Patient Registration

Patient's Name: _____ Date: _____ Time: _____
First/Middle/Last

Street Address: _____ City: _____ State: ____ Zip:_____

Home phone: _____ Cell Phone:_____ Date of Birth:___/___/___ Age:_____

SSN#____/____/____ Marital Status ☐ Single ☐ Married ☐ Female ☐ Male Race: _____

Employer's Name: _____ Work Phone: _____

Employer's Address: _____ City: _____ State____ Zip_____

Scheduled for: ☐ **Right eye** ☐ **Left eye** ☐ **Both eyes**

☐ Cataract Surgery ☐ Lasik ☐ Blepharoplasty
☐ Viscocanalostomy/ Goniotomy ☐ Ptosis Repair ☐ YAG Laser Treatment
☐ SLT Laser Treatment ☐ Trabeculectomy ☐ Other_____
☐ Argon Laser Treatment ☐ Vision ICL Phakic Implant
☐ Refractive Lensectomy with LRI

☐ **Patient Identification Badge Applied**

Emergency Contact

Pt accompanied By: _____ Emergency Contact: _____
Relationship to Patient: _____ Relationship to Patient: _____
Post-Op Contact Phone #:_____ Emergency Contact Phone #:_____

Advance Directives

☐ Patient has Advance Directive (Patient informed that DNR not honored by facility)
☐ Patient does NOT have Advance Directive

Registration Completed By: _____

Patient Privacy Questionnaire

Patient's Name: _____ Chart # _____

Please list the family member(s) or other persons, if any, whom we may inform about your eye medical condition and your diagnosis (including treatment, payment, and health care operations):

_____ _____
Person's Name Relationship to Patient

_____ _____
Person's Name Relationship to Patient

_____ _____
Person's Name Relationship to Patient

Please print the address of where you would like your billing statements and/or correspondence from our office to be sent, if other than your home:

_____ _____ _____
Street Address City Zip Code

Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other eye care information, if other than your home telephone:

Phone number: (____)_____

I am fully aware that a cell phone is not a secure and private line. _____
Your Signature

Can confidential messages (i.e. appointment reminders) be left on your answering machine or voicemail?

☐ Yes ☐ No

_____ _____
Signature of Patient or Guardian

HISTORY AND PHYSICAL ASSESSMENT

Name: _____ **D.O.B.** _____

Surgery Date: _____ **Surgery Time:** _____ **Arrival Time:** _____

Smoking Hx: ☐Yes ☐No **If yes, how much:** _____ **Duration:** _____ **Date Quit:** _____

Alcohol Use: ☐Yes ☐No **Substance Abuse:** ☐Yes ☐No **If yes, Frequency:** _____

ALLERGIES/Sensitivities: _____

Reaction: _____

CURRENT MEDICATIONS

Drug Name	Drug Dose	Frequency	Reason
1.			
2.			
3.			
4.			
5.			

SIGNIFICANT PAST HX OF:

Hypertension	☐Y	☐N	Seizure	☐Y	☐N
Heart Disease	☐Y	☐N	Bleeding Tendency	☐Y	☐N
Diabetes	☐Y	☐N	Arthritis	☐Y	☐N
Lung Disease	☐Y	☐N	Anesthetic Troubles	☐Y	☐N
Airway Problems	☐Y	☐N	Migraines	☐Y	☐N

Other: _____

If **YES** to any of the above, please explain: _____

_____

Surgical Hx: _____

Family Hx: _____

Social Hx: _____

Diagnosis: _____

GY

Physician Signature: _____ Date: _____

Authorization for Surgery and/or Surgical Procedures

DESOTO EYECARE

Patient's Name: _____ Date: _____

1. I hereby authorize Dr Schaefer, and/or such assistants as may be selected by him/her and the medical staff at Eye Care Surgery Center to remedy the condition or conditions which appear indicated by the diagnostic studies already performed, or to perform diagnostic studies as deemed necessary.

2. The procedure(s) necessary to be performed has/have been explained to me by my doctor, and I understand the nature of the procedure to be: _____

3. It has been explained to me that during the course of the operation, unforeseen conditions may be revealed that necessitate an extension of the original procedure(s) or different procedure(s) than those set forth in Paragraph 2. I therefore authorize and request that the above named physician, their assistants, or their designees perform such medical and surgical procedures as are necessary and desirable in the exercise of professional judgment. The authority granted under this Paragraph 3 shall extend to remedying all conditions that require treatment and are not known to the doctor or the medical staff of Eye Care Surgery Center at the time the operation is commenced.

4. I have been advised of alternative means of therapy and of risks and consequences associated with these procedures and also of other risks such as loss of blood, infection, and cardiac arrest, which are attendant on the performance of any surgical or medical procedure. I am further aware that the practice of medicine and surgery is not an exact science and acknowledge that no guarantees have been made to me concerning the risk or results of this operation or procedure.

5. I consent to the administration of anesthesia to be applied by a qualified member of the anesthesia staff approved by my physician/surgeon and Eye Care Surgery Center and the use of anesthetics as may be deemed advisable, with the exception of: _____

6. I consent to the taking and publication of any photographs in the course of this operation for the purpose of advancing medical education and to the disposition of any tissues or parts removed at this operation, including their dissection for scientific or diagnostic purpose.

7. I certify that I have read and fully understand the above information. Inapplicable paragraphs were stricken before I have signed.

Signature of Patient	Signature of Witness	Date

If the patient is unable to sign or is a minor, please complete the following:

The patient is a minor _____ years of age or is unable to sign because: _____

Signature of Relative or Guardian	Signature of Witness	Date

Advanced Beneficiary Notice (ABN)

Patient's Name: _____ Chart#: _____

We expect that your insurance will not pay for the item(s) or service(s) that are described below. The fact that your insurance provider may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it.

Right now, your insurance probably will not pay for: _____

because _____.

The purpose of this form is to help you make an informed choice about whether you want to receive these items or services, knowing that you may need to pay for them yourself. Before you make a decision about your options, you should **read this notice carefully.** Please ask us to explain if you do not understand why your insurance provider probably will not pay for this service. Ask us how much these items or services will cost in case you have to pay for them yourself (Estimated Cost: $_____).

Please select **one** option below and sign your name.

☐ **YES, I want to receive these items or services.**

I understand that my insurance will not decide whether to pay for an item or service unless I receive these items or services. Please submit my claim to my insurance provider. I understand that Desoto Eye Surgery Center may bill me for these items or services, and I may be required to pay the bill while my insurance is making its decision. If my insurance provider does pay, Desoto Eye Surgery Center will refund me any payments that I had made for the above mentioned items or services. If my insurance denies payment, I agree to be personally responsible for payment of these items or services, either out of my own pocket or through any secondary insurance that I have. I understand I can appeal my insurance provider's decision.

☐ **NO, I have decided not to receive these items or services.**

I will not receive these items or services. I understand that Desoto Eye Surgery Center will not be able to submit a claim to my insurance and that I will not be able to appeal the opinion that my insurance will not pay.

_____ _____ _____

Signature of Patient/Responsible Party **Signature of Witness** **Date**

Note: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to your insurance provider, your health information on this form may be shared with your insurance provider. Your health information, which your insurance provider sees, will be kept confidential by your insurance provider.

Driving Policy Following Surgery

Patient Information
Sticker Here

Thank you for allowing us the opportunity to take care of you and your vision. The staff of Desoto Eye Surgery Center has made your safety our number one priority. Due to our use of light sedation during your surgical procedure, a responsible adult must be present to drive you home from our facility. We ask that you and your driver sign in the spaces below stating your understanding of our safety policy.

Signature of Patient

Signature of Patient's Driver

Acknowledgement of Receipt of Privacy Notice

Patient Information
Sticker Here

I, _____, hereby acknowledge receipt of the Notice of Privacy Practices given to me by Desoto Eye Surgery Center.

_____ _____

Signature of Patient/Guardian **Date**

For Office Use Only

If not signed, please note the reason why acknowledgement was not obtained:

_____

_____

_____

_____ _____

Person Seeking Acknowledgement **Date**

Insurance Verification Form

Referring Doctor: _____

Referring Doctor Phone #: _____

Reason for Visit: _____

Appointment: ____/____/____@_____

New Patient Package Sent By:

☐ OD Office ☐ Eye Care

Patient: _____ DOB: ___/___/___ Phone #: _____

Primary Insurance: _____ Plan Type: ☐ HMO ☐ POS ☐ PPO ☐ Other

Network Name: _____ ☐ In Network ☐ Out of Network

Policy or ID #: _____ Group #: _____ Insurance Phone #: _____

Insured's Name: _____ DOB: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Effective Date: ____/____/____ Expiration Date: ____/____/____ Co- Pay: _____ Co-Ins: _____

Referral Required? ☐ Yes ☐ No PCP Name: _____ PCP Phone #: _____

Deductible: $_____ Met: $_____ Does deductible apply to surgery? ☐ Yes ☐ No

Is pre-cert required for out-patient procedure in office? ____ in hospital? ____ Pre-Cert Phone #: _____

Deductible: $_____ Met: $_____ Does deductible apply to office visit? ☐ Yes ☐ No

Does deductible apply to surgery? ☐ Yes ☐ No

Benefits Verified With: _____ Benefits Verified By (Employee): _____

Additional Information: _____

Secondary Insurance: _____ Plan Type: ☐ HMO ☐ POS ☐ PPO ☐ Other

Network Name: _____ ☐ In Network ☐ Out of Network

Policy or ID #: _____ Group #: _____ Insurance Phone #: _____

Insured's Name: _____ DOB: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Effective Date: ____/____/____ Expiration Date: ____/____/____ Co- Pay: _____ Co-Ins: _____

Referral Required? ☐ Yes ☐ No PCP Name: _____ PCP Phone #: _____

Deductible: $_____ Met: $_____ Does deductible apply to surgery? ☐ Yes ☐ No

Is pre-cert required for out-patient procedure in office? ____ in hospital? ____ Pre-Cert Phone #: _____

Deductible: $_____ Met: $_____ Does deductible apply to office visit? ☐ Yes ☐ No

Does deductible apply to surgery? ☐ Yes ☐ No

Benefits Verified With: _____ Benefits Verified By (Employee): _____

Additional Information: _____

Financial Assignment and Agreement

1. I request that payment of authorized Medicare and/or Insurance benefits be made on my behalf to Desoto Eye Surgery Center for any services furnished me by them. I authorize any holder of medical information about me to release to the Health Care Financing Administration/Center for Medicare and Medicaid Services, its agents, or any other insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.
2. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release information necessary to secure the payment.
3. Desoto Eye Surgery Center may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which s or may be liable or under contract to for reimbursement for services rendered, and (2) any health care provider for continued patient care. Desoto Eye Surgery Center may also disclose, on an anonymous basis, any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, status, or regulation.
4. I agree that in return for the services provided to the patient by Desoto Eye Surgery Center, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Desoto Eye Surgery Center for payment. If my account is sent to a collection agency for collection, I agree to pay collection expenses if applicable. I understand and agree that if my account is delinquent, I may be charged a service fee. Any benefits of any type under any policy of insurance insuring the patient or any other party liable to the patient is hereby assigned to Desoto Eye Surgery Center. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Desoto Eye Surgery Center. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.
5. I understand that any requirement for completion of insurance precertification or referral is the responsibility of the policyholder. Desoto Eye Surgery Center will assist with obtaining precertification or referral but will not assume the responsibility for obtaining precertification or referral, and therefore will not be responsible for any impact which it may have on insurance payment.
6. I agree that I have been given the opportunity to read and receive a copy of the Desoto Eye Surgery Center- Notice of Privacy Practices.

Signature of Patient	Printed Name of Patient	Date
Signature of Legal Guardian/Representative	Relationship/Authority (ie court order)	Date