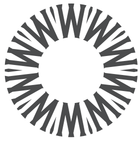


Waco Ophthalmology
Medical and Surgical Eye Care

PATIENT DEMOGRAPHICS

Patient Name: ____
First *Middle* *Last*

Sex: _____ Date of Birth: ____/____/____ Social Security No. ______________

Primary Language

❍ *English* ❍ *Spanish* ❍ *Other (Please List)* ______________

____
Mailing Address *City* *State* *Zip*

____
E-mail Address

____
Home Phone *Cell Phone* *Work Phone*

____
Employer

____
Primary Care Physician

____
Referring Doctor

____
Marital Status *Spouses Name*

Emergency Contact (not living with you):

____
Name *Relationship* *Phone Number*

INSURANCE INFORMATION

Primary Insurance Company Name: ______________________________

Insured's Name: ______________________ *Insured's DOB:* ______________________

Insured's Social Security No.: ______________________________

Relationship to Patient: ______________________________

Policy Number: ______________________ *Group Number:* ______________________

Secondary Insurance Company Name (if applicable): ______________________________

Insured's Name: ______________________ *Insured's DOB:* ______________________

Insured's Social Security No.: ______________________________

Relationship to Patient: ______________________________

Policy Number: ______________________ *Group Number:* ______________________

ASSIGNMENT / MEDICAL RECORD RELEASE AUTHORIZATION

I authorize payment of medical benefits to Waco Ophthalmology, PLLC, and Dr. Michael Rolfsen, Jr. for any services furnished to me by these providers. I also authorize Waco Ophthalmology to release to my insurance company information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

______________________________ ______________________

Signature *Date*

CONSENT TO MEDICAL TREATMENT

I have requested and consent to medical services and treatment from Waco Ophthalmology, PLLC, and Dr. Michael Rolfsen, Jr. on behalf of myself and/or my dependents.

______________________________ ______________________

Signature *Date*

CONSENT TO CALL

I agree that Waco Ophthalmology and/or its agents may contact me at any telephone number or e-mail address associated with my account. Phone calls may be about appointments, test results, surgical follow-up, and more.

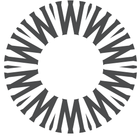
Preferred Method of Communication

❍ *E-mail* ❍ *Phone Call* ❍ *Text Message*

______________________________ ______________________

Signature *Date*

patient demographics continued



Waco Ophthalmology

Medical and Surgical Eye Care

MEDICAL HISTORY

Patient Name: ______________________ Date of Birth: ____/____/____

DO YOU HAVE, OR HAVE YOU EVER HAD:

YES	NO	
❍	❍	*Hypertension (high blood pressure)*
❍	❍	*Diabetes*
❍	❍	*Cancer (type________________)*
❍	❍	*Kidney Disease (dialysis ❍ Yes or ❍ No)*
❍	❍	*Asthma*
❍	❍	*COPD / Emphysema*
❍	❍	*High Cholesterol (hyperlipidemia)*
❍	❍	*Heart Failure (CHF)*

YES	NO	
❍	❍	*Stroke*
❍	❍	*Thyroid Disease*
❍	❍	*Lazy Eye / Amblyopia*
❍	❍	*Glaucoma*
❍	❍	*Cataracts*
❍	❍	*Macular Degeneration*
❍	❍	*Depression / Anxiety*

Any other medical diagnosis not listed: ______________________

Surgeries: ______________________

Eye Surgeries / Laser (including LASIK): ______________________

Eye Injuries: ______________________

Medications you are currently taking: ______________________

____

Drug Allergies: ______________________

DO YOU CURRENTLY USE:

YES	NO	
❍	❍	*Cigarettes / Tobacco (If yes, packs per day ________)*
❍	❍	*Alcohol*
❍	❍	*Other Drugs*

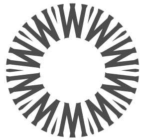
FAMILY HISTORY

- ❍ *Glaucoma*
- ❍ *Macular Degeneration*
- ❍ *Retinal Detachment*
- ❍ *Heart Attacks*
- ❍ *Diabetes*
- ❍ *Other:* ______________________

REVIEW OF SYMPTOMS

- ❍ *Fever*
- ❍ *Weight Loss*
- ❍ *Night sweats*
- ❍ *Fatigue*
- ❍ *Weakness*
- ❍ *Chest Pain*
- ❍ *Irregular Heart Beat*
- ❍ *Shortness of Breath*
- ❍ *Cough*
- ❍ *Wheezing*
- ❍ *Dizziness*
- ❍ *Recent change in vision*
- ❍ *New Floaters*
- ❍ *Eye Pain*
- ❍ *Eye Redness*
- ❍ *Bleeding / Bruising*
- ❍ *Weight Gain*
- ❍ *Nausea*
- ❍ *Diarrhea*
- ❍ *Rash*
- ❍ *Arthritis*
- ❍ *Anxiety / Depression*
- ❍ *Painful Urination*
- ❍ *Hearing Loss*
- ❍ *Ringing in Ears*
- ❍ *Headaches*
- ❍ *Double Vision*
- ❍ *New Flashers*
- ❍ *Light Sensitivity*
- ❍ *Other:* __________________________
- ❍ *Other:* __________________________
- ❍ *Other:* __________________________

medical history continued



Waco Ophthalmology
Medical and Surgical Eye Care

FINANCIAL DISCLOSURE

At Waco Ophthalmology, we are committed to providing you with the highest level of service and quality care. If you have medical insurance, we will strive to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our financial policy. Ultimately, however, any and all financial liability rests with the patient.

Our office participates with most major medical insurance plans. We provide MEDICAL AND SURGICAL ophthalmologic care to our patients. While annual exams are frequently needed to monitor these medical eye conditions, most medical health insurance does NOT cover routine eye exams checking only for glasses, leaving the patient responsible for full cost of the exam. We do not participate with any vision plans, which would pay for these routine eye exams and glasses checks. A refraction (determining if there is a need for corrective eyeglasses or contact lenses) is also not covered by most health insurance plans. The patient will be responsible for payment of the entire $35 charge for this service.

If you have a managed care plan that requires a referral to see a specialist, you are responsible for obtaining a referral in order for your visit in our office to be covered under your medical insurance. If you do not have a valid referral and still wish to be seen, you will be asked to pay for the visit prior to your examination.

If Waco Ophthalmology does not participate in your insurance plan, you will be responsible for filing your own claims and for paying in full at the time service is rendered.

It is the patient's/parent's/guardian's responsibility to:

- Be familiar with the benefits of your plan, including co-pays, coinsurance and deductibles.
- Bring all of your current information including address, phone numbers and employer.
- Bring all of your insurance cards to each visit.

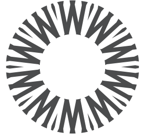
In accordance with your insurance contract, you must be prepared to pay your co-pay at each visit.

We accept cash, checks and most major credit cards for services. We appreciate prompt payment in full for any outstanding balance. If your account is turned over to our collection agency, you agree to pay any fees imposed by the collection agency in order to collect the overdue amount. Any check payments that do not clear the bank will be subject to a $25.00 returned check fee.

SURGERY CHARGES: Waco Ophthalmology will make every effort to determine your insurance benefits prior to your scheduled surgery. We will notify you of the amount you will be responsible for paying prior to your scheduled surgery. Please keep in mind that this is just an estimate. You may incur additional charges (in addition to the surgeon's fees) from the surgery facility, anesthesiologist, laboratory and/or radiologist.

I have read and understand the above financial policy

____________________________________ ____________________
Signature *Date*



Waco Ophthalmology

Medical and Surgical Eye Care

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICE FORM

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 Waco Ophthalmology'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

---

for office use only

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

________________________________ ________________

Name of Staff Member *Date*

Reason(s) Acknowledgment was not obtained: ________________________________