WOOLFSON EYE INSTITUTE

PATIENT DATA SHEET

201221

Contact Information

Today's Date: _____

First Name: _____ Last Name: _____

Street Address: _____ City/State: _____

Zip Code: _____ DOB: _____ Birth Sex: _____

Phone Number (day): _____

Email Address: _____

Emergency Contact: _____

Phone Number: _____ Relationship: _____

Preferred Pharmacy

Name: _____

Phone Number: _____

Fax Number: _____

City or Zip Code: _____

Referring Provider

Name: _____

Practice Name: _____

Address: _____

Phone Number: _____

Fax Number: _____

Insurance

Do you have health insurance? ☐ **Yes** ☐ **No** ***If yes, please complete information below.***

Primary Insurance Policy

Payer: _____ Policy Number: _____

Policy Type (Medicare, HMP, PPO, Tricare, etc.):

_____ Group Number: _____

Policy Holder

Patient's Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

If it is not Self, Policy Holder's information must be completed below

First Name: _____ Last Name: _____

☐ Billing address is the same as patient's

Street Address: _____ City/State: _____

Zip Code: _____ DOB: _____ Birth Sex: _____

Phone Number (Day): _____

Past Medical History

Select any of the following medical conditions you currently have:

- ☐ None
- ☐ Anxiety disorder
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Benign prostatic hyperplasia
- ☐ Cerebrovascular accident / Stroke
- ☐ Chronic obstructive lung disease
- ☐ Coronary arteriosclerosis
- ☐ Depressive disorder
- ☐ Diabetes mellitus, type: _____
- ☐ Disease caused by 2019-nCoV
- ☐ End-stage renal disease
- ☐ Epilepsy
- ☐ Gastrooesophageal reflux disease
- ☐ Graves' disease
- ☐ H/O: hypertension
- ☐ Hearing loss
- ☐ HIV
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Malignant lymphoma
- ☐ Malignant tumor of colon
- ☐ Obstructive sleep apnea of adult
- ☐ Radiation therapy treatment
- ☐ Transplantation of bone marrow
- ☐ Other:

_____

_____

_____

_____

Past Surgical History

Have you had any surgeries in the past?

- ☐ Biopsy of breast
- ☐ Coronary artery bypass graft
- ☐ Entire transplanted kidney
- ☐ Excision of basal cell carcinoma
- ☐ Excision of melanoma
- ☐ Excision of squamous cell carcinoma
- ☐ History of colectomy
- ☐ History of percutaneous transluminal coronary angioplasty
- ☐ History of tissue graft heart valve replacement
- ☐ Mechanical heart valve replacement
- ☐ Prosthetic arthroplasty of bilateral hips
- ☐ Splenectomy
- ☐ Total nephrectomy
- ☐ Total replacement of left hip joint
- ☐ Total replacement of left knee joint
- ☐ Total replacement of right hip joint
- ☐ Total replacement of right knee joint
- ☐ Transplantation of heart
- ☐ Transplantation of liver
- ☐ Other:

_____

_____

_____

_____

Past Ocular History

- ☐ None
- ☐ Allergic conjunctivitis ☐ L ☐ R
- ☐ Cataract ☐ L ☐ R
- ☐ Corneal dystrophy ☐ L ☐ R
- ☐ Macular degeneration ☐ L ☐ R
- ☐ Dry eyes ☐ L ☐ R
- ☐ Elevated intraocular pressure ☐ L ☐ R
- ☐ Epiretinal membrane ☐ L ☐ R
- ☐ Glaucoma ☐ L ☐ R
- ☐ Glaucoma suspect ☐ L ☐ R
- ☐ Keratoconus ☐ L ☐ R
- ☐ Nonproliferative retinopathy due to diabetes ☐ L ☐ R
- ☐ Narrow angle glaucoma ☐ L ☐ R
- ☐ O/E - background diabetic retinopathy ☐ L ☐ R
- ☐ Ophthalmic migraine ☐ L ☐ R
- ☐ Posterior vitreous detachment ☐ L ☐ R
- ☐ Proliferative retinopathy due to diabetes ☐ L ☐ R
- ☐ Pseudoexfoliation glaucoma ☐ L ☐ R
- ☐ Retinal tear without detachment ☐ L ☐ R
- ☐ Strabismus ☐ L ☐ R
- ☐ Other: _____ ☐ L ☐ R

_____ ☐ L ☐ R

_____ ☐ L ☐ R

_____ ☐ L ☐ R

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Past Ocular Surgery

- ☐ None
- ☐ Amniotic membrane graft to cornea ☐ L ☐ R
- ☐ Chalazion removal ☐ L ☐ R
- ☐ Corneal collagen cross linking ☐ L ☐ R
- ☐ Corneal transplant ☐ L ☐ R
- ☐ Descemet's membrane endothelial keratoplasty (DMEK) ☐ L ☐ R
- ☐ Descemet's stripping endothelial keratoplasty (DSEK) ☐ L ☐ R
- ☐ Cataract extraction ☐ L ☐ R
- ☐ Dacryocystorhinostomy ☐ L ☐ R
- ☐ Excision of pterygium with graft ☐ L ☐ R
- ☐ Insertion of drainage tube into anterior chamber ☐ L ☐ R
- ☐ Laser trabeculoplasty ☐ L ☐ R
- ☐ Pan-retinal photocoagulation (PRP) ☐ L ☐ R
- ☐ Penetrating keratoplasty (PKP) ☐ L ☐ R
- ☐ Photorefractive keratectomy ☐ L ☐ R
- ☐ Repair of blepharoptosis ☐ L ☐ R
- ☐ Repair of eyelid ☐ L ☐ R
- ☐ Repair of hole of macula lutea ☐ L ☐ R
- ☐ Repair of retinal detachment ☐ L ☐ R
- ☐ Repair of retina for retinal tear or defect ☐ L ☐ R
- ☐ Strabismus surgery ☐ L ☐ R
- ☐ Trabeculectomy ☐ L ☐ R
- ☐ Vitrectomy ☐ L ☐ R
- ☐ Injection of drug into vitreous ☐ L ☐ R
- ☐ Insertion of punctal plug ☐ L ☐ R
- ☐ LASIK ☐ L ☐ R
- ☐ Laser iridotomy ☐ L ☐ R
- ☐ Laser therapy for retinal lesion ☐ L ☐ R
- ☐ Simple excision of pterygium ☐ L ☐ R
- ☐ YAG laser capsulotomy of lens ☐ L ☐ R
- ☐ Other:
  - _____ ☐ L ☐ R
  - _____ ☐ L ☐ R
  - _____ ☐ L ☐ R
  - _____ ☐ L ☐ R
  - _____ ☐ L ☐ R

Medication

List all current medications:

_____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____

Allergies

List all allergies and reactions if known:

_____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____

Social History

Smoking Status:
- ☐ Current every day smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Unknown if ever smoked

Alcohol Intake:
- ☐ None
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day

If you are over 65, how many times this year have you had 5 or more drinks in 24 hours? _____

Occupation and Workplace:

_____

_____

_____

Family History

_____ Member: _____
_____ Member: _____
_____ Member: _____
_____ Member: _____
_____ Member: _____

_____ Member: _____
_____ Member: _____
_____ Member: _____
_____ Member: _____
_____ Member: _____

Review of Systems

Are you currently experiencing any of the following? Please check Yes or No

	System	Yes	No
Excessive Bleeding with Procedures	Hematologic / Lymphatic	☐	☐
Anxiety	Psychiatric	☐	☐
Unexplained Weight Loss	Constitutional / Symptom	☐	☐
Fever	Constitutional / Symptom	☐	☐
Headache	Neurological	☐	☐
Urinary frequency	Genitourinary (G.U.)	☐	☐
Earache	ENT and Mouth	☐	☐
Shortness of breath	Respiratory	☐	☐
Allergies	Allergic/Immunologic	☐	☐
Scalp tenderness	Eyes	☐	☐
Dry mouth	ENT and Mouth	☐	☐
Anemia	Hematologic / Lymphatic	☐	☐
Wheezing	Respiratory	☐	☐
Jaw pain	Eyes	☐	☐
Rapid heart beat	Cardiovascular	☐	☐
Chills	Constitutional / Symptom	☐	☐
Rash	Integumentary	☐	☐
Diabetes	Endocrine	☐	☐
Stuffy nose	ENT and Mouth	☐	☐
Depression	Psychiatric	☐	☐
Cough	Respiratory	☐	☐
Upset stomach	Gastrointestinal (G.I.)	☐	☐
Heat intolerance	Endocrine	☐	☐
Tremor	Endocrine	☐	☐
Difficulty Swallowing	ENT and Mouth	☐	☐
Sinus Congestion	ENT and Mouth	☐	☐
Complaint about Vision, Eye Comfort or Eyelid	Eyes	☐	☐
Severe back pain or Immobility	Musculoskeletal	☐	☐

Other Symptoms: _____

_____

_____

Medical Alerts

Please check Yes or No

	Yes	No		Yes	No
Allergy to adhesive	☐	☐	Narrow angle	☐	☐
Artificial heart valve	☐	☐	Flomax	☐	☐
Steroid responder	☐	☐	Defibrillator	☐	☐
MRSA	☐	☐	Artificial joints within past 2 years	☐	☐
Pseudoexfoliation syndrome	☐	☐	Pregnancy or planning a pregnancy	☐	☐
Pacemaker	☐	☐	Recent unexplained loss of smell or taste	☐	☐
Blood thinners	☐	☐			

Woolfson Eye Institute – Woolfson Ambulatory Surgery Center

Financial Policy/Insurance Submissions

Payment in full is required at the time of service for all non-insured patients and insured patients with past due balances, deductible amounts that have not been met, and any other coverage that could not be verified at the time of service. As the patient, you are required to pay the co-pay/coinsurance at the time of service. Claims are billed to the insurance carrier as a courtesy; however, you are responsible for payment of all charges incurred. Please be advised that there are some clinical and surgical procedures that your insurance will not cover. Therefore, by signing this document, you agree to be held financially responsible for services rendered on or before the time of surgical or clinical service. All balances not paid by the insurance carrier within 90 days of the date of service will be your responsibility. We will be happy to refund you for any payments made by you after your insurance company has paid in full for covered services.

_____ **INITIAL** – I have read and agree to the above statement.

Insurance Changes

If there are any changes to your insurance information, please notify our office immediately. Woolfson Eye Institute/Woolfson Ambulatory Surgery Center will not be responsible for timely filing if we do not receive the correct insurance information prior to or at the time of the visit. It is mandatory to notify your provider of any other insurance carrier who is responsible for payment.

_____ **INITIAL** – I have read and agree to the above statement.

Returned Checks

All checks returned for insufficient funds, closed accounts or for any other reason will be subject to a $25.00 service charge. All further payments must be made either by credit card, money order or cash.

_____ **INITIAL** – I have read and agree to the above statement.

Deductibles/Co-insurance/Co-payments

Deductibles, co-insurance and co-payments will be collected at the time services are rendered. These are required by your insurance company and agreed upon by you when you accept their insurance. We also must contract with insurance companies, agreeing to collect co-payments, co-insurance and deductibles, in order to participate with their plans.

_____ **INITIAL** – I have read and agree to the above statement.

Collection Policy

Once a charge becomes a patient's responsibility, any balance not paid after 90 days will be turned over to an outside collection agency. Balances will also be turned over to patient responsibility if insurance is unable to process claims due to missing or incomplete information not provided by policy holder to their insurance company. Any account turned over to collections will be assessed a collection fee of 30 percent of the total amount due.

_____ **INITIAL** – I have read and agree to the above statement.

Social Security Number

Our office policy requires your social security number to be provided for billing and insurance purposes. By declining to provide us with a social security number, you agree to pay for your services prior to services being rendered.

_____ **INITIAL** – I have read and agree to the above statement.

Surgical Predetermination Process

Predetermination takes place prior to surgery and requires that a letter of medical necessity, any photographs and/or testing be sent to your insurance company for review and possible approval. This process can take four to six weeks, and if surgery is approved, there is no guarantee of payment. *Should you wish to proceed with an unapproved surgical procedure, you will be asked to sign the waiver in lieu of insurance claim filing, and we will ask for payment in full. Woolfson Eye Institute will not refund any private pay monies collected on an unapproved surgery. You may wish to file the claim on your own and agree to accept what your insurance company PAYS YOU after the surgery has taken place.*

_____ **INITIAL** – I have read and agree to the above statement.

External Photo Charge

In order to evaluate and treat your condition, external photos maybe required. Although insurance companies require proper documentation with photos, it may not be a covered service. A photo charge of $15.00 is due at the time of initial service. This charge is in addition to your office visit, copay or deductible. If you are covered by insurance, we will file for this charge for reimbursement. If we are reimbursed by your insurance company for this charge, your account will be credited back the fee.
I understand that Woolfson Eye Institute may use photos for the treatment of my care. I understand that the charge may not be a covered service and that I am responsible for payment at the time of service.

_____ **INITIAL** – I have read and agree to the above statement.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. We would be willing to discuss reasonable payment plans. If you have any question about the above information, please do not hesitate to ask us.

I hereby assign all medical and/or surgical benefits, to include major medical benefits that I am entitled, including Medicare, private insurance and any other health plan to Woolfson Eye Institute/Woolfson Ambulatory Surgery Center. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges, whether or not these charges are paid by my medical insurance. I hereby authorize Woolfson Eye Institute/Woolfson Ambulatory Surgery Center to release any and all information necessary to secure payment.

_____ _____

Signed – Patient or Patient's Personal Representative Date

_____

Print Name

_____ _____

Witnessed by staff member Date

Notice of Privacy Practices
PHI – Protected Health Information

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.*

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. We must obtain your authorization before the use and disclosure of any psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosure that constitute a sale of PHI. Uses and disclosures not described in this Notice of Privacy Practices will be made only with authorization from the individual.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the Practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the Practice or the hospital. For example, we may disclose medical information about you to people outside the Practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the Practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other Practice personnel for review and learning purposes. For example, we may review your record to assist our quality improvement efforts.

WHO WILL FOLLOW THIS NOTICE? This notice describes our Practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other Practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the Practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the Practice, whether made by Practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; inmates; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; protective services for the President and others; public health risks; and worker's compensation.

Notice of Individual Rights

You have the following rights regarding medical information we maintain about you:

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.
Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.
Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the Practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.
Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.
Right to Request Removal from Fundraising Communications. You have the right to opt out of receiving fundraising communications from the Practice.
Right to Restrict Disclosures to Health Plan. You have the right to restrict disclosures of PHI to a health plan if the disclosure is for payment of health care operations and pertains to a health care item or service for which the individual has paid out of pocket in full.
Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.
Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer.
CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the Practice's waiting room.
COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact Doug Frye, Privacy Officer, (770) 921-4300, 627 Beaver Ruin Road, Suite B, Lilburn, GA 30047. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**
OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time.
If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.

_____ _____
Signed – Patient or Patient's Personal Representative Date

_____ _____
Witnessed by staff member: Date

I give authorization for Woolfson Eye Institute to discuss appointment/rescheduling details/medical information if necessary with:

Name:_____Relationship:_____Phone Number:_____

Name:_____Relationship:_____Phone Number:_____