EYE SPECIALISTS OF LOUISIANA

CHECK WHICH DOCTOR YOU ARE SEEING TODAY:

☐ THOMAS C. STUCKEY III, M.D. ☐ DAVID M. DRAGON, M.D. ☐ TIM D. JOHNSON, M.D. ☐ VICTOR OLIVER, M.D. ☐ LILLIAN M. FORSTALL, O.D.

PATIENT REGISTRATION

(Please Print Clearly)

Today's Date ____ / ____ / ____ **Is this your first visit:** ☐ Yes ☐ No

Name of Patient: _____
First Middle Last

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Date of Birth: _____ **SSN:** _____ **Home Phone:** _____

Cell Phone: _____ **Referred By:** _____

Responsible Party: _____ **Relationship:** _____

Spouse's Name: _____ **Spouse's SSN:** _____

Primary Care Doctor: _____

Address: _____ **Phone #:** _____

Emergency Contact (nearest relative not living with you) Phone #: _____

Name: _____ **Relationship:** _____

****

INSURANCE INFORMATION

Medicare #: _____

Medicaid #: _____

PRIMARY INSURANCE CO.: _____

Insurance Address: _____

City: _____ **State:** _____ **Zip:** _____ **Phone #:** _____

Name of Policy Holder: _____ **SSN:** _____ **DOB:** _____

Policy ID#: _____ **Group #:** _____

SECONDARY INSURANCE CO.: _____

Insurance Address: _____

City: _____ **State:** _____ **Zip:** _____ **Phone #:** _____

Name of Policy Holder: _____ **SSN:** _____ **DOB:** _____

Policy ID#: _____ **Group #:** _____

Assignment / Medical Record Release Authorization

I request that payment of authorized Medicare or other insurance benefits be made on my behalf to Eye Specialists of Louisiana, Thomas C. Stuckey III, M.D., David M. Dragon, M.D., Tim D. Johnson, M.D., Victor Oliver, M.D., Lillian M. Forstall, O.D. and Eye Specialists Optical Shop for any services furnished me by these providers. I authorize any holder of medical information about me to release to the Health Care Financing Administration or other insurance company any information needed to determine these benefits or the benefits payable for related services. I understand that I am financially responsible for charges at all times.

Consent to Contact

I authorize Eye Specialists of Louisiana, Thomas C. Stuckey III, M.D., David M. Dragon, M.D., Tim D. Johnson, M.D., Victor Oliver, M.D., Lillian M. Forstall, O.D. and Eye Specialists Optical Shop and their agents, including attorneys, collection agencies and other service providers acting on their behalf, to contact me regarding appointments, exams, exam results and other issues related to my care as well as my financial obligations, including but not limited to outstanding balances, payment reminders, delinquent notifications, instructions, and links to billing or payment information or options, through various means of communication including, but not limited to any cell phone or landline numbers that I provide and any number fowarded or transferred from that number, including via text message/SMS, pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable, and/or via email message to an email address that I have provided and any address forwarded or transferred from that email address.

Signature of Patient or Authorized Representative _____ **Date** _____

EYE SPECIALISTS OF LOUISIANA

MEDICAL INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____

Do you have, or have you ever had:

YES	NO		YES	NO	
____	____	Hypertension (High Blood Pressure)	____	____	HIV Positive
____	____	Diabetes	____	____	Glaucoma
____	____	Thyroid Disease	____	____	Blindness in either eye
____	____	Kidney Disease	____	____	Tuberculosis
____	____	Stroke	____	____	Cancer
____	____	Color Blindness	____	____	Macular Degeneration
____	____	"Lazy" Eye	____	____	Multiple Sclerosis
____	____	Rosacea	____	____	Shingles

Any other medical dx not listed (ex: Auto Immune) _____

_____

Do you have any drug allergies? If yes, please list:

_____

Are you currently taking any medications? If yes, please list:

_____

_____

Are you currently experiencing any of the following problems?	YES	NO
– Recent changes in your vision	____	____
– Vision is sometimes blurry	____	____
– Itchy eyes	____	____
– Burning sensation in your eyes	____	____
– Pain in your eyes	____	____
– Frequent headaches or eyestrain	____	____
– Twitches or tics around your eyes	____	____
– Light flashes, floaters, or shadows	____	____
– Eye redness, swelling, puffiness, bloodshot, etc.	____	____

If you checked yes to any of the above questions, please provide details:

_____

_____

Have you ever had any eye surgery, including LASIK or laser procedures? YES ____ NO ____
If yes, what kind? _____

Have you ever had an eye injury? YES ____ NO ____
If yes, what happened? _____

Do you use:
Cigarettes/Tobacco: YES ____ NO ____ Alcohol: YES ____ NO ____ Other drugs: YES ____ NO ____

Do you have any family history (blood relative) of:
____ Glaucoma ____ Cataracts ____ Macular Degeneration ____ Blindness
Other eye problems _____

Is there anything else you would like to discuss with the doctor?

_____

_____

EYE SPECIALISTS OF LOUISIANA

Thomas C. Stuckey III, M.D. • David M. Dragon, M.D. • Tim D. Johnson, M.D.
Victor Oliver, M.D. • Lillian M. Forstall, O.D.

OFFICE POLICIES

By Federal and Managed Care Contract Law this practice is required to collect co-payments and deductibles for every encounter. Penalty for not doing so could result in termination of insurance coverage, as we are required to notify your insurance carrier of failure to pay at time of services rendered.

Consent to Contact - I authorize Eye Specialists of Louisiana, Thomas C. Stuckey III, M.D., David M. Dragon, M.D., Tim D. Johnson, M.D., Victor Oliver, M.D., Lillian M. Forstall, O.D. and Eye Specialists Optical Shop and their agents, including attorneys, collection agencies and other service providers acting on their behalf, to contact me regarding appointments, exams, exam results and other issues related to my care as well as my financial obligations, including but not limited to outstanding balances, payment reminders, delinquent notifications, instructions, and links to billing or payment information or options, through various means of communication including, but not limited to any cell phone or landline numbers that I provide and any number fowarded or transferred from that number, including via text message/SMS, pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable, and/or via email message to an email address that I have provided and any address forwarded or transferred from that email address.

Statements are mailed every thirty (30) days for any outstanding balances that remain after your insurance company has processed a claim. Balances must be paid in full within thirty (30) days of the statement date unless the business office has approved payment arrangements. Failure to make payments in a timely manner will result in your account being placed with a collection agency.

It is the policy of this office to make a copy of your driver's license to prevent identify theft. This action allows us to verify that your signature matches the one on our sign-in sheets and any other forms that require a signature.

_____ _____

Signature of Patient/Guardian Date

_____

Relationship of signing party to patient

EYE SPECIALISTS OF LOUISIANA

NON-COVERED SERVICES

Dear Patient:

Medicare regulations require that in order to collect payment, you must be informed in advance that a service may not be covered by your insurance plan. This does not imply that the services recommended by your physician are not medically necessary.

Many insurance companies, as well as Medicare and Medicaid, do not pay for the refraction portion of an eye exam nor for some diagnostic tests, including but not limited to A-Scans and Optic Nerve Tomography.

Beneficiary Agreement

I have been notified by Eye Specialists of Louisiana that reimbursement for certain services and/or procedures may be denied by my health insurance coverage and I agree to be personally and fully responsible for payment of same.

Patient's Signature _____ Date _____

EYE SPECIALISTS
OF LOUISIANA

Thomas C. Stuckey III, M.D.
Board Certified Ophthalmologist

David M. Dragon, M.D.
Board Certified Ophthalmologist

Tim D. Johnson, M.D.
Board Certified Ophthalmologist

Victor Oliver, M.D.
Board Certified Ophthalmologist

Lillian M. Forstall, O.D.
Optometrist

ROUTINE EXAM VS. MEDICAL EXAM, REFRACTION

Your symptoms/visual complaints, or lack of, will determine if your vision exam is coded as "Routine" or "Medical". The decision to file as routine or medical must be made on the day of your eye examination. We will not alter chart notes at a later date to change which plan your exam is to be billed to.

ROUTINE EXAM - A routine exam, by definition, is an exam for people who have no eye disease or symptoms of disease. Your eyes will be examined for any needed correction (glasses or contact lens) and any potential indicators of eye disease. If our doctor finds anything abnormal during your vision exam, further testing using your medical insurance will be needed.

Routine eye examinations through most Vision plans require prior authorizations. You must provide us with your Vision Plan policy information prior to services.

MEDICAL EXAM - Exam for evaluation of a medical-related complaint or follow-up of an existing medical condition. Examples that will necessitate your visit being submitted to your medical insurance include headache, eye irritation, dry eyes, floaters, glaucoma, cataract, double vision, macular degeneration, high risk medications, etc.

Refraction - A test that measures the eyes' need for corrective lenses, and also assists in monitoring medical conditions of the eye. This test, however, will not provide sufficient information to write a prescription for contact lens, which requires a contact lens fitting.

Insurance companies separate the components of an eye exam, one being the comprehensive exam and the other being the refraction. Typically, vision plans cover both the exam and the refraction, while medical policies cover only the exam. Medicare enforces the policy of requiring eye doctors to separately charge and collect for refractions. As many private insurance carriers adopt the policies of the federal government, many of our contracts with private insurance carriers now require us to separately collect for this non-covered service also.

We hope that this information will help you understand how your visit will be submitted to your insurance for today's visit and future visits. If you are uncertain about your vision/medical benefits, please contact your insurance carrier.

Patient Signature/Responsible Party Date

EYE SPECIALISTS OF LOUISIANA

Acknowledgment of Receipt of Notice of Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used and disclosed to:

- Evaluate my health, diagnose my medical condition and provide treatment;
- Obtain payment from third-party payors;
- Conduct normal operations of our medical practice such as quality assessments, physician certifications, appointment and surgery scheduling;
- Fulfill other purposes which are listed in our Notice of Privacy Practices.

I have received a copy of Eye Specialists of Louisiana, L.L.C.'s Notice of Privacy Practices containing a more detailed description of the uses and disclosures of my health information as well as certain rights that I have as a patient. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Patient's Printed Name Date

_____

Patient's Signature or Representative's Signature

_____

Relationship to Patient if signed by Personal Representative

OFFICE USE ONLY

Patient's signature was not able to be obtained for the reasons documented below:

_____

Date

Reason(s) Acknowledgment was not obtained: _____

Name of Staff Member: _____

EYE SPECIALISTS OF LOUISIANA

RESTRICTION REQUEST ON USES AND DISCLOSURES

You have a right to request restrictions on the uses and disclosures of your protected health information as described in the Notice of Privacy Practices. Eye Specialists of Louisiana, L.L.C. is not obligated to accept your proposed restrictions, but will give them consideration. Please describe any restriction requests that you would like to make in the section provided below.

I, _____ (print name) hereby request the following restrictions on the use and disclosure of my personal health information for the purposes of treatment, payment and health care operations. This is a complete list of my restriction requests. All previously signed expressions of my wishes concerning the use and disclosure of my personal health information for the purposes of treatment, payment or health care operations are null and void.

RESTRICTIONS:

_____

_____

_____

_____

_____

_____ _____

Signature **Date**

REVIEWER SECTION

The terms of this request are/are not (circle one) acceptable to **EYE SPECIALISTS OF LOUISIANA, L.L.C.**

_____ _____

Signature **Date**

_____ _____

Print Name **Title**

Comments:

_____

_____

EYE SPECIALISTS OF LOUISIANA, L.L.C.

Designation of Individual Involved in My Care

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you have the right to authorize the release of your protected health information, including medical and billing records, to an individual(s) you designate. Please complete this form in its entirety designating the individual(s) with whom you would like Eye Specialists of Louisiana, L.L.C. to share your information.

Patient Name: _____ **Date of Birth:** _____

Designation of Individual(s) Involved in My Care:

At my request, I hereby identify the following individual(s):

_____

(List names of designated individual(s))

_____

(collectively, the "Designated Individual") as an individual(s) involved my care and I hereby authorize EYE SPECIALISTS OF LOUISIANA, L.L.C. (the "Clinic") to release any and all protected health information about me, including billing and medical records, to the Designated Individual. This authorization permits both the disclosure of paper records and verbal communications. Additionally, to the extent my medical or billing records contain information related to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, hepatitis B or C testing, HIV/AIDS, and/or other sensitive information, I hereby agree to its release.

Termination/Revocation of Designation:

Unless terminated sooner in writing by me, this authorization will terminate three (3) years after my last date of treatment by the Clinic. I understand that I may revoke this authorization and cancel this designation by sending a written Revocation of Designation Form to the Clinic at 6220 Perkins Road, Baton Rouge, Louisiana 70808. I understand and acknowledge that the revocation or cancellation of this designation shall not apply to information that has already been released prior to the revocation/cancellation date.

Re-Disclosure:

I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.

No Obligation to Sign:

I understand that I do not have to sign this authorization and treatment of me will not be denied if I do not sign this form. I hereby release and discharge the Clinic, its employees, agents, and owners of any liability and will hold them harmless for complying with this authorization.

_____ _____

Signature of Patient **Date**