Med Center Health®

Eye Care

Patient's Name (First, Middle, Last):				
Email Address:	Social Security #:	Birth Date:	Age:	Sex:
Mailing Address:	City, State:		Zip:	
Home Phone:	Cell Phone:	Other:		
Occupation:	Employer:	Employer Phone #:		
RESPONSIBLE PARTY (IF DIFFERENT FROM ABOVE)				
Name (First, Middle, Last)		Relationship		
Mailing Address:	City, State:		Zip:	
Email Address:	Social Security #:	Birth Date:	Age:	Sex:
Home Phone:	Cell Phone:	Other:		
INSURANCE INFORMATION				
Primary Insurance Name and ID#:		Secondary Insurance Name and ID#:		
Policy Holder Name, SS#, DOB:		Policy Holder Name, SS#, DOB:		
PRIMARY CARE PHYSICIAN				
Name:		Phone #:		
REFERRING PROVIDER (IF OTHER THAN PCP)				
Name:		Phone #:		
EMERGENCY CONTACT				
Name:		Home #:		
Relationship:		Cell #:		
PHARMACY INFORMATION				
Name:		Phone #:		

Patient Signature: **Date:**

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Consent, Assignment of Benefits & Financial Agreement

Consent to Diagnostic Tests, Medical Treatment and Procedures:
I do voluntarily consent to care involving diagnostic tests, medical treatment and procedures by the physicians/practitioners of Commonwealth Health Corporation, d/b/a Med Center Health Eye Care, their assistants and designees, and other employees of Med Center Health Eye Care as is necessary or advisable in their judgment. This consent includes testing for communicable diseases, including but not limited to Human Immunodeficiency Virus (HIV), hepatitis or any other blood-borne infectious disease if ordered for a diagnostic purpose or due to occupational exposure of a health care worker. I acknowledge no guarantee has been made to me as to the results of examination and treatment.

Assignment of Benefits and Financial Agreement:
I certify all information given by me is correct and I accept responsibility for the charges for the care provided. I agree to the assignment of all third-party benefits to Med Center Health Eye Care and to any physician, practitioner, organization or independent contractor who provided products or services, and agree to pay all charges not covered by third-party payers. If I am covered by an ERISA plan, with this assignment I specifically authorize my providers to receive copies of all notifications and information that I am legally entitled to receive under the terms of my insurance/health plan and to act on my behalf to appeal benefit determinations. I acknowledge any claim for benefits from a third party payer may be filed by Med Center Health Eye Care as a courtesy to me. However, I am primarily responsible for monitoring the filing process and making certain the claim is filed in compliance with the provisions specified by the applicable third party payer. The filing of the claim by Med Center Health Eye Care in no way releases me from liability for any portion of the bill not paid by a third party payer for any reason. This writing is intended to be the complete and exclusive statement of the terms and conditions regarding my assignment of benefits and supersedes all previous communications, representations or agreements, whether oral or written. Any terms or conditions proposed by me or on my behalf that differ from or are in addition to the terms of this agreement are rejected and shall not become part of this agreement.

Unless other payment arrangements are approved by Med Center Health Eye Care, the account balance is due upon demand. Failure to pay for the services may result in the placement of an account with a collection agency or attorney for collection. All amounts due, as shown in the final statement and/or amended final statement, shall bear interest from the due date until paid at a per annum rate of eight percent (8%). In the event there is a judgment, the amount due shall accrue interest at the judgment rate of six percent (6%) until paid in full. Further, I agree to pay all costs of collection including court costs, interest, attorney fees and collection agency fees.

Contact Information:
I agree Med Center Health Eye Care, Commonwealth Health Corporation and their agents, attorneys or collection agencies may contact me regarding medical information or information about my account or for the purposes of collection by telephone at any number provided by me including wireless telephone numbers, and via text messaging or e-mail to any e-mail address provided. Methods of contact may include the use of pre-recorded or artificial voice messages and/or automated dialing.

Release of Information:
I authorize the release of all or part of my records, including information stored in Med Center Health Eye Care corporate-wide database, to my physician(s), whose name I provided at the time of registration, and to any physician or practitioner who has or will provide services to me. I authorize the release of statistical information as required by any local, state or federal agency or managed care program. I authorize the release of my HIV test results to health care personnel in the event of an occupational exposure.

I authorize Med Center Health Eye Care and any other holder of medical or other information to release information about me (including medical information concerning psychological or psychiatric conditions, alcoholism and/or drug related conditions and HIV or other blood-borne infectious diseases) as required to complete any claim for benefits due to services rendered to me to any person or corporation which is or may be responsible for all or part of the total charge incurred. The persons or corporations to which this information may be released includes, but is not limited to insurance companies, the Social Security Administration, its intermediaries and carriers, state agencies and workers' compensation carriers, as well as the review organization employed by my employer or the employer of the insured member of my family and any corporation engaged by Med Center Health Eye Care to make collection of any unpaid charges. I further authorize my employer to release to Med Center Health Eye Care or any agency engaged for the purpose of collecting any unpaid charges, verification of my employment status, including the amount of salary or wages and the number of hours worked.

Information Received:

_____ I acknowledge receipt of the NOTICE OF PRIVACY
(initial) PRACTICES.

_____ This authorization is valid until revoked in writing.
(initial)

_____ My medical/financial information may also be released to the
(initial) following persons.

_____
_____

Primary Care Physician: _____

If you were sent to us by another physician, please list the physician: _____

Print patient name: _____

_____	_____	_____	_____
Signature	*Date*	*Time*	*Relationship (if not patient)*

_____
Witness

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Treatment with Controlled Substances

Patient Name:_____ DOB:_____

The physician/practitioner has discussed with me the option of treating my condition/pain with a controlled substance. By accepting the prescription for the controlled substance(s) that was prescribed to me, I acknowledge I understand there are inherent risks and benefits associated with treating my condition/pain with a controlled substance. These risks include developing drug tolerance and dependence.

It is my responsibility to take the medicine as prescribed and not more frequently than prescribed. I am not to share this medication with anyone else, including family members. The use of controlled substances can depress my senses and impact driving and work safety. It is discouraged during pregnancy, and may harm the unborn child. There is a potential for overdose, and if I suspect I have had an overdose I should call 911 or go to the emergency room as soon as possible.

The medication should be stored in a safe place, out of the reach of children, and should be properly disposed of after expiration. Any requests for refills must be made during weekday hours before the prescription has expired and may require an office visit.

I give permission for my entire prescription history to be obtained from my pharmacy.

_____ _____
Witness Patient Signature or Person Authorized to Consent for Patient

_____ _____ _____
Date Time Relationship to Patient

MEDICAL HISTORY QUESTIONNAIRE

Patient Name: **DOB:** **Location:**

Reason for today's visit: _____

_____

List ALL Medications,Supplements / Vitamins you currently take, including eyedrops/ ointments:_____

_____

_____

_____

List any **OCULAR** surgery, laser, trauma: _____

_____

List any other hospitalizations/surgeries that you have had:_____

_____

List any other problems with your eyes: NONE ☐

(Type) Contact Lens Wear for years -Dispose of every days/ weeks/ month

Medical & Social History

Have you ever had any reaction to anesthesia? **Yes / No**

Do you drink alcohol? **Yes / No** How much?

Do you smoke? **Yes / No** How much?

Allergy to medication Yes / No if so give details:

	Yes	No	STAFF USE ONLY PROVIDE DATES AND DETAILS
GENERAL / CONSTITUTIONAL (fever, heatstroke, weight loss, weight gain, unusually tired, serious childhood illness, etc.)	☐	☐	
EARS, NOSE, THROAT (hard of hearing, congestion, earache, cough, dry mouth, etc.)	☐	☐	
CARDIOVASCULAR (pacemaker, defibrillator, High BP, racing pulse, etc.)	☐	☐	
RESPIRATORY (congestion, wheezing, short of breath,etc.)	☐	☐	
GASTROINTESTINAL (stomach upset, diarrhea,constipation, hernia, ulcers, etc.)	☐	☐	
GENITAL,KIDNEY,BLADDER (painful urination, frequent urination, impotence, yellow jaundice, prostate problems,etc.)	☐	☐	
FEMALES Are you pregnant? Nursing?	☐	☐	
MUSCLES, BONES, JOINTS (joint pain, stiffness,swelling, cramps, arthritis, etc.)	☐	☐	
SKIN (pimples, warts, growths, rash, etc.)	☐	☐	
NEUROLOGICAL (numbness, headache, seizure, paralysis, loss of consciousness, etc.)	☐	☐	
ALLERGIC / IMMUNOLOGIC(sneezing,swelling, redness, itching, hives, Lupus, Sjogrens etc.)	☐	☐	
PSYCHIATRIC (Anxiety, Depression, Insomnia)	☐	☐	
BLOOD / LYMPH (Bleeding, Cholesterolemia, anemia, problems related to blood transfusion, etc.)	☐	☐	
CANCER (Site)	☐	☐	
ENDOCRINE (Diabetes, Hypothyroid, etc.) Insulin ☐ NonInsulin ☐	☐	☐	
Last blood sugar level Date taken			

Circle any of the following diseases your family members have been diagnosed with: **NONE** **UNKNOWN**

Blindness/ Cataract/ Glaucoma/ Diabetes/ Hypertension/ Heart Disease/ Stroke/ Cancer/ Thyroid Disease/ Arthritis

Other disease:

Patient Signature: _____ **Date:** _____