EYECARE EAST
9031 Valley Crest Lane
Germantown, TN 38138
(901) 757-2020

SQUARE EYECARE
50 North Main
Collierville TN 38017
(901) 404-7017

eyesociety
6450 Poplar Avenue
Memphis, TN 38117
(901) 797-9000

Fayette Eye Associates
3161 Hwy 64
Lads, TN 38029
(901) 465-3110

PATIENT INFORMATION AND HISTORY QUESTIONNAIRE

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____ ST: _____ Zip: _____

Telephone Preferred: _____ Alternative: _____

Email: _____ SSN: _____

Date of Birth: _____/_____/_____ Occupation/Grade: _____ Employer/School: _____

Sex: _____ Race: _____ Ethnicity: _____

Marital Status:
○ Single ○ Married ○ Domestic Partner
○ Separated ○ Divorced ○ Widowed

Preferred Contact Method:
○ Mobile Phone ○ Home Phone ○Work Phone
○ Email

How did you hear about us _____

MEDICAL INSURANCE

Primary Medical Insurance: _____ ID #:_____

Primary Policyholder's Name: _____ Relation to Patient: _____

Policyholder's Date of Birth: _____/_____/_____ Policy holder's SSN: _____

Secondary Medical Insurance: _____ ID # _____

Secondary Policyholder's Name: _____ Relation to Patient: _____

Policyholder's Date of Birth: _____/_____/_____ Policyholder's SSN_____

VISION PLAN

Vision Plan: _____ Policyholder's Name: _____

Primary Policyholder's Name: _____ Policy holder's SSN: _____

Date of Last Eye Exam: _____ Last Eye Doctor: _____

What Concerns are you having with your Eyes/Vision? _____

_____

Do you use any of the following: Alcohol Yes/No If Yes, how much_____

Tobacco Yes/No If Yes, how much _____

Illegal Drugs Yes/No If Yes, how much _____

Have you ever been infected with: (circle) Gonorrhea/Hepatitis/HIV/Syphilis

Primary Care Physicians: _____ Date of Last Visit: _____ Do

You Have Any Allergies? (If yes, please list) _____ Are

You Allergic To Any Medications? _____ What

Medications Are You Currently Taking? (Prescribed, Over the Counter, and Eye)

REVIEW OF SYSTEMS

Eyes: Are YOU currently experiencing, or have YOU ever had any of the following? Mark ALL that apply.

❒ NONE	❒ Blurred Vision	❒ Double Vision
❒ Loss of Vision	❒ Eye Injury	❒ Flashes
❒ Floaters	❒ Glare/Halos	❒ Crossed/Lazy Eye
❒ Cataracts	❒ Glaucoma	❒ Eye Pain/Soreness

Review of Symptoms: Are YOU currently experiencing, or have YOU ever had any of the following? Mark ALL that apply.

❒ NONE	❒ Cancer	❒ Asthma
❒ Eczema	❒ Hearing Loss	❒ Bronchitis
❒ Psoriasis	❒ Sinusitis	❒ Emphysema
❒ Rosacea	❒ Epilepsy	❒ Acid Reflux
❒ Herpes Zoster/Shingles	❒ Stroke/CVA	❒ Crohn's Disease
❒ Diabetes Type I	❒ Migraines	❒ Ulcer
❒ Diabetes Type II	❒ Depression	❒ Benign Prostate Hypertrophy
❒ Thyroid Dysfunction	❒ Attention Deficit Disorder	❒ Kidney Disease
❒ Hormonal Dysfunction	❒ Anxiety Disorder	❒ Pregnant/Nursing
❒ Anemia	❒ Bipolar Disorder	❒ Arthritis
❒ Drug Allergies	❒ Hypertension	❒ Osteoarthritis
❒ Environmental Allergies	❒ Heart Disease	❒ Fibromyalgia
❒ Lupus	❒ Rheumatoid Arthritis	❒ Sjogren's Syndrome

Please list any additional conditions you have that are not listed above:

Privacy Policy

Acknowledgement of Receipt of Notice of Privacy Policy

Your privacy is important to us. Please list an authorized person with whom we may discuss your Protected Health Information (PHI). Please notify us if you desire to remove a name from this list in the future.

	Authorized Person	Relationship
1.		
2.		
3.		
4.		

FAMILY MEDICAL HISTORY **- This section is regarding family members (not including yourself).**

Mark any ocular conditions that apply to a FAMILY MEMBER. (Please list the relation.)

❒None	❒Macular Degeneration	❒Retinal Detachments
_____	_____	_____
❑Cataract	❒Glaucoma	❒Blindness
_____	_____	_____

Mark any systemic conditions that apply to a FAMILY MEMBER. (Please list the relation.)

❒ None	❒ Hyperthyroidism	❒ Hypertension
_____	_____	_____
❑ Diabetes Type I	❒Hypothyroidism	❒Diabetes Type II
_____	_____	_____
❒ Thyroid Disorder	❒ Cancer	
_____	_____	

By signing, I attest that I am either the patient being seen, or the parent/legal guardian of this minor being seen. I certify that I have read and understood the above information to the best of my knowledge and that I have provided the information as accurately as possible. I understand that providing incorrect information can be dangerous to my health. I give permission for the doctor(s) to examine, diagnose, and initiate treatment as deemed appropriate. I authorize the doctor to release any information including the diagnosis and a summary of any treatment or examination rendered to me or my child to appropriate third party payers or other health care providers. I authorize and request my insurance company to pay all appropriate benefits directly to the doctor. I acknowledge that I have been given the opportunity to read a copy of the privacy practices of Eyecare East, PLLC, Square Eyecare, Eye Society & Fayette Eye Associates.

_____ _____

Signature Date

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6450 Poplar Avenue
Memphis, TN 38117
(901) 797-9000

Fayette Eye Associates
3161 Hwy 64
Lads, TN 38024
(901) 465-3130

OUR FINANCIAL POLICY

We appreciate your trust in us and we appreciate the opportunity to serve you. We are committed to providing the highest level of eye care to our patients. To ensure that our patients fully understand our billing process, we ask that you read and sign this financial policy statement.

PATIENT PAYMENTS

Payment is due at the time of service. You may use cash, check, credit card, or debit card to pay your account. Without exception, it is the responsibility of the patient to pay his/her co-payment and any unpaid portion of the deductible at the time of service. Any additional co-payments, deductibles and/or co-insurance will be billed to the patient as indicated by your insurance carrier on their Explanation of Benefits (EOB). *There will be a $35 charge for adjustment and a $50 charge for verification of prescription lenses fill outside our office.* **All patients without insurance must pay in full at the time services are rendered.**

INSURANCE COVERAGE

We make a good faith attempt to verify your insurance coverage. We are not able to guarantee that the information given to us by your insurance is correct. **It is your responsibility alone to know what insurance plan you are on, supply us with the correct information at the time you make your appointment and know what services may or may not be covered by your insurance**. We encourage you to refer to your benefits manual if you have any questions about covered services. Be aware that some and perhaps all the services provided may not be covered by your insurance. All orders for eyeglasses, frames, lenses and/or contact lenses are submitted immediately after payment and cannot be cancelled, returned, or refunded. All sales are final on eyeglasses, frames, lenses and contact lenses. *There will be a $35 charge for adjustment and a $50 charge for verification of prescription lenses fill outside our office.* **You will be responsible for payment of all non-covered services at the time they are rendered.**

INSURANCE PAYMENTS

Regarding insurance, your insurance policy is a contract between *you and your insurance company*. We are not a party to that contract. We require certain co-payments, deductibles or prepayment amounts depending on the type of insurance and insurance carrier. Be assured our office works diligently to obtain payment from your insurance company. However, if we file your insurance, and the claim has not been paid for any reason within 60 days, we require that you pay the balance using one of the approved payment methods without exception. In the event that your insurance pays us after that time, you will be reimbursed.

ESTABLISHED PATIENTS / MISSED / LATE CANCELED APPOINTMENTS

Please note, there is a $50.00 no-show fee for all appointments not canceled with at least 24 hours notice.

RETURNED CHECKS

Our bank charges us whenever a patient presents a check that does not have funds available. Therefore, we must charge you a $35.00 handling fee. All future visits will need to be paid with either cash or a credit card. We welcome the opportunity to discuss any aspect of our financial policy. Please ask our office manager if you have any questions, comments, or concerns. We sincerely regret having to maintain such a policy and hope you understand our reasoning.

-Patient Authorization

I have read, understand, and agree to abide by the terms stipulated above. I request that payment of benefits be made to Eyecare East, PLLC, Square Eyecare, Eye Society & Fayette Eye Associates. I hereby authorize the release of any information necessary to determine liability for payment and obtain reimbursement on any claim. I further authorize the use of my signature below on all insurance submissions for services rendered or to be rendered. I agree that a photocopy of this agreement shall be as valid as the original.

Patient Name _____ Date of Birth _____

Patient Signature _____ Date_____

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CONTACT LENS EXAM AND FITTING POLICIES

Eyecare East, PLLC, Square Eyecare, Eye Society & Fayette Eye Associates provide exceptional professional contact lens services. If you are interested in contact lenses or currently wear contact lenses, our doctors or staff can discuss your options with you for contact lenses. Our recommendations are individually tailored to each patient and are based on many factors including available modalities, your visual needs, and your overall eye health. ***Contact lens exams and fitting charges are not typically covered by vision plans and therefore result in additional charges in addition to your routine examination copayment.*** The contact lens exam and fitting charges are dependent on the complexity of the type of contact lens that you currently wear or are being fitted, and the complexity of the insertion and removal instruction if needed.

CONTACT LENS EXAM

A contact lens exam is a separate part of a comprehensive eye examination and requires additional testing that non contact lens wears do not need. Patients wearing contact lenses require more of the doctor's time and expertise. In order to prescribe contact lenses, the doctor must complete several additional tests including:

1. Evaluation of the health of the eye, with special observation of the cornea, eyelid, and conjunctiva. This evaluation will determine if the contact lens is affecting eye health or has the potential to affect eye health in the future.
2. Determination of the proper contact lens prescription is based on the individual patient's glasses prescription, visual needs, quality of the tear film, and corneal health and curvature.
3. Examination of the contact lens on the eye to ensure proper alignment on the cornea.
4. Measurement of the vision with the contact lenses and determination if adjustments needed to be made in the contact lens prescription.

CONTACT LENS EXAMINATIONS AND FITTINGS HAVE DIFFERENT LEVELS OF DIFFICULTY. THIS DEPENDS ON THE TYPE OF CONTACT LENSES NEEDED AND THE VISUAL REQUIREMENTS OF THE PATIENT'S EYES, THEREFORE THE DIFFERENT LEVELS OF CONTACT LENS EXAMS AND FITTINGS RESULT IN DIFFERENT LEVELS OF FEES FOR THOSE SERVICES.

YOUR VISION PLAN AND CL MANAGEMENT/FITTING FEES

Most, if not all, vision plans require doctors to separate routine comprehensive eye examination fees from the services provided for contact lenses. More time and testing are required for the patient who wears contact lenses in addition to the management of ocular health risks associated with wearing contact lenses. *Most, if not all, vision plans treat contact lens services as an additional and separate exam from the routine eye examination.*

WHAT IS A CONTACT LENS PRESCRIPTION?

Contact lenses ***are medical devices*** that can only be dispensed by a prescription. Contact lens prescriptions expire after one year (or sooner if the doctor determines that there is a medical reason for a shorter expiration). They must be regarded with the same caution as you would for prescription drugs, which includes expiration dates and follow-up visits with the eye doctor. Your eyes go through gradual changes in size, shape, and physiological requirements (such as oxygen) while you wear contact lenses and these changes can affect the health of the cornea and need to be monitored at least every year. The federal government requires contact lens prescriptions to expire after one year for these reasons.

-Patient Authorization

I have read, understand, and agree to abide by the terms stipulated above. (Please ask the receptionist if you have any questions about CL fees prior to your exam.) I understand that CL management, fitting and exam fees are not covered by insurance and agree to pay Eyecare East, PLLC, Square Eyecare, Eye Society & Fayette Eye Associates on the day that services are rendered. I understand that, without the exam, management, and fitting procedures, I will not receive diagnostic CLs and or CL prescription. Patient Name

_____ Date _____

Signature _____ Patient/ Authorized Guardian

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HIPAA CONSENT FORM

Drs. Mormon, Haba, Mormon, Duncan & Long of Eyecare East, PLLC, Square Eyecare, Eye Society & Fayette Eye Associates provide this Consent to Comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your protected health information is kept private.

This is a summary of consent for the privacy practices and patient care at Drs. Mormon, Haba, Mormon, Duncan & Long of Eyecare East, PLLC, Square Eyecare, Eye Society & Fayette Eye Associates and serves as a condensed version of our Notice of Privacy Practices. You have the right to review our Notice before signing this Consent upon request. The terms of our Notice may change, and you may obtain a revised copy by contacting our office.

If you ever believe your privacy right has been violated, you may file a complaint with the Compliance Officer of Drs. Mormon, Haba, Mormon, Duncan & Long of Eyecare East, PLLC, Square Eyecare, Eye Society & Fayette Eye Associates or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing complaints.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY.

How will we use or disclose your information? Here are a few samples:

- For vision, medical eye treatment and referral
- To obtain payment and file insurance
- In emergency situations
- For appointment as recall reminders
- To run our practice more efficiently and ensure all our patients receive quality care
- For research and education
- Prevent serious threats to health safety
- For organ and tissue donation
- For worker's compensation programs
- In response to certain requests arising out of lawsuits or other disputes

You have certain rights regarding the information we may obtain about you. The rights include:

- The right to inspect and copy
- The right to amend
- The right to an accounting of disclosures
- The right to request restrictions
- The right to a paper copy of this notice
- The right to request confidential communication

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. Drs. Mormon, Haba, Mormon, Duncan & Long of Eyecare East, PLLC, Square Eyecare, Eye Society & Fayette Eye Associates may condition treatment upon the execution of this Consent. Additionally, by signing this form, you acknowledge that by presenting yourself as a patient or child you consent for vision and medical eye care by the doctors and staff of Drs. Mormon, Haba, Mormon, Duncan & Long of Eyecare East, PLLC, Square Eyecare, Eye Society & Fayette Eye Associates. You hereby grant full authority to the optometrists and their respective assistants to administer and perform any and all drugs, treatments, tests or diagnostic procedures to or upon me, which may be advised necessary.

By signing below, I agree that I have read and understand the privacy policy which protects my medical information from being given out without my consent.

Patient Name_____

Signature _____Date _____

Relationship (if other than patient) _____

I give my consent to discuss or release my medical information to

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

If you do not want your medical information given to anyone, please read and sign below:
I <u>DO NOT</u> give my consent to discuss or release my medical records or medical information to anyone other than myself.

Signature _____ Date _____