TODAY'S DATE:

FOR OFFICE USE ONLY: MRN #

Bohn, Joseph & Swan Eye Center

Jonathan M. Joseph, MD ~ Kevin R. Swan, MD ~ Auzita Sajjadi, OD

WELCOME TO OUR OFFICE ~ PLEASE PRINT CLEARLY

Name: ____ **Date of Birth:** ____________________

LAST, FIRST, MI

ADDRESS: ____

CITY:______________________________ **STATE:** ____________ **ZIP:** ____________ **RACE:** ________________

SOCIAL SECURITY # ______________________________ **SEX: M F MARITAL STATUS:** ____________________

HOME PHONE: ____________________ **WORK PHONE:** ____________________ **CELL:** ____________________

EMAIL: ______________________________________

EMPLOYER NAME: ______________________________ **OCCUPATION:** ______________________________

*****IF THE PATIENT IS A MINOR OR YOU HAVE POWER OF ATTORNEY AND WOULD LIKE THE BILLING TO BE SENT TO A DIFFERENT ADDRESS THAN ABOVE, PLEASE FILL OUT THE FOLLOWING INFORMATION*****

PARENT OR GUARDIAN'S NAME: ____

SSN: ______________________________ **RELATIONSHIP TO PATIENT:** ______________________________

ADDRESS: ____

CITY: ______________________________ **STATE:** ____________________ **ZIP:** ____________________

HOME PHONE: ____________________ **WORK PHONE:** ____________________ **CELL:** ____________________

MEDICAL INSURANCE INFORMATION

PRIMARY INSURANCE: ____

POLICY HOLDER (IF OTHER THAN PATIENT): ______________________________________

POLICY HOLDER DOB: ________________________ **SSN # OF POLICY HOLDER:** ________________________

RELATIONSHIP TO PATIENT (CIRCLE ONE) SPOUSE PARENT SELF OTHER________________

SECONDARY INSURANCE: ____

POLICY HOLDER (IF OTHER THAN PATIENT): ______________________________________

POLICY HOLDER DOB: ________________________ **SSN # OF POLICY HOLDER:** ________________________

RELATIONSHIP TO PATIENT (CIRCLE ONE) SPOUSE PARENT SELF OTHER________________

TERTIARY INSURANCE: ____

POLICY HOLDER (IF OTHER THAN PATIENT): ______________________________________

POLICY HOLDER DOB: ________________________ **SSN # OF POLICY HOLDER:** ________________________

RELATIONSHIP TO PATIENT (CIRCLE ONE) SPOUSE PARENT SELF OTHER________________

EMERGENCY CONACT

NAME: ______________________________________ **RELATIONSHIP:** ______________________________

PHONE NUMBER: ______________________________ **ALTERNATE PHONE :** ______________________________

PATIENT HISTORY QUESTIONNAIRE

NAME: ______________________________ **DOB:** ______________________

PRIMARY CARE PHYSICIAN: ______________________ **CARDIOLOGIST:** ______________________

HOW DID YOU HEAR ABOUT US? ______________________________

CURRENT EYE MEDICATIONS: ______________________________

____

CURRENT OTHER MEDICATIONS: (please include strength and dosage)______________________________

____

____

____

ALLERGIES: ______________________________

____

____

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING SURGERIES:

☐ ANGIOPLASTY	☐ BYPASS SURGERY	☐ KNEE REPLACEMENT
☐ APPENDECTOMY	☐ COLONECTOMY	☐ MASTECTOMY
☐ BLADDER SUSPENSION	☐ HIP REPLACEMENT	☐ TONSILLECTOMY
☐ BREAST BIOPSY	☐ HYSTERECTOMY	

CHECK IF YOU HAVE:

- DIABETES ☐
- HIGH BLOOD PRESSURE ☐
- HEART TROUBLE ☐
- BREATHING TROUBLE ☐
- RENAL DISEASE (KIDNEY) ☐
- CANCER ☐
- OTHER SERIOUS ILLNESS ☐
- NONE OF THE ABOVE ☐

CHECK IF YOU HAVE FAMILY HISTORY OF:

- DIABETES ☐
- GLAUCOMA ☐
- MACULAR DEGENERATION ☐
- CORNEAL DISEASES ☐
- RETINAL DETACHMENT ☐

CHECK IF YOU HAVE BEEN DIAGNOSED WITH ANY OF THE FOLLOWING:

- CATARACTS ☐
- GLAUCOMA ☐
- CROSSED EYES ☐
- LAZY EYE ☐
- EYE INJURY ☐
- BAD HEADACHES ☐
- MACULAR DEGENERATION ☐
- OTHER EYE PROBLEM: ☐

____

CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING EYE SURGERIES:

CORNEAL ☐	CATARACT ☐
GLAUCOMA ☐	RETINAL ☐
REFRACTIVE ☐	EYE REMOVAL ☐

CONTACT LENS WEARER

	YES	NO
HARD LENSES	______	______
SOFT LENSES	______	______

PLEASE CHECK YES OR NO FOR THE FOLLOWING QUESTIONS:

	YES	NO
BLURRY VISION	_____	_____
DOUBLE VISION	_____	_____
LOSS OF VISION	_____	_____
GLARE	_____	_____
LIGHT SENSITVITY	_____	_____
FLOATERS	_____	_____
FLASHES	_____	_____
MUCUS	_____	_____
DISCHARGE	_____	_____
PAIN	_____	_____
SORENESS	_____	_____
INFECTION (EYES OR LIDS)	_____	_____

WHAT PROBLEMS DO YOU WANT TO DISCUSS WITH YOUR DOCTOR?

____

____

____

____

____

____

I Understand the importance of providing truthful personal and medical information to assist my doctor in providing the best care possible. The information I have provided here is complete and accurate. I understand that payment is due when services are rendered and that I am financially responsible for any charges not covered by the insurance coverage I may have.

Patient/Guardian Signature______________________________ Date:______________________

Bohn, Joseph & Swan Eye Center
Jonathan M. Joseph, MD ~ Kevin R. Swan, MD ~ Auzita Sajjadi, OD

AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION

I give Bohn, Joseph, & Swan Eye Center permission to release medical information to the following individuals:

Name: ___________________________________ **Relationship:**_____________________ **Phone #:**______________________
Name: ___________________________________ **Relationship:**_____________________ **Phone #:**______________________
Name: ___________________________________ **Relationship:**_____________________ **Phone #:**______________________
Name: ___________________________________ **Relationship:**_____________________ **Phone #:**______________________
Name: ___________________________________ **Relationship:**_____________________ **Phone #:**______________________
Name: ___________________________________ **Relationship:**_____________________ **Phone #:**______________________

****

REMINDER NOTICE AUTHORIZATION

Our automated system will contact you with a reminder for your upcoming appointments 1 week before, 3 days before and 1 day before. By signing below you are authorizing us to do so. This may also be used for notifying you of emergency closures on a day you are scheduled.

I would like to be contacted regarding upcoming appointments in the method checked below:
(Please check a minimum of one of the line below)

______ **Please email me regarding my appointments at the following email address**

_________________________________@___________________.___________

_______ **Please text me regarding my appointments @** ____________________________

______ **Please call me regarding my appointments @** ______________________________

______ **I wish to opt out of ALL reminders. By opting out I accept any responsibility for missed appointments.**

Patient Signature ____ **Date** ____________________________

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REFRACTION POLICY

One of the most important parts of your eye exam is the refraction. That is the part of the exam by which we determine the best possible acuity for your eyes, which is an essential piece of medical information that is used to assess your eyes and search for medical conditions and other vision problems. In is NOT a covered service by Medicare and many other insurance plans. The refraction fee is collected AT THE TIME OF SERVICE. This is in addition to any co-payment, co-insurance, or deductible your plan may require. Should your plan pay us for the refraction, we will reimburse you.

By signed you are indicating that you have read the above information and understand that the refraction is a non-covered service. You accept full responsibility for the cost of this service and understand it is due at the time of service. You understand that any co-payment, co-insurance or deductible that you may have is separate from and not included in the refraction fee.

*****SHOULD YOU CHOOSE NOT TO HAVE A REFRACTION AND YOU BREAK OR LOSE YOUR GLASSES, WE WILL NOT BE ABLE TO PROVIDE YOU WITH A GLASSES PRESCRIPTION. YOU WILL BE ASKED TO SCHEDULE A RETURN APPOINTMENT AND CHARGED ANOTHER OFFICE VISIT ALONG WITH THE REFRACTION FEE.*****

Patient Printed Name ____

Patient Signature ____ **Date**___________________

****

DILATION CONSENT

Dilation is necessary to perform a complete eye exam of the retina and back of the eye. This may reveal the presence of a serious systemic condition as well as eye conditions. You may require driving assistance until the drops wear off.

Risks include: Blurred vision after dilation until drops wear off, Glare and distorted vision until drops wear off, In rare cases extreme elevation of the eye pressure can occur, allergic reaction can occur, increased blood pressure, cardiac arrhythmias, tachycardia, dizziness, increased swelling. <u>Please inform us immediately if any of these rare side effects occur</u>.

I authorize my physician and his staff to administer dilating eye drops.

Printed Name ____________________________________

Signature ____________________________________

Date ____________________________________

Bohn, Joseph & Swan Eye Center

Jonathan M. Joseph, MD ~ Kevin R. Swan, MD ~ Auzita Sajaddi, OD

In connection with the medical services currently received from Bohn, Joseph & Swan Eye Center, ("the practice"), the undersigned hereby agrees as follows:

Authorization to Release Information: Insurers and managed care companies occasionally review medical charts to ensure compliance with the company procedures. I understand that my chart may be selected for such review and that the confidentiality of this information in my chart will be preserved and I hereby consent to such review and release the physician and such insurer or managed care company for liability for any reasonable review of my chart.

Payment Agreement: I request that payment of authorized medical benefits be made on my Behalf to the Practice or any physician in their association or employ, for services furnished me by said physicians. I further understand that I will be solely responsible for any deductibles, co-insurance and/or non-covered services not payable by my insurance plan. I further understand that most insurance companies will not pay for an examination for glasses or contact lens or change of lenses and that I will be asked to pay for this service at the time the service is done. I authorize the release of medical information about me to my insurance carrier and its agents needed to determine the benefits payable for related services. In the event I am not covered by an insurance plan to which Bohn, Joseph & Swan Eye Center belong to at the time of my visit, I understand that I am responsible to pay for services provided at standard clinic charge amounts.

Medicare Signature Authorization: Medicare *does not* pay for services provided if there is no medical eye disease or medical eye problem. If you are here to have your eyes examined for glasses only, you will be responsible for full payment because Medicare does not cover a standard eye exam for eyeglasses. Medicare has made it very clear that this is not a covered service, just as standard dental work is not a covered service. If you are here for problems with your eyes (blurry vision, red eyes, swollen eyes, glaucoma, cataracts, etc.) Medicare will cover the visit, however, they will not cover the refraction. Most Medicare supplements will also not pay. I request payment of authorized Medicare benefits be made to the Practice for any services furnished to me by the Practice. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related service.

No Insurance Coverage: I understand that should I not have insurance coverage, I am fully responsible for payment of services provided by the Practice to me and/or my dependents, AT THE TIME SERVICES ARE RENDERED, unless other financial arrangements have been made with the practice PRIOR to being seen by my physician.

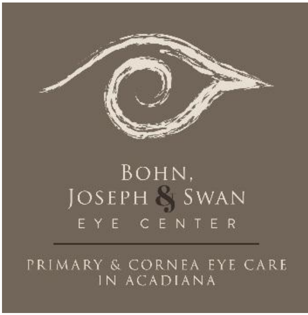
Financial Agreement: I understand that Bohn, Joseph & Swan Eye Center will file a claim on my behalf for the services rendered at the time of service and I authorize Bohn, Joseph & Swan Eye Center to receive payment from my insurance company. Should it be determined that my insurance is not valid when my insurance company receives and processes the claim, I understand that I will be fully responsible for all charges incurred on the date of service.

CANCELLATION AND "NO SHOW" FEE POLICY: We reserve the right to charge a fee of $20 for all missed appointments (No Shows) and appointments which are not cancelled with a 24-hour advanced notice. This fee is not covered by insurance and MUST be paid prior to your next appointment being scheduled. Multiple "no shows" in any 12 month period may result in termination from our practice.

Notice of Privacy Policies: I have read and been offered a copy of the Notice of Privacy Practices located in the main lobby.

Printed Name ___________________________________ Signature of Patient ________________________________

Printed Name if Signature is not patient ________________________________ Date __________________________



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www.bohnjosephswaneye.com

DISCLOSURE OF FINANCIAL INTEREST
(As Required by R.S. 37:1744 and LAC:XLV.4211-4215)

Date: ____________________________________

Patient: ____

Louisiana Law requires physicians and other health care providers to make certain disclosures to a patient when they refer a patient to when they refer a patient to a facility in which the physician has a significant financial interest. We may refer you, or the named patient for whom you are legal representative, to:

> **Bohn & Joseph Optical Boutique, L.L.C.**
> **609 Guilbeau Road**
> **Lafayette, LA 70506**

To obtain the following health care services, products, or items: **<u>Prescription lens, contact lens, lens frames and other eyewear.</u>**

We have a financial interest in Bohn, Joseph & Swan Optical Boutique, L.L.C. to whom we are referring you, or to whom we may refer you in the future, the nature and extent of which are as follows:

> **Bohn, Joseph & Swan Optical Boutique, L.L.C., is wholly owned by Bohn, Joseph & Swan Eye Center, A Professional Medical Corporation.**

PATIENT ACKNOWLEDGEMENT
I, the above-named patient, or legal representative of such patient, hereby acknowledge receipt, on the date indicated and prior to the described referral, of a copy of the foregoing Disclosure of Financial Interest.

____
Signature of Patient or Patient's Representative

____
Printed Name of Person Signing