

GLOBAL EYE CARE CO.
PATIENT QUESTIONNAIRE

(Mr., Ms., Dr.)

LAST NAME _____ FIRST NAME _____ MIDDLE NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ BIRTH DATE _____ AGE _____ SEX _____ SOCIAL SECURITY # _____

WORK PHONE _____ EMPLOYER _____ OCCUPATION _____

EMAIL ADDRESS _____ SPOUSE'S/PARENT'S NAME _____

SPOUSE'S/PARENT'S EMPLOYER _____ THEIR WORK PHONE _____

HOW DID YOU HEAR ABOUT US? _____

FINANCIAL INFORMATION.

PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED AND/OR MATERIALS ORDERED.

PLEASE CIRCLE TODAY'S METHOD OF PAYMENT: CASH CHECK CREDIT CARD (TYPE: _____)

INSURANCE COMPANY _____ MEMBER'S NAME _____

MEMBER'S NUMBER _____ MEMBER'S EMPLOYER _____

STATEMENT TO PERMIT PAYMENT OF MEDICARE AND ALL OTHER INSURANCE BENEFITS TO

PROVIDER, PHYSICIANS AND PATIENT: I HEREBY REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE OR ANY OTHER INSURANCE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF FOR ANY SERVICES FURNISHED TO ME BY J. BART BRADY, O.D., DOING BUSINESS AS GLOBAL EYE CARE, INCLUDING PHYSICIAN SERVICES. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS OR ANY OTHER THIRD PARTY INSURANCE CARRIER, ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR BENEFITS FOR RELATED SERVICES. HOWEVER, I AGREE TO ACCEPT RESPONSIBILITY FOR ANY SERVICES PERFORMED THAT ARE DENIED COVERAGE BY MEDICARE OR ANY OTHER INSURANCE.

DILATION POLICY. DR. BRADY CONSIDERS DILATION OF THE PUPILS AN IMPORTANT PART OF A COMPLETE EYE EXAMINATION. THE PURPOSE OF PUPIL DILATION IS TO ENABLE DR. BRADY TO EXAMINE THE INSIDE OF THE EYE MORE THOROUGHLY. IT HELPS WITH EARLY DETECTION OF EYE DISEASES SUCH AS CATARACTS, GLAUCOMA AND RETINAL DISORDERS. IT ALSO HELPS WITH MONITORING AND DETECTING SYSTEMIC DISEASES SUCH AS HYPERTENSION AND DIABETES. DROPS ARE USED TO DILATE THE PUPILS WHICH WILL CAUSE TEMPORARY SENSITIVITY TO LIGHTS AND DIFFICULTY WITH READING OR NEAR WORK FOR AN HOUR OR MORE. IF YOU DO NOT HAVE A DRIVER TODAY OR CANNOT WAIT FOR THE TEMPORARY SIDE EFFECTS TO SUBSIDE, YOU MAY SCHEDULE THE DILATION FOR ANOTHER TIME. IT MAY BE NECESSARY FOR PATIENTS SHOWING SIGNS OF EYE DISEASE AND YOUNG CHILDREN TO BE DILATED AT TODAY'S VISIT. DR. BRADY RECOMMENDS DILATION EVERY YEAR FOR PATIENTS OVER THE AGE OF 50.

PLEASE CHECK ONE:

I WOULD LIKE PUPIL DILATION TODAY FOR A MORE COMPREHENSIVE EXAMINATION.

I DO NOT WANT MY PUPILS DILATED AND UNDERSTAND THAT REFUSING THIS PROCEDURE WILL MAKE EARLY DETECTION OF EYE DISEASE MORE DIFFICULT.

I HAVE READ AND UNDERSTAND THE PRECEDING POLICIES AND ANSWERED THE QUESTIONS TO THE BEST OF MY KNOWLEDGE.

PATIENT OR GUARDIAN SIGNATURE

DATE

THANK YOU FOR TAKING THE TIME TO FILL OUT THIS FORM.

Our Office has an instrument, which **enables** us to provide a more thorough peripheral visual field screen analysis.

Visual Field Screening can assist us in early detection of glaucoma, retinal problems, and neurological diseases (such as optic nerve disease). The fee for this procedure is **\$10.00** and is **NOT** covered by most insurance companies.

Please check the appropriate line below stating your preference and sign the form at the bottom. If you have any questions we will be happy to discuss this in more detail.

I **DO** want the Visual Field Screening

Though it may be in my best interest, I **DO NOT** want the Visual Field Screening

Patient Signature _____ Date _____

Global Eye Care J. Bart Brady, O.D.

3065 Hwy 367 Ste 4 Cabot, AR 72023 (501) 941-4321
Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature: _____

Date

--

Office Use Only

I attempted to obtain the patient’s signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:
-------	-----------	---------