WILLIAMSON ALLEMOND
REGIONAL EYE CENTER

Patient Medical History Form

Name: _____ **Date:** _____

Male / Female **Race / Ethnic Group:** _____

Please list all medication allergies: _____

_____

Please list all current medications: _____

_____

Please list all current eyedrops or eye medications: _____

_____

REVIEW OF SYSTEMS: (CIRCLE ALL THAT APPLY)

High Blood Pressure Heart Disease Diabetes Arthritis Osteoporosis Thyroid

Dizziness Pain Headaches Stroke Cancer Recent Fever Weight Loss

Weight gain Chronic Cough Sore Throat Lungs Breathing Bronchitis

Sinus Swelling of Glands Coumadin User Plaquenil User

LIST PRIOR SURGERIES, EYE DISEASE, EYE INFECTIONS, EYE INJURY, CONTACTS:

_____

_____

Have you experienced any of the following symptoms lately?
Please explain if yes.

Change in Vision _____
Blurry, Cloudy, or Poor Night Vision _____
Double Vision _____
Distorted Vision _____

CONTINUED ON BACK

Spider Webs, Floaters, or Flashes of Light _____
Sensitivity to Light _____
Pain in the Eye _____
Chalazion, Stye _____
Rainbows, Halos _____
Sudden Loss of Vision _____
Crossed Eye, Lazy Eye _____
Redness, Discharge _____
Dryness, Itchy Eye, Tearing _____

FAMILY HISTORY: (RELATIONSHIP TO PATIENT)

Blindness _____
Cataract _____
Glaucoma _____
Macular Degeneration _____
Stroke _____
Sjogren's Syndrome _____
Tuberculosis _____
Arthritis _____
Cancer _____
Diabetes _____
Heart Attack _____
High Blood Pressure _____
Lupus _____
Thyroid Disease _____
Other _____

SOCIAL HISTORY:

Primary Care Doctor: _____

Current Occupation: _____

Do you Drink? / How Often? _____

Do you smoke? / How many packs a day? _____

REASON FOR YOUR VISIT TODAY:

_____

_____

_____

iWellness Exam

Your eyesight is priceless and we are here to protect it!

Vision threatening diseases such as glaucoma, macular degeneration and diabetic retinopathy often have no outward signs or symptoms in the early stages, so our practice has begun using state-of-the-art technology to assess the health of your eyes.

The iWellnessExam® is a quick, non-invasive scan that allows our doctors to see beneath the surface of your retina. This unique technology can help our doctors detect vision threatening and systemic diseases in their very early stages, when they are most treatable. Like an MRI of the eye, but taking only seconds to perform, the iWellnessExam provides a high-definition cross sections of your retina and optic nerve which can reveal signs of disease in exquisite detail that are invisible to traditions examination methods. Retinal Imaging captures comprehensive digital images of the surface of the retina.

As part of your pre-exam testing, our technician will perform the iWellnessExam which your doctor will review with you during your examination today. The $39 charge is not covered by your vision or medical insurance, so this will be added into the cost of your visit today. Any questions you have about iWellnessExam and the results of the test can be discussed with your doctor during your examination.

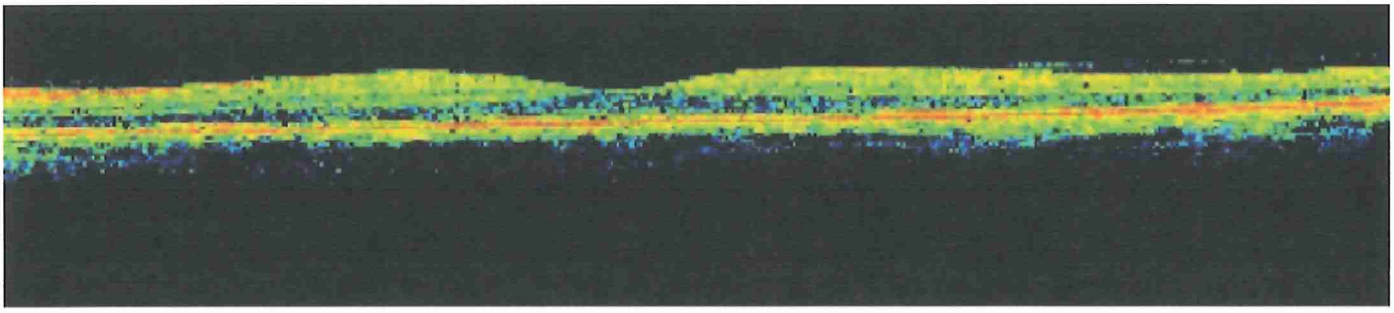
Thank you for choosing our practice to protect the health of your eyes!

____ Yes, I would like to have this test. ____ No, I do not wish to have this test.

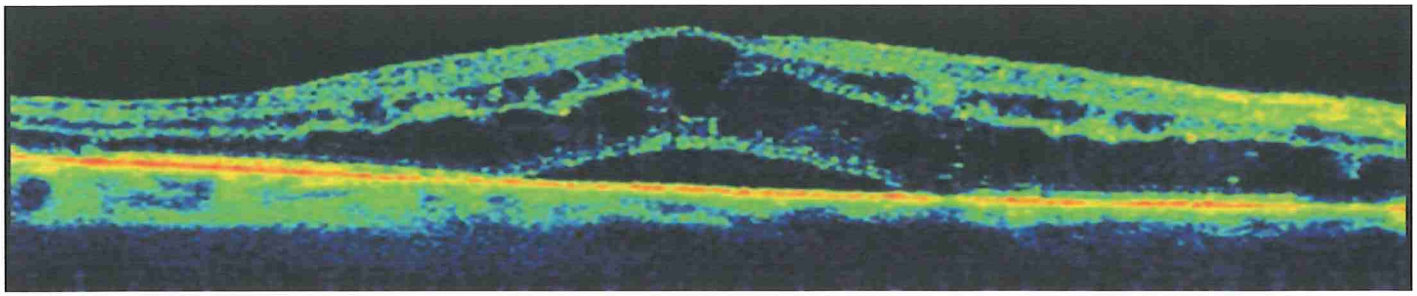
_____ _____

Patient/Guardian Signature **Date**

Healthy Retina



Unhealthy Retina



VERSION: 2023

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WILLIAMSON ALLEMOND
REGIONAL EYE CENTER

APPOINTMENT NO-SHOW POLICY

Effective August 2018

We are experiencing an increasing number of no-show appointments. We would appreciate a simple phone call to our office 24 hours in advance to let us know that you are unable to make your appointment. Our patients are very important to us and we strive to meet their needs. If you do not show up for your appointment OR if you call us to cancel with less than 24 hours' notice, there will be a $25 charge applied to your account. Thank you for helping us keep our schedule as open as possible for patients that are in need.

By signing below, I acknowledge that I have been informed of Williamson Allemond Regional Eye Center's No-Show Policy.

_____ _____

Patient or Guardian Signature **Date**

PATIENT DEMOGRAPHICS
Version 09.24.2015

WILLIAMSON ALLEMOND REGIONAL EYE CENTER

NAME *(Please Circle One)* MR. MRS. MS. DR.

DATE: _____

FIRST:_____ MI:_____ LAST:_____

DATE OF BIRTH: _____ GENDER:_____ NICKNAME:_____

ADDRESS

MAILING ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

HOME PHONE:_____ DAYTIME PHONE:_____ MOBILE PHONE:_____

SSN:_____ MARITAL STATUS: O - SINGLE O - MARRIED O - DIVORCED O - WIDOWED

GUARANTOR INFORMATION

IS THE GUARANTOR THE SAME AS THE PATIENT? O - YES O - NO

IF NOT, PLEASE COMPLETE THIS SECTION: SOCIAL SECURITY NUMBER:_____

FIRST NAME:_____ MIDDLE NAME:_____ LAST NAME:_____

STREET ADDRESS:_____ DATE OF BIRTH: _____

CITY:_____ STATE:_____ ZIP:_____

ADDITIONAL INFORMATION

EMAIL ADDRESS:_____ PATIENT EMPLOYER:_____

HOW DID YOU FIND OUT ABOUT US? _____

ETHNIC GROUP: O - HISPANIC / LATINO O - NON-HISPANIC / LATINO O - UNKNOWN

RACE: *(Please Check)*
O - AMERICAN INDIAN / ALASKAN NATIVE
O - ASIAN
O - AFRICAN AMERICAN / BLACK
O - NATIVE HAWIAN / PACIFIC ISLANDER
O - CAUCASIAN / WHITE
O - MORE THAN ONE RACE
O - UNKNOWN

EMERGENCY CONTACT:_____ PHONE:_____

LEGAL REPRESENTATIVE:_____ LANGUAGE:_____

PRIMARY CARE PHYSICIAN:_____ PHONE:_____

OTHER PHYSICIAN:_____ PHONE:_____

INSURANCE & PAYMENT

Version 09.24.2015

WILLIAMSON ALLEMOND REGIONAL EYE CENTER

HEALTH INSURANCE CARRIER(S)

PRIMARY:_____ **SECONDARY:**_____

VISION INSURANCE CARRIER(S)

PRIMARY:_____ **SECONDARY:**_____

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY AND SIGN BELOW:

I request payment of authorized Medicare, Medicaid or other insurance carrier's benefits be made on my behalf to Williamson Allemond Regional Eye Center for any services furnished. I authorize the holder of medical information to release to the Health Care Financing Administration and its agents, and any other authorized insurance carrier, information needed to determine these benefits or the benefits payable for related services.

There are some services that Medicare, Medicaid and most other insurance carriers **Will Not Pay For**. In these cases I may be responsible for the remaining balance on my account. These fees **Plus** any co-payments or deductibles are **Due At The Time Of Service**.

I have read and understand this information.

PATIENT SIGNATURE (OR REPRESENTATIVE): _____ **DATE:**_____

FINANCIAL AGREEMENT

I understand that payment is due at the time of service. I agree to pay for all past due balances that were unpaid by my insurance company from previous visit and/or treatment. This includes: copays, coinsurance, deductibles or any other non-covered charges for medical care. If I do not have medical insurance, I understand that it becomes my responsibility to make financial arrangements prior to the medical services rendered. I further authorize third parties to pay directly the **Williamson Allemond Regional Eye Center** any insurance benefits due for services rendered on my behalf or the named patient that I am a guarantor for. I hereby assign all medical and vision benefits to include major medical benefits and vision plan benefits to which I am entitled, including Medicare, Medicaid, private insurance policies and other related health and/ or vision plans to the **Williamson Allemond Regional Eye Center.**

I agree to notify the **Center** of any changes in insurance, changes in my address or in the case of any other changes to information included in my demographic or registration paperwork. I understand that I am responsible for all charges not paid by my insurance carriers. If it becomes necessary to collect any sum of money due through the use of a collection agency or attorney, then I agree to pay all reasonable costs of collection proceedings and attorney's fees, whether a suit is filed or not. Additionally, I agree to pay court costs associated with such collection efforts as well. I understand that I am responsible for verifying that my providers participate with my insurance plan and that I must present my insurance cards at each office visit.

PATIENT SIGNATURE (OR REPRESENTATIVE): _____ **DATE:**_____

CONSENT & RELEASE

Version 09.24.2015

WILLIAMSON ALLEMOND REGIONAL EYE CENTER

CONSENT TO TREAT

I hereby, authorize and direct the doctor(s) at the **Williamson Allemond Regional Eye Center** to assess, diagnose, and treat my medical condition(s). I further authorize and direct the doctor(s) and their designated staff to prescribe medications for me and perform any procedures on me which in their judgment is advisable for my well-being, and to provide such additional services as he or she may deem appropriate. I understand these medications and/or procedures may come with associated benefits as well as risks and/or side effects and these will be discussed with me at the time of treatment.

I acknowledge I have read and understand this consent form (or that it has been read to me). I acknowledge that I understand the information contained in this consent form, including all of the medical terminology, about which I have asked if unsure. I have been given an adequate opportunity to ask whatever questions I have about the treatment and my care, and all of my questions about the treatment have been answered by my physician and/or his associates or assistants in a satisfactory manner. I understand the nature and purpose of the treatment, its risks, and the alternatives.

This consent form is valid until it is expressly revoked and the revocation is communicated to my physician. I understand and agree that it is my responsibility to communicate any revocation of this consent to my physician and/or the medical staff.

PATIENT SIGNATURE (OR REPRESENTATIVE): _____ **DATE:**_____

NOTICE OF PRIVACY PRACTICES & RELEASE OF INFORMATION

I have received a copy of the Notice of Privacy Practices of the Williamson Allemond Regional Eye Center. This Notice describes how my health information may be used or disclosed. I understand that I should read it carefully and ask questions if there is any part of the Notice that I do not understand. I am aware that the Notice may be changed at any time.

*If you are a minor, your healthcare provider has the right to disclose protected health information to your parents or guardians should he/she deem necessary.

By signing below, I attest that all of my questions have been answered satisfactorily, and I understand that I may obtain a copy of the Notice if I wish.

PATIENT SIGNATURE (OR REPRESENTATIVE): _____ **DATE:**_____

In addition to those entities listed in the Notice, I am authorizing the Williamson Allemond Regional Eye Center to release my personal health information to the following individuals listed in the table below. I understand I may change or revoke this authorization at any time by submitting a written letter declaring my desires to add or remove individuals and by presenting my ID.

Date	Name	Relationship To Patient	Phone Number