BOWDEN
EYE & ASSOCIATES
*Eyes • Aesthetics • Hearing*

Patient Name: ________________
Account #: ____________________

## CONFIDENTIAL PATIENT INFORMATION

Patient's Name: ____________________________________________ Date: _______________

Sex: M F Date of Birth: ______________________________ Age: _______________

Home Address: ____________________________________________ Apt: # _______________

City: ______________________ State: ____________________________________ Zip: _______________

Home Phone Number: ___________________________ Cell/Alternate: ______________________________

Social Security Number: __________________________ Email Address : ____________________________

If Child, parent's/guardian's name: ___________________________________________________________

Primary Care Physician: _________________________ Referring Physician: ________________________

Employer: _____________________________________ Work Number: _____________________________

Emergency Contact Name: __________________________________________________________________

Relation:_____________________________________ Phone Number: __________________________________

**Would you like us to communicate to any other family members, Power of Attorney, or other individuals pertaining to your medical records, treatment plan, billing/insurance questions, appointments, etc.? If so, please list below.**

Name :____________________________________ Relation to You: __________________________

**Do you allow us to release your medical records to a referring physician or primary care physician if they request such to jointly treat your medical condition? If so, PLEASE INITIAL HERE.** ________________

**INSURANCE INFORMATION**
**Insurance Company:** ________________________ **Policy Number:** _____________________**Group Number:** ________________

**What name is the policy under?** ______________________ **Relationship to Patient: SPOUSE PARENT OTHER**

### Patient HIPAA Consent:

In each of our offices, we have our Notice of Privacy Practices published. This Notice contains a Patient Right's Section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have a right to request how protected health information about you is used or disclosed for your treatment, payment, and health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. Marketing- we may use or disclose your Health Information to make a marketing communication to you that occurs in a face-to-face encounter with us or which concerns a promotional gift of nominal value provided by us.
By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment, and health care operations. You have the right to revoke this consent, in writing, signed by you at any time; however, that does not affect any disclosures we have already made in reliance with your prior consent. This consent is required so that Bowden Eye is in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**Patient Signature:** ___________________________________ **Staff Initials:** ________________

**Relationship if other than patient:** ______________________

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**INSURANCE/PAYMENT INFORMATION:With the ever changing healthcare industry, we want to make sure every patient is aware of our insurance and billing policies. The more you know, the better we can service your eyecare needs.**

**Payment is due at the time of your exam.**
Do to the increasing costs of providing medical care, we require patients to pay their co-pay, deductible and all out of pocket expenses before they leave the office. Failure to pay this at the time services are rendered will result in a $25 billing charge.

**Patients on HMO Policies:**
Our staff will strive to make sure that all patients on an HMO plan has a referral for their visit, however it is the patient's responsibility to insure the office has this before services are rendered. Patients on an HMO policy are required to present a referral from the Primary Care Physician on every visit to our office. We cannot bill your insurance without the referral.

**Non-Covered Services:**
If we suspect that your insurance company may not cover a service, we will ask that you sign a form in advance acknowledging that you have been advised the service may not be covered and that you will be financially responsible. This applies to services that we feel is needed in your treatment plan, but that your insurance company may deem non-covered. All other non covered services will be billed to you in accordance with your specific insurance policy. All cosmetic surgery, refractive surgery such as LASIK, and elective procedures are paid 1 week prior to services being rendered.

**Refraction Policy:**
It may be necessary for our office to perform a Refraction Test. While Medicare and some major insurance carrier do not cover this test, it is necessary to determine your visual acuity. This test can be used to determine your need for glasses, but it can also detect vision loss. Some of the time vision loss is slow and progressive and the patient may not even notice, that is why a physician will check the patient's vision by refracting them. This test can also uncover other problems a patient may be unaware of. This test is charged separate from the exam because Medicare has deemed that a refraction is not a "medical service". However, this is the ONLY way to detect some types of vision loss. The Office of Inspector General has deemed that not charging a patient for a service is an "inducement" to the patient, and therefore illegal, which is why we charge for this service to be done. A refraction may not be done at every visit. This varies based on the patient's diagnosis. **The fee for a refraction is $70, and due at the time of service in addition to any copays or deductibles.**

**Billing to your Insurance:**
Our office will bill all covered services to a Primary and Secondary Insurance policy. We do not bill to more than two insurance carriers. By giving us your insurance information you authorize our office to request payment be sent directly to us. We will also make reasonable appeals for payment when necessary. **We will give insurance carriers a maximum of 60 days to pay the claim. Failure for them to pay in a timely manner will result in the balance being turned over to you.** We encourage you, the patient, to be involved and make sure your insurance is paying in a timely manner.

**Unpaid Claims:**
After 120 days if the balance on your account has not been paid, and a payment arrangement has not been set up with our Billing Department, the balance will be forwarded to our collection agency. The patient is responsible for any collection charges, attorney fees, court costs and finance charges that accrue. Continued access to our practice will be terminated if billing policies are ignored. If financial obligations arise, please contact our Billing Department immediately. Monthly payment plans can be set up with payments as low as $100 a month.

*The patient or responsible party agrees to the Physician's reasonable and customary fee for medical services. The receptionist will accept cash, check or credit card for routine visits as you leave. If financial problems arise, please make special arrangements. By signing this form, you acknowledge financial responsibility and authorize Bowden Eye & Associates to release any information acquired in the course of your exam or treatment to other physicians, etc for health reasons and consent to the use of photographs for the purpose of documentation, publications in medical journals or presentations during medical meetings.*

**Patient Signature:** ___________________________________ **Date:** ________________________

**Staff Initials:** __________________

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**Recent CMS (Centers for Medicare and Medicaid Services) guidelines require us to report this information on your claim for insurance reimbursement. Thank you for your cooperation.**

**Do you currently use tobacco products?** ____ **YES** ____ **NO**

*If **yes**, how many packs do you smoke per day?*

_____ *less than 1 pack* ____ *1 pack* ____ *2 packs* ____ *3 packs* ____ *more than 3 packs*

*If **yes**, how long have you used tobacco products?*

_____ *less than 5 years* ____ *5-10 years* ____ *10-15 years* ____ *more than 15 years*

**Have you ever used tobacco products?** ____ **YES** ____ **NO**

*If yes, how long ago did you quit?*

____ *less than 1 year* ____ *1-5 years* ____ *5-10 years* ____ *10-15 years ago* ____*more than 15 years ago*

**What is your height?** _______________

**What is your weight?** _______________

**Do you drink alcohol?** ____ **YES** ____ **NO** ***If so, how much?*** _________________ ***How long?*** _____________________

**What was your last blood pressure reading?** __________ **/** ___________

**Were you sent to our office by another Medical Provider?** ____ **YES** ____ **NO**

**List your medication allergies:** ___________________________________________________________________

**List your current medications you are taking:**

___________________________ ____________________________ _______________________

___________________________ ____________________________ _______________________

**Please check the box if the condition applies to you, and explain when necessary.**

____ Eye pain
____ Red eyes
____ Watery eyes
____ Film over eyes
____ Road Signs are blurry
____ Small print is blurry
____ Dry or scratchy eyes
____ Eye swelling or itch
____ Migraine Headaches
____ Droopy Eyelids

____ Other Headaches? Explain_________________________
____ Difficulty driving due to vision
____ Glare from car lights or sunlight
____ Double vision
____ Vision blackout
____ Flashes of light, floaters or spots in vision. Explain ___________________
____ Do you wear glasses? If yes, are they:
____Prescription and/or _______ Reading glasses

____ Do you have a known eye disease? If yes, what type? ________________
____ Have you ever had eye surgery? If yes when? ______________________

**Please check the box if you are experiencing any symptoms or have been diagnosed with a condition in these areas:**

____ Chronic Fever, unexpected weight gain/loss, fatigue? If yes, when? ________________________________________
____ Ear, nose, throat problems? (e.g. Hearing loss, sinus, sore throat) ________________________________________
____ Heart problems? (e.g. Murmur, CHF, stroke, heart attack, irregular heart beat) ____________________________
____ High blood pressure? If yes, is it ______ controlled or _____ uncontrolled?
____ Respiratory problems? (e.g. Asthma, emphysema, TB, shortness of breath) If so, when? ____________________
____ Urinary problems? (e.g. Pain or discomfort, kidney stones, dialysis, kidney disease) _______________________
____ Diabetes or other endocrine problems? ____________________________________________________________
____ Blood or lymphatic disease? (e.g. Free bladder, bleeding disorders, leukemia, etc) ________________________

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**Have you ever been told that you have:**
Gastrointestinal problems? (stomach ulcer, abdominal pain, etc) If yes, when? ____________________________________________
Allergic or immunologic problems? ____________________________________________________________________________
Cancer? If yes, what type ____ skin ____ pituitary ____ lung ____ colon ____ breast ____ stomach *Other:* ________________
Musculoskeletal problems? (e.g. Joint pain, arthritis) If so, when? ___________________________________________________
Skin conditions? Please describe: _____________________________________________________________________________
Neurological problems? (e.g. Numbness, weakness, tingling, headache) ________________________________________________
Psychological problems? (e.g. depression, anxiety) ___________________________________________________________________

**PAST HISTORY:**
Do you have any other medical conditions that you have NOT listed in the categories above? _________________________________
Have you had any surgery in the past 10 years? ____ YES ____ NO If yes, when? _______________________________________
What type of surgery? ______________________________________________________________________________________

**CURRENT HISTORY:**
Do you have any known drug allergies? ____YES ____ NO If yes, what drug? __________________________________________
Do you use a wheelchair, walker, or cane? ____YES ____ NO
Have you ever had general anesthesia? ____YES ____ NO
Have you ever had an HIV (AIDS) test? ____YES ____ NO If so, was it _____ Positive or ____ Negative
Why was it done? __________________________________________________________________________________
Do you have hepatitis of any form? ____YES ____ NO If so, what type? ____________________________________________
Have you had any type of blood transfusion since 1980? ____YES ____ NO If yes, why? _________________________________
Are you taking Aspirin, Coumadin, or any other blood thinner? ____YES ____ NO If yes, please describe. ___________________
Have you ever been diagnosed or treated for alcoholism or drug abuse? ____YES ____ NO Please describe. _________________
Have you been diagnosed or treated for a mental or emotional condition? ____YES ____ NO Please describe. _________________

**FAMILY HISTORY: Does/Did anyone in your immediate family have any of the following:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Glaucoma | ____ YES | ____ NO | ____ Father | ____ Mother | ____ Brother | ____ Sister | ____ Grandparent |
| Blindness | ____ YES | ____ NO | ____ Father | ____ Mother | ____ Brother | ____ Sister | ____ Grandparent |
| Diabetes | ____ YES | ____ NO | ____ Father | ____ Mother | ____ Brother | ____ Sister | ____ Grandparent |
| Heart Disease | ____ YES | ____ NO | ____ Father | ____ Mother | ____ Brother | ____ Sister | ____ Grandparent |
| High Blood Pressure | ____ YES | ____ NO | ____ Father | ____ Mother | ____ Brother | ____ Sister | ____ Grandparent |

**FOR MEDICATION PRESCRIPTIONS AND REFILLS, PLEASE LET US KNOW WHAT PHARMACY YOU PREFER:**

**Pharmacy:** _______________________________ **Address:** _________________________ **Phone Number:** __________________

**DOCTOR'S SIGNATURE :**___________________________________________ **DATE:** ___________________________