Welcome to Guntersville Eye Clinic

Dr. M Suzanne Holmes

Patient Information

First name _____ Last name _____ MI ___ Suffix ___ M F DOB ___/___/___

Address _____ City _____ State _____ Zip _____

Preferred Cell # _____ _____ Text # _____ Work # _____

Employer / School _____ Occupation _____

Social Security _____-___-_____ Email _____

How would you like to be contacted? Text Cell Phone Email // May we leave you a message on voicemail? Yes No

In case of Emergency or are unable to be reached who may we contact:

Name: _____ Phone # _____ Relationship _____

Primary Care Doctor _____ Pharmacy _____

Medical and Ocular History

What is the reason for today's Visit? ____ Yearly Eye Exam ____ Diabetic Exam ____ Other _____

Age of present Glasses _____ Age of Sunglasses _____ Last Exam _____ Previous Eye Doctor _____

Last time your eyes have been dilated? Year _____

Please list any eye drops you are using (Prescription or OTC) _____

Please list any current medications _____

Any medication allergies Y N Which medications _____

Are you planning to get new glasses today? Y N Are you planning to get new Sunglasses today? Y N

Are you planning to get Contacts today? Y N Do you currently wear contacts? Y N What Brand _____

Are you having any problems with your vision? Distance Near Night Driving Other _____

How many hours per day are you on a computer? _____

Do your eyes tire when reading? Y N Do you have problems with glare or bright sunlight? Y N

	Self	Family		Self	Family	
Cancer	____	____	Thyroid Problems	____	____	Do you See Double? Y N
Glaucoma	____	____	Heart Disease	____	____	Frequent Headaches? Y N
Cataracts	____	____	Retinal Disease	____	____	Are you Pregnant? Y N
High Blood Pressure	____	____	Eye Injury	____	____	Are you Nursing? Y N
Diabetes	____	____	Eye Surgery	____	____	Other _____

If you are a diabetic, what was your last A1C?_____When was your last A1C? _____

How will you be paying today? Vision Insurance / Medical Insurance / Cash / Check / Credit-Debit Card / Care Credit

_____ ___/___/_____

Signature of Patient or Guardian **Date**

FRONT & BACK

Guntersville Eye Clinic

Dr. M Suzanne Holmes
Financial & HIPAA Policy

OPTOS Photos

____ **Yes**, I wish to pay the **$39.00** for the OPTOS testing, in place of Dilation (Non Diabetic ONLY)

____ **No**, I have elected not to have an OPTOS today and wish to be Dilated, included in exam pricing.

I understand the benefits of the annual OPTOS as:

- Fast, easy, and comfortable
- A permanent record to compare and track potential eye diseases
- An in-depth view of nearly the entire retina
- Educational tool for your doctor to discuss your health and wellness

I understand that an ultra-widefield view of the retina is an important part of a comprehensive eye exam and that I am accepting / declining the Doctor's recommendation to obtain a comprehensive view of my retina.

_____ ____/____/_____
Patient's Signature **Date**

Read and Initial ALL

_____***Guntersville Eye Clinic will file medical/ vision insurance as a courtesy to the patient. Benefits are not a guarantee of payment.***
_____***All copays, deductibles, glasses or contact totals and any taxes are due at the time of visit.***
_____***If any financial assistance is needed prior arrangements should be made with the office.***
_____***You will however be responsible for any additional copays or deductible amounts due from insurance upon filing claim.***
_____***ANY amount remaining after insurance payment is made, the patient responsibility should be paid in full within 45 days or Guntersville Eye Clinic has the right to turn your account over to a collection agency.***
_____***If patient is a minor, the parent present on the day of visit will be responsible for copays or materials total. If any balance needs to be collected from coparent the parent present will be responsible for obtaining reimbursement from them.***

PERSONS AUTHORIZED TO RECEIVE HEALTH INFORMATION:

Health information/Financial that Guntersville Eye Clinic Collects or receives about you may be disclosed to the following person

_____ _____ _____
Name / Relationship **Name / Relationship** **Name / Relationship**

Use and Disclosure of Information:

_____ **I Authorize** the person(s) listed above to receive all health information about appointments, treatment, and/or other information pertinent to my healthcare and/or payment for my healthcare provided at Guntersville Eye Clinic

_____ I **DO NOT** authorize the following information to be disclosed to any parties except to me as the patient

RIGHT TO TERMINATE OR REVOKE AUTHORIZATION

You may revoke or terminate this authorization by submitting a written revocation to Guntersville Eye Clinic

POTENTIAL FOR RE-DISCLOSURE

The personal or organization to which health information is sent may repeatedly disclose health information that is identified by this authorization. The privacy of this information may not be protected under the federal privacy regulator.

OTHER USES AND DISCLOSURES

Disclosure of your health information or its use for any purpose other than those listed in the "Notice of Privacy Policies and Practices" brochure and/or consent required your specific written authorization. If you change your mind after authorization a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision. You have the right to request restrictions on use and disclosure of your health.

I HAVE READ AND UNDERSTAND THE HIPAA and Financial POLICY

_____ _____/_____/_____
Name of Patient (Print) / Signature of Patient or Representative and Relationship **Date**