

The Eye Center Surgeons and Associates

401 Meridian Street, Suite 200
Huntsville, AL 35801

Chart # _____

Patient Authorization to Use and / or Disclose Protected Health Information

I understand that under HIPAA guidelines, The Eye Center is authorized to use or disclose my Protected Health Information as stipulated in the Notice of Privacy Practices. In addition to the examples of uses and disclosures described in the Notice of Privacy Practices I additionally authorize the release of my Health Information to the person(s) listed below:

Name _____ Relationship _____

Name _____ Relationship _____

How We May Contact You

We may use and disclose medical information to contact you as a reminder that you have an appointment for medical care with or that you are due to receive periodic care from The Eye Center. This contact may be made by phone, in writing, by note card stating the type of exam you are due for, or otherwise and may involve the leaving of a message on an answering machine, with a contact person who answers the phone or reads the written reminder. This contact could potentially be received by or intercepted by others. The Eye Center may contact you at any phone number or address that you provide to us. If you do not wish for us to contact you at a specific number/address that you have provided, you must stipulate as to the nature of the restriction in writing. The Eye Center will make every effort to comply with your request but is not responsible for inadvertent contact made in the course of normal business operations.

Restrictions as to how I may be contacted are: _____

Restrictions to the Use and / or Disclose of Your Protected Health Information

If you have chose to restrict the Use and / or Disclosure of Your Protected Health Information you can list the restriction(s) below:

This authorization permits The Eye Center to send the protected health information ONLY to this address or fax number. Any other address or fax number is not permitted by this authorization.

The patient has a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during contestability period. In order for the revocation of this authorization to be effective, The Eye Center must receive the revocation in writing. This revocation must include:

- The patient's name, address, and date of birth,
- The effective date of this authorization, and the recipients of the protected health information according to this authorization,
- The patient's desire to revoke this authorization, and
- The date of the revocation, and the patient's signature.

The Eye Center will accept written revocations of this authorization via U.S. Mail or Facsimile at 256-705-3957. ALL revocations must be sent to The Eye Center to the attention of the Privacy Officer, Diane Castillo, C.O.A. and are not effective until received by the Privacy Officer.

This authorization is indefinite and can only be revoked as described above. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be Protected Health Information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below. This authorization is to be used for our own use, and The Eye Center will not condition treatment or payment on this authorization. Moreover, the patient has a right to inspect or copy the information to be used or disclosed and may refuse to sign this authorization.

I have read this authorization and understand what information will be used or disclosed, who may used and disclose the information, and the recipient(s) of that information. I specifically authorize any current employee or owner of The Eye Center to disclose my protected health information as described on this form to the recipients listed. I fully understand and accept the terms of this authorization.

Patient's Signature

Date

I acknowledge receipt of the Notice of Privacy Practices form which details how Protected Health Information may be used and disclosed, and how I may access that information.

Patient's Signature

Date

Witness



Surgeons and Associates, L.L.C.

Service 1st Bank Building
401 Meridian Street
Huntsville, AL 35801

Phone (256) 705-3937

Dear _____

Appt: _____

To see Dr.: McCoy Derivaux Hindman Stevens Malone

Thank you for choosing us to handle your eye care needs. We would like your visit to our office to be as pleasant as possible, so we would like to share some of our concerns and policies with you.

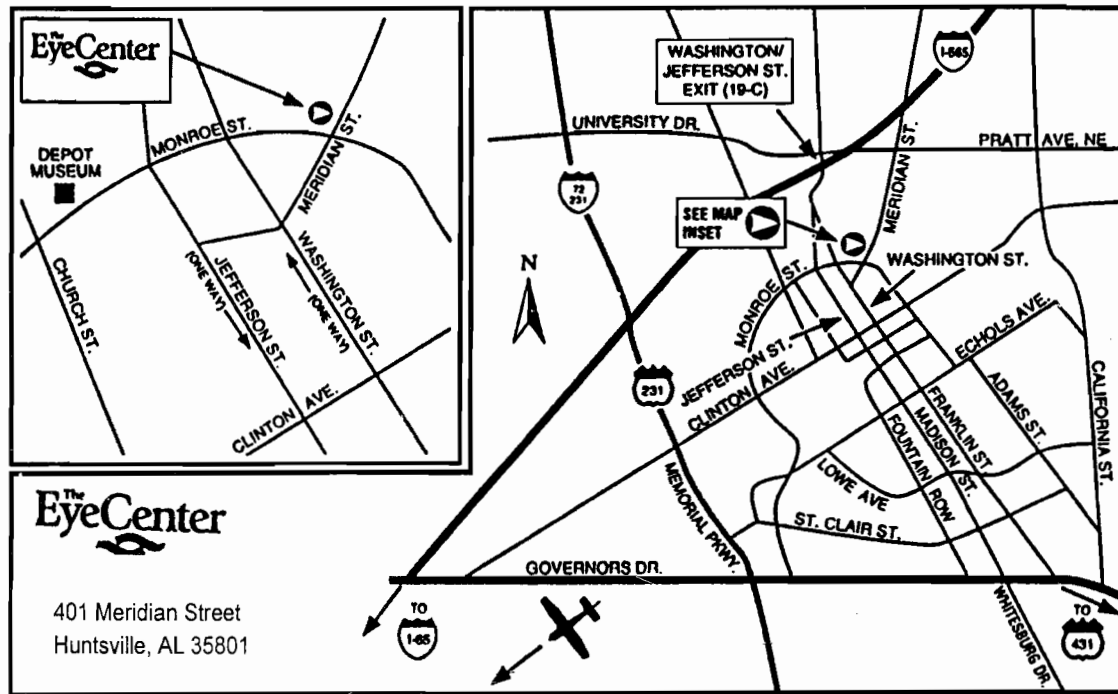
Please complete the enclosed forms and bring them to the office with you on your visit. We understand that you may have completed paperwork in the past but your insurance company dictates that we update your history yearly. If the appointment is for a child under the age of nineteen, a parent must accompany them to the office on each visit.

We don't participate in all insurance plans and request that payment be made at the time of service for nonparticipating plans. We will file for covered items on any participating plan. **Please check with your insurance company to determine whether our physicians are participants of your plan before coming to the office.** It is your responsibility to pay your copay, deductible, and any noncovered services. Some insurance companies do not pay for routine eye exams, so you must have a medical problem for the insurance to be considered. If your insurance requires a physician referral, you must get this before making an appointment otherwise your visit is not covered and payment is requested at the time of the visit. **Bring all insurance cards, Medicare, BCBS, Medicaid and all others.**

Refraction (a reading done to decide corrective lenses) and contacts are usually not covered. You will be asked to pay for these services. **Please bring your glasses and contacts on the day of your visit.**

APPOINTMENTS USUALLY TAKE 2 - 3 HOURS. It takes this long for work-up and preliminary exam by a technician, dilation of the pupils, and physician's exam. Many complain of light sensitivity after dilation, if you own dark/sun glasses please bring them. Dark disposable glasses are available. You may want to bring someone to drive after your visit.

If you have any questions, please do not hesitate to call.



HWY 231 North/South:

From Memorial Parkway, Take the Downtown/Clinton Exit, turn right (east) onto Clinton Avenue. From Clinton, turn left onto Monroe Street (see instructions below from Monroe Street).

I-565 East:

From the east, HWY 72 becomes I-565. Take I-565 east to exit 19 A Jefferson Street. Turn left at ramp at the first intersection, turn left onto Monroe Street. We are in the first building on the left immediately past the park.

I-565 West:

From the west, 565 (Madison) exit 19 C towards downtown, Jefferson Street at light. Turn left onto Monroe. Our office will be on the left.

HWY 431 East:

Go over Monte Sano Mountain on HWY 431 to Governors Drive past Huntsville Hospital East. Turn right(north) onto Frankin Street. Proceed through the downtown area. Turn right off of Franklin/Washington Street onto Monroe Street (see instructions below from Monroe Street).

On Monroe Street, head northeast, immediately past the Washington Street intersection of Monroe, to the left is the Meridian Pointe Building. You will see the Service 1st Bank Building located on the ground level of the building. If you enter through the Meridian Street entrance our office will be on ground level.



Surgeons and Associates, L.L.C.

Service 1st Bank Building • Second Floor • 401 Meridian Street • Huntsville, AL 35801
(256) 705-EYES (3937)

Today's Date _____

Patient Billing Information

Chart # _____

Patient's Name (last, first, middle initial)			Date of Birth		Sex	Home Phone
Street Address		City		State	Zip	Work Phone
Referring Physician			Family Physician			Cell Phone
Is Patient? Single [] Married [] Widowed [] Divorced [] Full-time Student [] Part-time Student []						Social Security #
Employer's Name		Street Address			Is patient's condition related to? A. Employment [] B. Auto Accident [] C. Other Accident [] If yes, explain _____ _____ Date of accident _____	
Business Phone	City		State	Zip		
Spouse Name (last, first, middle)		Date of Birth	Social Security #			
Spouse's Employer	Business Phone	Emergency Contact (does not live with you)			Relationship	Phone #

If patient is a child, please complete:

Father's Name		Street Address			Home Phone
SS #	DOB	City	State	Zip	Work Phone
Mother's Name		Street Address			Home Phone
SS #	DOB	City	State	Zip	Work Phone

Complete the Insurance information below

Do you have Medicare? Yes [] No []		Do you have Medicare Part B? Yes [] No []	
Do you have Medicare Part D? Yes [] No []		Are you under Hospice Care? Yes [] No []	
Do you have Supplemental Insurance? Yes [] No []			
If so please provide the following information: Company: _____ Contract Number: _____			
If you DO NOT have Medicare please provide us with your Insurance Information:			
Insured Name: _____		Contract Number: _____	
Group Number: _____		Relationship to Patient: _____	

Please complete back of form!

Patient Billing/Payment Authorization

Each patient is responsible for obtaining a referral if one is required by your insurance carrier. It is the patient's responsibility to ensure that The Eye Center is a participating provider with their insurance carrier. If The Eye Center is a participating provider with the patient's insurance carrier, we will file your claim for your office visit or surgery and allow 45 days for payment in full. If you do not have insurance, do not have a referral for the service date or we are not a participating provider with your insurance carrier, payment is expected at the time services are rendered.

Co-payments and non-covered fees, such as refraction fees, are the responsibility of the patient and are due at the time of service.

A refraction is a reading to determine your best corrected vision. Insurance does not usually cover the cost of refractions.

It is the policy of The Eye Center to collect payments in full at the time of service. If your visit is a result of an injury or accident involving a lawsuit, (excluding workers comp), we will gladly provide receipts for all services rendered for your reimbursement.

Extended Patient Signature Authorization

Authorization for The Eye Center, 401 Meridian Street, Huntsville, AL 35801

I request that payment of authorization Medicare benefits be made either to me or on my behalf to The Eye Center for any services or items furnished to me by the physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration or other insurance company and its agents any information needed to determine these benefits or the benefits payable for related services.

I request that payment of (*patients insurance company/companies on file*) benefits be made directly to The Eye Center.

By signing below, I understand that routine vision care, refractions fees, diagnostic testing, and co-pays may not be covered by my insurance carrier and I am responsible for these services at the time they are rendered.

*

Signature of beneficiary or person signing for beneficiary

Date signed

Parental Consent for the Treatment of a Minor

Please be advised that anyone seeking medical treatment or routine eye care under the age of 19 is required to have parental consent. This consent must be given by a parent or legal guardian. Your signature below gives us consent to provide the necessary medical care and/or vision care deemed necessary by the physician providing the care.

By signing below you additionally accept financial responsibility for the treatment of the dependant child. All co-pays and/or fees are the responsibility of the guarantor presenting the minor for services/treatment regardless of any legal and/or verbal agreement between the parents.

Patient's Name

Guarantor's Signature

Guarantor's DOB

Relationship of guarantor

Guarantor's Social Security #

Today's Date

M / F
Sex of the guarantor

Family History and Visual Inventory

Your Eye History...

Right	Left		Right	Left	
_____	_____	Amblyopia (lazy eye)	_____	_____	Muscle Disorder
_____	_____	Cataract	_____	_____	Lacrimal Obstruction
_____	_____	Corneal Transplant	_____	_____	Macular Degeneration
_____	_____	Diabetic Retinopathy	_____	_____	Retinal Detachment
_____	_____	Glaucoma	_____	_____	Iritis
_____	_____	Eye Injury, please provide date _____	Describe: _____		

List all eye medications you use (including over-the-counter meds):

_____, _____, _____, _____

Have you ever worn glasses or contact lenses? Yes No How old is your prescription? _____

Are you happy with your current glasses? Yes No or Do you need an eye glass exam? Yes No

Your Family History...

Do/did any family members have?	Yes	No	Father	Mother	Sibling	Other, explain
Blindness	_____	_____	_____	_____	_____	_____
Cataract	_____	_____	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	_____	_____
Macular Degeneration	_____	_____	_____	_____	_____	_____
Strabismus (crossed eye)	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Thyroid Disease	_____	_____	_____	_____	_____	_____

Social History...

		Yes	No		Yes	No
Marital Status: S M W D	Live alone?	_____	_____		Nursing Home	_____
Do you?	Smoke?	_____	_____		Chew Tobacco	_____
	Use Drugs?	_____	_____		Drink Alcohol	_____

I have reviewed both sides of this questionnaire with patient

Date	MD Initials	Date	MD Initials	Date	MD Initials
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

YOUR PHYSICIAN WOULD LIKE TO PROVIDE YOU WITH THE HIGHEST QUALITY CARE POSSIBLE. TO ASSIST HIM/HER, WE ASK THAT YOU COMPLETE THE FOLLOWING HEALTH HISTORY SO THAT YOUR OVERALL HEALTH MAY BE ASSESSED AND INCORPORATED INTO YOUR EYE CARE.

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Sex: M F Age: _____ Today's Date: _____

Current EYE Problem: _____

Drug Allergies: _____

Are You On Blood Thinners? Yes No If Yes, Which? _____

Who is your Family Physician? _____

YOUR MEDICATIONS

List All Medications you take, including Over-The-Counter medicines and vitamins/supplements:

_____	_____
_____	_____
_____	_____
_____	_____

MEDICAL HISTORY

Do You Have a Problem With:	Yes	No	If yes, please explain	Yes	No	If yes, please explain
Skin Disease	_____	_____	_____	_____	_____	_____
Head (Headaches)	_____	_____	_____	_____	_____	_____
Ear/Nose/Throat/Mouth	_____	_____	_____	_____	_____	_____
Lungs/Breathing(TB/Asthma)	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stomach/Intestines	_____	_____	_____	_____	_____	_____
Genitals/Kidney/Bladder	_____	_____	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____	_____	_____
Bones/Joints/Muscles	_____	_____	_____	_____	_____	_____
Neuro/Stroke	_____	_____	_____	_____	_____	_____
Lymph Nodes/Swelling	_____	_____	_____	_____	_____	_____
Other Problems: Please List:	_____	_____	_____	_____	_____	_____
Treatment	_____	_____	_____	_____	_____	_____

OPERATIONS

List any previous operations, general and eye related	Date	Complications or Difficulties
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Please Complete Back Of Form!