NH EYE ASSOCIATES

MEDICAL & OCULAR HISTORY QUESTIONAIRRE

Name: _____ Date: _____ Age: _____

Preferred Pharmacy Name: _____ Address: _____

Primary Care Doctor Name:_____Referring Doctor Name:_____

1. Please briefly describe the main reason you are being examined today.

2. Do you have any of the following conditions (check all that apply)?

☐ Diabetes	**Type I or Type II: _____**	**Recent Blood Sugar: _____**	**Recent HbA1c: _____**
☐ Cancer (specify):	☐ Sinus Disease	Other:_____	
☐ Anxiety	☐ Arthritis	☐ Asthma	☐ COPD
☐ Cholesterol	☐ Depression	☐ GERD	☐ Hyperthyroid
☐ Hypothyroid	☐ High Blood Pressure	☐ Hearing Loss	☐ Hepatitis
☐ HIV/AIDS	☐ Irregular Heartbeat	☐ Seizure	☐ Stroke
☐ Skin Disorder	☐ Heart Disease	☐ Pregnancy	☐ Dyslexia

3. Please list any surgeries and dates of surgeries:

_____

_____

_____

4. Do you have any of the following eye disorders?

☐ Allergies	☐ Blepharitis	☐ Cataracts	☐ Contact Lens
☐ Corneal Dystrophy	☐ Diabetic Retinopathy	☐ Dry Eye	☐ Glasses
☐ Glaucoma	☐ Macular Degeneration	☐ Macular Pucker	☐ Narrow Angles
☐ Ocular Migraine	☐ Pseudoexfoliation	☐ Retinal Tear	☐ Lazy Eye
☐ Floaters	☐ Other:		

5. Have you had any of the following eye surgeries or procedures?

☐ Cataract Surgery	☐ Corneal Transplant	☐ Eye Muscle Surgery	☐ Injections
☐ LASIK	☐ Laser	☐ Lid Surgery	☐ Glaucoma Surgery
☐ Retina	Other:		

OVER

6. Is there a family history of the following eye diseases? Which family members?

- ☐ Glaucoma
- ☐ Cataracts
- ☐ Lazy Eye
- ☐ Macular Degeneration
- ☐ Blindness
- ☐ Other:
- ☐ Diabetes
- ☐ Retinal Detachment
- ☐ Cataracts

7. Please list all medications, including eye drops (or provide list):

8. Please list any allergies to any medications or substances:

9. How would you describe your smoking history?

- ☐ Current smoker, every day
- ☐ Current smoker, not every day
- ☐ Former smoker
- ☐ Never smoked

10. Do you have any of the following problems?

- ☐ Blurry vision
- ☐ Frequent urination
- ☐ Diabetes
- ☐ Arthritis
- ☐ Dryness, Grittiness or Scratchiness
- ☐ Rash
- ☐ Fever
- ☐ Seizure
- ☐ High Blood Pressure
- ☐ Anxiety
- ☐ Shortness of Breath
- ☐ Anemia
- ☐ Eye Fatigue
- ☐ Soreness or Irritation
- ☐ Burning or Watering
- ☐ Allergies
- ☐ Upset Stomach

NH EYE ASSOCIATES, P.A.

INSURANCE REFERRAL AND FINANCIAL RESPONSIBILITY WAIVER

Insurance Referral: If your insurance policy requires a primary care physician (PCP) referral, prior approval or other pre-authorization for you to receive services from NH EYE ASSOCIATES it is your responsibility to see that the necessary referral is current and any necessary prior approval or other pre-authorization has been presented to NH EYE ASSOCIATES prior to receiving services. If no required referral, prior approval or other pre-authorization is present in advance, you will be personally responsible to pay for any services rendered to you by NH EYE ASSOCIATES.

Insurance Claims: You are required to present current Insurance Card(s) prior to services being rendered by NH EYE ASSOCIATES for NH EYE ASSOCIATES to submit claims to all primary and secondary insurance carriers and assign benefits payable for physician services to the physician furnishing this service. If you fail to present your current Insurance Card(s), you will then assume all financial responsibility for all services rendered to you by NH EYE ASSOCIATES at the time of service. ***PLEASE REMEMBER THAT YOUR INSURANCE COVERAGE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE CARRIER AND THAT NH EYE ASSOCIATES IS NOT PARTY TO YOUR INSURANCE CONTRACT. *There are insurances that NH EYE ASSOCIATES does NOT participate with.*** If Insurance Card(s) are presented after the time of services rendered and found to be in that category, the patient is financially responsible for payment in full.

Patient's Financial Responsibility: You, the insured, must pay all co-pays and or deductibles. You may be responsible for payment on any claim that is: (1) denied; (2) unpaid due to deductible; (3) coinsurance; and/or (4) balances left by insurance specified as patient responsibility. If your claim is involved in litigation and/or is being disputed among insurers, you are still financially responsible. ***You must pay any balance that your insurance carrier designates as your responsibility that may include the $47 refraction fee.***

Uninsured Patients: If you do not have insurance, full payment is expected at the time of service unless prior arrangements have been made.

Delinquent Accounts: In the event that we must take legal action to collect an unpaid account, the patient or the responsible party must pay NH EYE ASSOCIATES costs of collection, including attorney fees. After an account is sent to a collection agency/attorney, all further services must be paid in cash, in full, prior to the receipt of the services.

PATIENT AUTHORIZATION AND ACKNOWLEDGEMENT

I hereby authorize payment of health insurance benefits directly to NH EYE ASSOCIATES for services furnished me. I authorize the release of any of my medical information necessary to process my claims. I understand, acknowledge and agree that I am financially responsible for my deductible, co-pay, coinsurance and any amount exceeding what my insurance company pays except where exempt by contractual agreement. I further understand that I am responsible for complying with any requirements that my insurance carrier may have regarding referrals, prior approvals, pre-authorizations and second opinions.

If for any reason my insurance does not pay, I am financially responsible to NH Eye Associates for my charges.

I HAVE READ THE ABOVE WAIVER, AUTHORIZATION AND ACKNOWLEDGEMENT AND/OR IT HAS BEEN FULLY EXPLAINED TO ME, AND I CERTIFY THAT I UNDERSTAND ITS CONTENTS AND THAT I AM COMPETENT TO EXECUTE IT OR THAT I AM AUTHORIZED TO EXECUTE IT ON THE PATIENT'S BEHALF.

Signature of Patient/Legal Guardian/DPOA: _____

Date: _____

(Expires 1 year from date of signature.)

SUMMARY OF PRIVACY PRACTICES

Effective Date: October 1, 2014

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices. We may amend the notice at any time. All amendments apply retroactively. In the event we make revisions it will be posted and you may request a copy.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your health information is kept private.

How will we use or disclose your information? Here are a few examples (for more detail please refer to the Notice of Privacy Practices that follows this summary):

- Medical treatment/emergency situations
- To obtain payment for our services
- To report public health concerns
- For appointment and patient call reminders
- To run our practice more efficiently and ensure patients receive quality care
- Coordinate your care with others who may treat you
- To report implant lens information
- For worker's compensation programs
- In response to certain requests arising out of legal or other disputes

You have certain rights regarding the information we maintain about you, these include:

- The right to inspect and copy your records
- The right to amend your records
- The right to an accounting of disclosures
- The right to request restrictions
- The right to a paper copy of this notice
- The right to request confidential communications

For more information about these rights, please refer to the **detailed Notice of Privacy Practices** in the reception area.

If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services.

To file a complaint with the practice, contact the Administrator. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

NH EYE ASSOCIATES

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling NH EYE ASSOCIATES at **603-669-3925** or by requesting a copy at the office.

_____
(Please print your full name)

_____ _____/_____/_____
(Signature) Date

As the representative of the above individual, I acknowledge receipt of the Notice on his or her behalf.

_____ _____
(Please print your full name) (Relationship)

_____ _____/_____/_____
(Signature) Date

DO NOT REMOVE THIS DOCUMENT FROM THE CHART