Drs. Lawaczeck,McKinnon, Feagin, Carter, Gee and Dahl, P.C

Patient Name_____ Goes By:_____
FIRST MIDDLE LAST

Mailing Address_____

City_____State_____ Zip Code_____

Daytime Phone:_____ Cell Phone:_____

Date of Birth_____ Age _____ Gender: ☐ M ☐ F Social Security Number_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Employed ☐ Student ☐ Retired

Employer/Parent's Employer_____Occupation_____

Work Phone_____

Spouse name (Parent name if minor)_____Spouse/Parent Work Phone_____

Emergency Contact : _____Phone number:_____

Relationship_____ **Primary Care doctor:**_____

Primary Insurance Company		
ID#	Group #	**Effective Date**
Subscriber Name		**Relationship to Patient**
Social Security Number	**Date of Birth**	Employer

Secondary Insurance Company		
ID#	Group #	Effective Date
Subscriber Name		**Relationship to Patient**
Social Security Number	Date of Birth	Employer

Tertiary Insurance Company		
ID#	Group #	Effective Date
Subscriber Name		**Relationship to Patient**
Social Security Number	Date of Birth	Employer

TODAY'S DATE:_____

office phone: 205.397.9400 option 2

AUTHORIZATION FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION:

Name: _____ **Date of Birth:**_____

May we leave messages/detailed medical information on voicemail at either of these phone numbers?

□ Yes □ No Day Phone: _____ □ Yes □ No Cell Phone: _____

May we contact you at your place of employment? □ Yes □ No If so, may we leave a message? □ Yes □ No

Do you have any particular person or family members that you authorize to receive and discuss information regarding your personal health information (general information, surgical and billing)? □ Yes □ No If yes, please provide:

Name: _____ Relationship: _____ Phone: _____
Is this person your Power of Attorney for medical purposes? □ Yes □ No

Name: _____ Relationship: _____ Phone: _____
Is this person your Power of Attorney for medical purposes? □ Yes □No

--If no one is listed above, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices. ***This authorization remains in effect until revoked.***—

I hereby authorize Drs. Feagin, Carter, Gee and Dahl and/or administrative and clinical staff of to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, laboratories, radiology facilities or other institutions.

A copy of this policy will be provided to me **upon request**. I have reviewed/understand the 2003 Notice of HIPAA Privacy Policy.

Patient Signature: _____ Date: _____

- **Insurance:**

I certify that I (or my dependent) have insurance medical coverage and agree to have insurance payments made directly to Drs. Lawaczeck, McKinnon, Feagin, Carter & Gee, and P.C. and to be applied to my account for services rendered. All Copayments, Co-Insurance, self-pay visits, deductible and or non-covered services must be paid at the time service is rendered. (We do not accept Vision Plans) For patients covered by Medicare the patient will be responsible for 20% of the Medicare allowable charges plus any deductibles, coinsurance and uncovered charges that apply.

- **Referrals:**

You are responsible for obtaining a referral if one is required by your insurance carrier. (A few that require referrals: BCBS, Medicare Complete, Cigna Healthsprings, United Healthcare with PCP referrals on front of card). If we are participating providers with your carrier, we will file your claim for your office visit or surgery and allow 45days for payment in full. Should payment not be received within 45days, the balance due will become the obligation of the guarantor on the account and must be paid within 30days.

- **Agreement to Pay:**

As consideration for the Physician's rendering services to the patient, the patient or person responsible for the account agrees to pay all charges for services at the completion of such services. In the event the account is not paid in full within 45days, the Physician, may, at his/her discretion, place the unpaid account with an attorney for collection. The patient or person responsible for the account agrees to pay all costs of collection, including reasonable attorney's fees and agrees to pay the legal rate of interest on the account until paid in full and hereby waives all rights of exemption under the Constitution and laws of the State of Alabama. I understand that I am financially responsible for all charges incurred in the event that my insurance denies payment. I am aware there may be additional collection and/or attorney's fees if my account is referred for collection.

_____ _____
Patient's signature **Today's date**

- **Consent to Treat:**

I hereby consent to the treatment for myself or the above listed patient

_____ _____
Patient's signature **Today's date**

Drs. Lawaczeck, McKinnon, Feagin , Carter, Gee & Dahl, P.C.
Alabama Eye M.D.
1009 Montgomery Highway, Suite 200
Birmingham, AL 35216

REFRACTION SERVICES AND FEES

Refraction is the process of determining your best corrected vision and if there is a need for corrective eyeglasses or contact lenses. It is an essential part of the eye exam and is necessary to write a prescription for glasses or contact lenses.
Refraction is NOT a covered service by Medicare or most medical insurance plans. These plans consider a refraction a "vision" service not a "medical" service.

We will NOT file the charge for refraction with a health insurance unless we know that your plan covers the refraction charge.

Our office fee for refraction is $35.00 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.

_____ _____
Patient's Name (printed) **Date**

_____ _____
Patient Signature (Legally responsible applicable) **Relationship to patient**

_____
Staff Witness

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ **Date of Birth:** _____ **Age:** _____ **Date:** _____

Review of Systems (ROS):	Circle any conditions that currently apply to you or check none.	NONE
EYES:	Burning, Itching, excessive tearing, discharge, redness, eye injury/trauma, sudden loss or change in vision, swelling of lid or growth	
CONSTITUTIONAL:	Fever, weight loss, weight gain, fatigue, headaches	
EARS, NOSE, THROAT:	Deafness, dry mouth, sinus infection, other	
CARDIOVASCULAR:	High B/P, heart attack, chest pain, congestive heart failure, high cholesterol, irregular heartbeat, low B/P, pace maker	
RESPIRATORY:	Bronchitis, Chronic obstructive pulmonary disease, emphysema, tuberculosis, asthma	
GASTROINTESTINAL:	Hepatitis, Jaundice	
GENITOURINARY:	Bladder or kidney problems	
INTEGUMENTARY:	Dermatitis	
MUSCULOSKELETAL:	Arthritis	
NEUROLOGICAL:	Multiple sclerosis, stroke,	
PSYCHIATRIC:	Anxiety, depression,	
ENDOCRINE:	Diabetes, hypothyroid, hyperthyroid	
HEMATOLOGY:	Infection, Prostate	
ALLERGIC/IMMUNOLOGIC:	Allergies, hay fever	

MEDICAL HISTORY: Please list any **MEDICAL CONDITION, Past and Present** such as: diabetes, heart disease, cancer, auto-immune disease, immune deficiency, organ transplant.

PRESENT: _____

PAST: _____

Please list any **EYE PROBLEMS**, current or past: _____

List all Eye Surgeries & Laser Eye Surgeries:

_____

_____

List all OTHER surgeries you have had:

_____

_____

FAMILY HISTORY: Has any member of your immediate family (blood relatives) have/had these diseases?

Disease/Condition			Family Member Maternal/Paternal	Disease/Condition			Family Member
Diabetes	yes	no	Mother Father Sibling Grandparent	Heart Disease	yes	no	Mother Father Sibling Grandparent
Macular Degeneration	yes	no	Mother Father Sibling Grandparent	Hypertension	yes	no	Mother Father Sibling Grandparent
Blindness	yes	no	Mother Father Sibling Grandparent	Stroke	yes	no	Mother Father Sibling Grandparent
Retinal Disorders	yes	no	Mother Father Sibling Grandparent	Thyroid Disease	yes	no	Mother Father Sibling Grandparent
Cataracts	yes	no	Mother Father Sibling Grandparent	Arthritis	yes	no	Mother Father Sibling Grandparent
Glaucoma	yes	no	Mother Father Sibling Grandparent	Cancer	yes	no	Mother Father Sibling Grandparent
Lazy Eye	yes	no	Mother Father Sibling Grandparent	Type of Cancer: _____			Mother Father Sibling Grandparent

Physician Signature: _____ **Date:** _____

All information you provide is confidential and will not be released to anyone without your consent
Use back of form for any additional information that you need to add.

MEDICAL HISTORY QUESTIONNAIRE

Patient Name:_____ **Date:**_____

Height:____ Weight: _____ Sex: Male / Female

SOCIAL HISTORY:

(Circle:) Student Homemaker Employed Retired **(Circle:)** Single Married Separated Divorced Widowed

Do you use Tobacco? Yes / No Cigarettes / Smokeless _____ # Packs/Times a Day _____# of Years

Do you use Alcohol? Yes / No Rarely Daily Weekly 1-2 drinks 2-4 drinks Other _____

Substance Abuse? Yes / No Rarely Daily Weekly _____

PHARMACY INFORMATION:

_____ _____ (____) _____

Name of Pharmacy Address Phone:

LIST ANY DRUG ALLERGIES: ☐NONE_____

List all Prescriptions and Over the Counter medications you are taking: (Including Eye Drops)

If you have a list, please give to receptionist to copy in lieu of filling out form: **REVIEWED:**

Medication Name	Dosage	Route	Reason for taking	Currently Taking Yes	No
		__ Oral __ Topical __ Injection			
		__ Oral __ Topical __ Injection			
		__ Oral __ Topical __ Injection			
		__ Oral __ Topical __ Injection			
		__ Oral __ Topical __ Injection			
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		__ Oral __ Topical __ Injection			
		__ Oral __ Topical __ Injection			
		__ Oral __ Topical __ Injection			
		__ Oral __ Topical __ Injection			

Staff	*Date*

Physician Signature: _____ **Date:** _____

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Use back of form for any additional information that you need to add.