Bloomberg Eye Center

☐ Newark – 1651 W Main Street, Newark, OH 43055

☐ Columbus – 3600 Stelzer Road, Columbus, OH 43219

Appointment Date: _____ Time: _____

CONFIDENTIAL PERSONAL RECORD

PERSONAL

MR/MS/MRS NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE #: _____ EMAIL: _____

S.S. #: _____ PREFERRED METHOD OF CONTACT: PHONE ☐ EMAIL ☐

DATE OF BIRTH: _____ MARITAL STATUS: _____ SEX: _____

RACE: _____ ETHNICITY: HISPANIC ☐ NON-HISPANIC ☐

PREFERRED LANGUAGE: _____

PHARMACY/LOCATION: _____

NAME OF RESPONSIBLE PARTY: _____

EMPLOYER: _____ OCCUPATION: _____

EMPLOYER'S ADDRESS: _____PHONE: _____

INSURANCE INFORMATION *(WE WILL NEED TO MAKE COPIES OF YOUR INSURANCE CARDS)*

PRIMARY CARD HOLDER: _____ DATE OF BIRTH: _____

We welcome you to our office and thank you for entrusting you eye health care to us. We would be most interested in knowing why you selected our office for your care.

REFERRED BY: _____

My decision to come to this office was influenced by:

☐ Doctor_____ ☐ Friend or Family Member_____

☐ Newspaper Ad ☐ Telephone Book ☐Internet ☐Television Ad ☐ Radio Ad☐ Other_____

Comments: _____

Specialty Eye Care, Inc. Surgicenter, Ltd. Refractive Center, Ltd.

1651 W Main Street, Newark, OH 43055
3600 Stelzer Road, Suite 200, Columbus, OH 43219
(740) 522-3937 / (800)221-4129
Fax (740)522-0063

MEDICAL RECORD RELEASE/AUTHORIZATION & ASSIGNMENT OF PAYMENTS

1. I hereby authorize Specialty Eye Care, Inc., Surgicenter, Ltd., and/or Refractive Center, Ltd. to release all medical records related to me as they deem necessary for my/their care.
2. I authorize payment of any medical benefits, including Medicare, private insurance, and supplementary insurance, for services performed at the Specialty Eye Care, Inc., Surgicenter, Ltd., and/or Refractive Center, Ltd. to be sent directly to the company that performs the services.
3. I also request payment of government benefits to the party who accepts assignment below for services provided at the company:
    a. Specialty Eye Care, Inc.
    b. Surgicenter, Ltd.
    c. Refractive Center, Ltd.
4. I understand that if a facility fee or any other applicable fee, is not covered by my insurance I will be responsible for the charges.
5. This assignment will be valid as long as I remain a member of Medicare or private insurance, or until I cancel this assignment in writing to Specialty Eye Care, Inc., Surgicenter, Ltd., and/or Refractive Center, Ltd.

Patient Signature_____Date_____

Parent or Guardian Signature_____ Date_____

HEALTH HISTORY

(Please complete information below to the best of your ability)

Name: _____ Date of Birth: _____Today's Date:_____

DOCTOR INFORMATION

Referring Physician_____ Eye Doctor_____

Primary Care Physician_____

ALLERGIES

Please list all allergies and reactions (Medications, Latex, Food) [ ]No Known Allergies

_____

_____

PAST OCULAR CONDITIONS (Check all that apply)

[ ] Cataracts [ ] Eye Infections
[ ] Glaucoma [ ] Retinal Disease
[ ] Iritis [ ] Dry Eyes
[ ] Lazy Eye [ ] Macular Degeneration

PAST OCCULAR SURGIES (Write date of surgery)

[ ] Cataracts_____ [ ] Laser _____
[ ] Eyelids_____ [ ] LASIK_____
[ ] Glaucoma_____ [ ] Muscle_____
[ ] Injections _____ [ ] AK/RK_____

PAST MEDICAL HISTORY (Check all that apply)

[ ] Acid Reflux [ ] Alzheimer's/Dementia [ ] Arthritis [ ] Asthma [ ] Anxiety/Depression
[ ] Atrial Fibrillation [ ] Cholesterol [ ] COPD/Emphysema [ ] Heart Attack [ ] Heart Disease
[ ] Heart Failure [ ] Hepatitis [ ] Herpes [ ] HIV/AIDS [ ] High Blood Pressure
[ ] Kidney Disease [ ] MS [ ] Nursing *(Currently)* [ ] Pregnant*(Currently)* [ ] Prostate
[ ] Sarcoidosis [ ] Seizure [ ] Sjorgen's [ ] Stroke/CVA [ ] Thyroid
[ ] TIA [ ] Cancer/Type:_____ [ ] Diabetes/Type__I __ II Yr Diagnosed____
[ ] Other_____

PAST SURGERIES (Check all that apply)

[ ] Appendectomy [ ] Back/Spinal [ ] Brain [ ] Cancer [ ] Carotid Artery
[ ] Cesarean [ ] Defibrillator [ ] Gall Bladder [ ] Heart [ ] Heart Bypass
[ ] Heart Stent [ ] Hernia [ ] Hip/Knee [ ] Hysterectomy [ ] Kidney
[ ] Lung [ ] Pacemaker [ ] Prostate [ ] Thyroid [ ] Tonsils/Adenoids
[ ] Other_____

FAMILY HISTORY (Check all that apply)

[ ] Diabetes
[ ] Glaucoma
[ ] Other _____

SOCIAL HISTORY (Check all that apply)

[ ] Smoker
[ ] Alcohol
[ ] Drugs

CURRENT MEDICATIONS (Name, dosage, # of times per day)

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Additional Information:

_____

_____

PATIENT HIPAA ACKNOWLEDGMENT AND DESIGNATION DISCLOSURE

I. ACKNOWLEDGMENT OF PRACTICE'S NOTICE OF PRIVACY PRACTICES:

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so choose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

_____ _____ _____ _____

Name of Patient | Date of Birth | Signature of Patient/Parent/Guardian | Date

II. DESIGNATION OF CERTAIN RELATIVES, CLOSE FRIENDS, AND OTHER CAREGIVERS AS MY PERSONAL REPRESENTATIVE:

I agree that the practice may disclose certain pieces of my health information to a Personal Representative of my choosing, since such person is involved with my healthcare or payment relating to my healthcare. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my healthcare.

Print Name: _____ Phone Number: _____ DOB or other identifier: _____

Print Name: _____ Phone Number: _____ DOB or other identifier: _____

III. REQUEST TO RECEIVE CONFIDNENTIAL COMMUNICATIONS BY ALTERNATIVE MEANS:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me as I have listed below:

Home telephone number:

___ok to leave a message with detailed information –OR– ___Leave message with call back number only

Work telephone number:

___ok to leave a message with detailed information –OR– ___Leave message with call back number only

Cell telephone number:

___ok to leave a message with detailed information –OR– ___Leave message with call back number only

Email:

___ok to email address Practice has on file

1. The above authorizations are voluntary and I may refuse to their terms without affecting any of my rights to receive healthcare at the Practice.
2. These authorizations may be revoked at any time by notifying the Practice in writing at the Practice's mailing address marked to the attention of "HIPAA Compliance Officer".
3. The revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation.
4. If you request it, a copy of the information described can be obtained at the front desk.
5. This form was completely filled in before I signed it and I acknowledge that all of my questions were answered to my satisfaction and that I fully understand this authorization form.
6. This authorization is valid as of the date I have signed below and shall remain valid until changed or revoked.

_____ _____ _____

Name of Patient (PRINT) | Signature of Patient | Date