monroe for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Eye Associates of Northeast Louisiana and Surgery Center of West Monroe. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Eye Associates of Northeast Louisiana and Surgery Center of West Monroe. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

X _____ _____

Beneficiary Signature or Authorized Party | Date