DR. SUMMERS
OPHTHALMOLOGY
Board-Certified Ophthalmologist

5000 Ambassador Caffery Pkwy Bldg 13
Lafayette, LA 70508
Ph 337-233-3368
F 337-233-3367
LafayetteiCare.com

Patient Demographics

Name_____Age_____Birthdate_____
Address_____City_____
Zip code_____ Home phone_____Cell phone_____
Social Security #_____ Work Phone _____

Spouse Name_____Birthdate_____
Work Phone_____Cellphone_____Social Security#_____

Emergency Name and phone #:_____

Do you wear glasses?_____Contacts?_____

How long have you had this latest prescription?_____

Summarize your problem: (include if it is right or left eye and duration of problem)_____
_____

Name of Insured_____Birthdate_____
Insurance Company Name_____Phone Number _____
Employer_____Employer Phone_____

Do you have Medicare?_____Medicaid?_____Insurance?_____
Please show your latest insurance cards and Drivers License to the secretary.

Notice: All procedures such as exams and visits shall be paid at the time of service unless your insurance is liable. The patient is responsible for knowing the benefits, copays, etc. that are available through their insurance for exams, visits, and supplies. Surgery and medical procedures will be pre-certified by the office staff.

Please read and sign below:

1. **I understand the above rules and stipulations.**
2. **I authorize the release of the minimum necessary information required for insurance claim filing.**
3. **I authorize payment of medical benefits to Mary F. Summers, M.D. for services requested, agreed upon and performed.**

Signature_____Date_____

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PRIVACY NOTICE

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payments, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions, and revoke consent in writing after you have reviewed our privacy notice.

Printed Name:_____

Signature:_____ **Date:**_____

HIPAA Right of Access Form for Family Members/Friends

I, _____, authorize Dr. Summers and staff to disclose and release my protected health information to:

Name: _____Relationship: _____
Contact information: _____

Name: _____Relationship: _____
Contact information: _____

This authorization shall remain in effect from the date signed below until (please check one):
□ (specify expiration date or event) _____
□ NO EXPIRATION DATE

Signature: _____**Date**:_____
Relationship to Patient (If signed by personal representative of patient):_____

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Patient Medical Summary

Name_____**Date**_____**Age**_____

Family Physician_____**Referring Physician** _____

Optometrist _____ **Cardiologist** _____

Have you ever been treated for any medical conditions?(Diabetes, High Blood Pressure, Heart Disease, etc.) _____
_____

Have you ever been treated for any eye diseases? (Glaucoma, Cataracts, Retinal Detachment, etc.)
_____
_____

Have you ever had any surgeries? Please list. _____
_____

Do you have any drug or food allergies? Please list. _____
_____

Do you take any medications? Please list._____
_____
_____
_____

Do any medical or eye diseases run in your family?

- **Diabetes, High Blood Pressure, Cancer,etc.** _____
- **Glaucoma, Macular Degeneration, etc.** _____

Do you currently smoke?_ _____ **Are you a former smoker?**_____

Are you currently experiencing any of these? Please circle.

Fever – Weight loss/gain – Blurred vision – Double vision – Hearing loss – Sinus problems – Chest pain – Irregular heart beat – Shortness of breath – Wheezing – Abdominal pain – Nausea – Blood in urine – Joint pain – Low back pain – Rashes – Skin tumors – Numbness/weakness – Anxiety – Depression – Heat intolerance – Thyroid problems – Anemia – Unusual bleeding – Hives – Seasonal allergies

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FINANCIAL POLICY ACKNOWLEDGEMENT FORM

In our commitment to provide the highest quality of healthcare available to all of our patients and to have those services comfortably affordable, we require that you read, understand, and sign acknowledgment of our financial policy prior to treatment. The following is a statement of our Financial Policy.

- All patients must complete our Information and Insurance form before seeing the doctor. We verify your insurance at each visit, so **please bring your insurance card(s) with you to every appointment**. In order for us to bill your insurance company we need complete, current and accurate information, including a copy of your card. It is your responsibility to inform the front desk personnel when the cause for treatment has resulted from an injury that should be billed to worker's compensation
- If you currently have no insurance, all services provided are to be paid in full at the time of service. All co-payments, deductibles, and co-insurance are due at the time of service.
- All Medicare patients will be required to pay their yearly deductible, and the 20% coinsurance based upon the current Medicare Fee schedule at the time of services, unless proof of secondary policy is evident.
- Payments may be made with cash, personal check, VISA, MasterCard, or Discover.

I have read and agree to the above financial policy for Dr. Summers Eye Clinic.

Printed Name:_____

Signature:_____**Date:**_____

REFRACTION SERVICE AND FEE

A refraction is the process of determining if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and necessary to find a prescription for glasses or contact lenses to determine if poor vision is due to prescription or another medical condition. **Most medical insurance plans, including Medicare, do NOT cover routine refractions or routine eye examinations** (when no medical eye problem is known or suspected). Medicare allows that we charge separately for that portion of the examination, since it is not a covered service. Our office fee for a refraction is **$25.00** and this fee is collected at the time of service in addition to any co-payment your plan may require. Should your plan pay us for the refraction, we will reimburse you accordingly.

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

_____ _____

Patient Signature (Parent for Minor) **Date**

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RECORDS RELEASE AUTHORIZATION

To: _____

Patient Name: _____Date of Birth:_____

__I hereby authorize Dr. Summers to obtain copies of any and all of my medical records pertaining to my medical history and treatment. This authorization may include hospitals, physicians, nurses, insurance companies and their representatives and any institution, agency and/or individual representing me.

__I hereby authorize Dr. Summers to release any and all of my medical information and or copies of such records including diagnosis, treatment or examinations rendered to me during the period of my medical care.

I further agree that this authorization shall be valid and effective unless and until it is revoked by me in writing and that a photocopy of this authorization may serve as an original.

Dates of records: from:_____to:_____

Signature:_____Date:_____

- Patient
- Parent
- Guardian

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Contact Lens Fit Information

Lens Type: **Fee:** **Follow Up Fee:**

First time Contact Lens Fit Fees:

Soft Spherical	$60.00	No Charge
Soft Toric	$80.00	No Charge
Multifocal/Monovision	$100.00	No Charge

Established Contact Lens Fit Fees:

Soft Spherical	$30.00	No Charge
Soft Toric	$40.00	No Charge
Multifocal/Monovision	$50.00	No Charge

- Please note that the Contact Lens fitting is not a part of a typical eye examination. Thus, medical insurance does not cover this fee or the price of contact lenses.
- Should you decide to order contacts through our office, we offer 20% off of orders done within 30 days of the fitting.

Would you like to be fitted for contact lenses today? **YES / NO**

I have read the above information and understand that the contact lens fitting is not covered by my insurance and that I am responsible for payment the day of service.

_____ _____

Patient Signature **Date**