



Patient Information Form – Adult

PLEASE PRINT AND COMPLETE FORM IN ITS ENTIRETY

ACCOUNT # \_\_\_\_\_

PATIENT'S LEGAL NAME: \_\_\_\_\_ DATE \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
First Middle Last City State Zip Code

PREFERS TO BE ADDRESSED BY: \_\_\_\_\_ BIRTHDATE \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE \_\_\_\_

SEX: M \_\_\_ F \_\_\_ PT SOCIAL SECURITY # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ PHONE (\_\_\_\_) \_\_\_\_\_  
CELL PHONE (\_\_\_\_) \_\_\_\_\_

MARITAL STATUS:  SINGLE  MARRIED  DIVORCED  SEPARATED  WIDOWED

PATIENT'S EMPLOYER: \_\_\_\_\_ PHONE (\_\_\_\_) \_\_\_\_\_

SPOUSE'S NAME: \_\_\_\_\_

SPOUSE'S EMPLOYER \_\_\_\_\_ PHONE (\_\_\_\_) \_\_\_\_\_

HOW WERE YOU REFERRED TO OUR OFFICE? \_\_\_\_\_

NEAREST RELATIVE \_\_\_\_\_ PHONE (\_\_\_\_) \_\_\_\_\_  
Not living at same address as patient

ADDRESS \_\_\_\_\_

RESPONSIBLE PARTY INFORMATION

RESPONSIBLE PARTY \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

RESPONSIBLE PARTY'S EMPLOYER \_\_\_\_\_ PHONE (\_\_\_\_) \_\_\_\_\_

INSURANCE INFORMATION – Please complete this section on the PATIENT

MEDICARE # \_\_\_\_\_

MEDICAID # \_\_\_\_\_

EFFECTIVE DATE FOR Part B \_\_\_\_/\_\_\_\_/\_\_\_\_

STATE \_\_\_\_\_

MANAGED CARE MEDICARE PLAN NAME \_\_\_\_\_ ID# \_\_\_\_\_

PRIMARY INSURANCE INFORMATION

INSURANCE CARRIER NAME \_\_\_\_\_ ID # \_\_\_\_\_ GROUP # \_\_\_\_\_

SUBSCRIBER'S NAME \_\_\_\_\_ SUBSCRIBER'S DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

SECONDARY INSURANCE INFORMATION

INSURANCE CARRIER NAME \_\_\_\_\_ ID # \_\_\_\_\_ GROUP # \_\_\_\_\_

SUBSCRIBER'S NAME \_\_\_\_\_ SUBSCRIBER'S DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

PLEASE COMPLETE ON REVERSE SIDE OF FORM

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WORKER'S COMP. INSURANCE CO.

CITY \_\_\_\_\_

EMPLOYER AT TIME OF INJURY

PHONE (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

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Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and other pay a percentage of the charge. It is the responsibility of the patient and/or responsible party to pay any deductible amount, co-insurance, or any other balance not paid for by the insurance carrier. I understand I will be responsible for payment in full for services rendered if I do not furnish the required referral forms.

**ALL CO-PAYMENTS, CO-INSURANCE, and NON-COVERED FEES ARE DUE THE DATE SERVICES ARE RENDERED.** In the event this account is assigned to a collection agency, **the patient and/or responsible party will incur all costs of collection and attorney fees in ADDITION TO THE ORIGINAL BALANCE.**

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including private insurance, and other health plans to:

**Eye Surgeons of Springfield, Inc.  
1330 E. Kingsley  
Springfield, MO 65804**

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges, paid or unpaid by the above said insurance. **Refraction fees (the testing for eye glasses) are a separate fee from an eye exam. This fee is approved but not covered by most insurance carriers. I understand I am responsible for this fee.** I hereby authorize Eye Surgeons of Springfield, Inc. to release all information necessary to secure payment for services rendered.

Signed \_\_\_\_\_  PATIENT  GUARDIAN  OTHER \_\_\_\_\_

Printed Name \_\_\_\_\_ Date \_\_\_\_\_

# HEALTH AND MEDICATIONS INFORMATION

Thank you for taking a few moments to complete this form

Patient Name: \_\_\_\_\_

Date \_\_\_\_\_

Update \_\_\_\_\_

Update \_\_\_\_\_

Update \_\_\_\_\_

Update \_\_\_\_\_

Update \_\_\_\_\_

Update \_\_\_\_\_

Update \_\_\_\_\_

Update \_\_\_\_\_

Primary Physician name and address:

(name) \_\_\_\_\_

(city) \_\_\_\_\_ (state) \_\_\_\_\_

Please list any other specialists you see.

Please list their name, specialty, and location (city & state).

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please circle any disease or medical condition you currently have or have had in the past.**

Eye Surgery \_\_\_\_\_ or Disease \_\_\_\_\_

Diabetes Type I, Type II, Thyroid Disease

Kidney, Prostate, Bladder, Uterus, Ovary

Heart Disease, High Blood Pressure, Cholesterol

Pacemaker, Defibrillator, Oxygen Use: \_\_\_\_\_

Asthma, Emphysema, Bronchitis, Lung

Difficulty Lying Flat

Sleep Disorder or Sleep Apnea: CPAP Use? Yes/No

Stomach, Ulcers, Acid Reflux, Colon

Liver Disease, Gall Bladder

Fever, Weight Gain or Loss: How Much: \_\_\_\_\_

Arthritis, Lupus, Bone, Muscle Disease

Skin, Breast Disease, Pregnant

Cancer: Type: \_\_\_\_\_

Headaches, Stroke (date) \_\_\_ Seizures, Neurological

Psychiatric/Mental Disorder, Anxiety, Depression

Hearing aids: Yes or No. (right, left, or both sides)

Ear, Hard of hearing, Nose, or Throat Disease

Blood, Lymph Disease, Hepatitis, HIV, AIDS

Seasonal or Food Allergies, Immunologic Disease

Adverse reaction to general anesthesia in the past

Other: \_\_\_\_\_

**Social History: Do You:**

Smoke, Use Tobacco: How Much: \_\_\_\_\_

Drink Alcohol: Frequency: \_\_\_\_\_

Sexually Transmitted Disease, Drug Abuse: \_\_\_\_\_

**Family History: Does anyone in your family have:**

Lazy Eye, Crossed or Turning Eye, Glaucoma,

Macular Degeneration, Retinitis Pigmentosis

**Please List Any Surgeries and the Date:**

\_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

Currently in Hospice Care or Care Facility? Y/N

Children (under 18) Current Height \_\_\_\_\_

Weight \_\_\_\_\_

List any Drug Allergies:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please list ALL Medications and Supplements:**

**Name of Drug    Mg                    Dosage                    Route**

\_\_\_\_\_

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\_\_\_\_\_

Name of Your Pharmacy

City and State

Pharmacy phone: \_\_\_\_\_

Physician's Signature

Eye Surgeons of Springfield, Inc.  
Springfield, Missouri

Authorization to Release Information, Assignment of Benefits, and Consent for Treatment

1. **Release of Information:** I authorize the disclosure of any or all of the information in my medical record to:

a. Any person, corporation, or agency responsible for all or part of Eye Surgeons of Springfield, Inc. services who may be responsible for determining the necessity, appropriateness, payment, or other matters related to Eye Surgeons of Springfield, Inc. treatment of services;

b. This includes but is not limited to, insurance companies, health maintenance organizations, preferred provider organizations, workers compensation carriers, welfare funds, the Centers for Medicare and Medicaid Services (CMS) or its intermediaries or carriers.

c. I further authorize Eye Surgeons of Springfield, Inc. at its discretion, to disclose such information to its insurance carrier or carriers when so requested by such carrier.

2. **Assignment of Benefits:** I assign to Eye Surgeons of Springfield, Inc. the benefits due me covering Eye Surgeons of Springfield, Inc. services, under my policy(s), managed care plan, HMO, or the Centers for Medicare and Medicaid Services (CMS) or its intermediaries or carriers.

3. **Medicare Patients:** I authorize Eye Surgeons of Springfield, Inc. to obtain information from the Social Security Administration regarding my entitlement and health insurance claim numbers.

4. **Financial Obligation for Eye Surgeons of Springfield, Inc:**

I agree that I am financially responsible for payment of all amounts for services provided by the office and/or physicians. I am responsible to pay for my services regardless of insurance coverage or other responsible parties. I will not be responsible to pay if my obligation is waived by contractual agreements between Eye Surgeons of Springfield, Inc. and my insurer, or if prohibited by state or federal laws or regulations. If my insurance plan is a Health Maintenance Organization (HMO), I understand that I am financially responsible for non-covered services or deductibles, co-pay, or co-insurance as defined in my policy or plan. I also agree that if the account is placed for collection, I will pay all collection agency costs, and reasonable attorney fees. I agree to waive venue and do agree that any action filed to collect any amounts due for services rendered shall be filed in Greene County, Missouri. This includes patient's account balances and the collection of other expenses related to the patient's account balance such as service fees, court costs, and attorney fees.

5. **Guarantor's Responsibility:** I have read and understand the financial obligation above and agree to the terms as stated.

**CONSENT FOR TREATMENT:** As a patient of Eye Surgeons of Springfield, Inc., I agree, request, and authorize my attending physician to administer such treatment as is necessary. This includes their associates and /or assistants. Treatment may include such services, care, diagnostic procedures, and/or medical treatments, as the physician(s) deems reasonable and necessary.

**AUTHORIZATION FOR DISCLOSURE:** I give express permission to discuss with the individual(s) I have listed:  
Please check appropriate box(es)

Any aspect of my health care                       Health information only                       Financial information only

I understand that I am responsible for notifying this office, in writing, of any changes to this authorization to disclose my personal health information.

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone# \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone# \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone# \_\_\_\_\_

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FORM:** The Notice of Privacy Practices of Eye Surgeons of Springfield, Inc. sets forth the ways in which my personal health information may be used or disclosed and outlines my rights with respect to such information. I acknowledge that on \_\_\_\_\_ (date),

I received a copy of the Eye Surgeons of Springfield, Inc. Notice of Privacy Practices

I declined a copy of the Eye Surgeons of Springfield, Inc. Notice of Privacy Practices

Patient Name (print) \_\_\_\_\_ Signature: \_\_\_\_\_  
(Patient or legal representative) Date

Patient Date of Birth or SSN: \_\_\_\_\_ Relationship if signed by other: \_\_\_\_\_

Eye Surgeons of Springfield

# HIPAA Notice of Privacy Practices

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\_\_\_\_\_  
[Name]

**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.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

## **I. Uses and Disclosures of Protected Health Information**

### **Uses and Disclosures of Protected Health Information**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.**

**You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.**

### **Your Rights**

Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

### **Complaints**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**