Shreveport Eye Specialists
Russell Van Norman MD
Rachel Meyer-Borel OD

NEW PATIENT REGISTRATION

Have you been here before? Yes No

Patient Name Date of Birth

If Minor, give person responsible Race

Spouse Name Language

Mailing Street Address Ethnicity Hispanic Non-Hispanic

City State Zip

Phone # Cell # SS #

May we call you at the above numbers? Yes No

Email

Employer Work # Job Injury? Yes No

If your insurance is under a spouse or parent, we need:

Insured Name Date of Birth SS #

Emergency Contact Emergency Phone:

Primary Care Physician Referring/Specialty Dr.

Pharmacy Location (street/city)

GIVE RECEPTIONIST YOUR INSURANCE / MEDICARE CARD. IF JOB INJURY, GIVE EMPLOYER INFORMATION.

I acknowledge that I have received Shreveport Eye Specialists Notice of Privacy Practices. I authorize use of this form for all my insurance claim submissions. I authorize the release of information to my insurance carrier(s). I authorize direct payment to my doctor if filing accordingly. I permit a copy of this document to serve in place of the original. I understand that I am responsible for my bill.

Signature Date

FOF/AP 726-06

8445 Line Avenue Suite 200, Shreveport, LA | (318) 703-5655 | info@shreveporteyespecialists.com

REVIEW OF SYSTEMS

Patient Name _____ Date _____

Previous Eye Surgery	YES		NO		Diabetic Retinopathy	YES		NO	
Contact Lenses	YES		NO		Dry Eyes	YES		NO	
Eye Pain	YES		NO		Hyperopia (far sighted)	YES		NO	
Double Vision	YES		NO		Myopia (near sighted)	YES		NO	
Glaucoma	YES		NO		Tearing	YES		NO	
Cataracts	YES		NO		Optic Neuritis	YES		NO	
Macular Degeneration	YES		NO		Retinal Detachment	YES		NO	
Flashes / Floaters	YES		NO		Other				

OCULAR SURGERIES: (please mark all that apply)

Foreign Body Removal	L		R	
Blepharoplasty	L		R	
Strabismus Surgery	L		R	
Punctal Plugs	L		R	
Corneal Transplant	L		R	
PRK (eye muscle surgery)	L		R	
Other				

☐ No prior ocular surgery

Retinal Laser Surgery	L		R	
Vitrectomy	L		R	
Laser	L		R	
RK	L		R	
Cataract Surgery	L		R	
LASIK	L		R	

CURRENT EYE MEDICATIONS (please list)

OTHER MEDICAL HISTORY

☐ No history of illness

- ☐ Thyroid Disease
- ☐ Anemia
- ☐ Arthritis
- ☐ Arrhythmia
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Cancer _____
- ☐ Chicken Pox
- ☐ Hepatitis A / B / C
- ☐ Heart Disease
- ☐ COPD
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Eczema
- ☐ Fibromyalgia
- ☐ Herpes Zoster/Shingles
- ☐ Histoplasmosis
- ☐ MRSA
- ☐ Headache
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Herpes Simplex
- ☐ Kidney Disease
- ☐ Multiple Sclerosis
- ☐ Liver Disease
- ☐ Meningitis
- ☐ Toxoplasmosis
- ☐ Lung Disease
- ☐ Lupus
- ☐ Migraine
- ☐ Psychiatric Disorder
- ☐ Myasthenia Gravis
- ☐ Sarcoidosis
- ☐ Stroke
- ☐ Sjogren's Syndrome
- ☐ Syphilis
- ☐ Other _____

REVIEW OF SYSTEMS

Have you even been diagnosed with HIV / AIDS or Hepatitis A / B / C ☐ Yes (circle which one) ☐ No

Have you had your flu vaccine? ☐ Yes ☐ No Have you had your pneumonia vaccine? ☐ Yes ☐ No

Have you fallen in the last 12 mo ☐ Yes ☐ No

GENERAL SURGERIES / OPERATIONAL: (please check and list)

☐ Heart Bypass ☐ Pacemaker ☐ Sinus ☐ Gastric Bypass

ALL OTHER MEDICATIONS: (please check and list)

☐ Plaquenil ☐ Prednisone ☐ Diamax ☐ Topamax ☐ Asprin

FAMILY HISTORY:

☐ Arthritis ☐ Diabetes ☐ Stroke ☐ Kidney Disease ☐ TB

☐ Blindness ☐ Glaucoma ☐ Lazy Eye ☐ High Blood Pressure ☐ Cataracts

☐ Heart Disease ☐ Retinal Disease ☐ Cancer ☐ Macular Degeneration

SOCIAL HISTORY (please mark all that apply)

Smoking: ☐ Never ☐ Former smoker ☐ Current daily ☐ Current occasional

Alcohol Use: ☐ Yes ☐ No If yes, how much/often:

Drug Use: ☐ Yes ☐ No If yes, what/how often:

Allergies ☐ Yes ☐ No

Reaction	Severity		
	mild	moderate	severe
	mild	moderate	severe
	mild	moderate	severe
	mild	moderate	severe

REVIEW OF SYSTEMS

Please mark all that apply:

EAR, NOSE & THROAT
- Hard of Hearing
- Ringing in Ears
- Vertigo

CARDIOVASCULAR
- Chest Pain
- Dizziness
- Fainting Spells
- Shortness of Breath
- Irregular Heart Beat
- Difficulty Lying Flat

CONSTITUTIONAL
- Fatigue/Weakness
- Fever
- Weight Gain/Loss

RESPIRATORY
- Cough
- Congestion
- Wheezing
- Asthma

GASTROINTESTINAL
- Heartburn
- Nausea/Vomiting
- Jaundice/Hepatitis

GENITO-URINARY
- Pain/Difficulty
- Blood in Urine
- History of Kidney Stones
- History of STDs

PSYCHIATRIC
- Anxiety/Depression
- Mood Swings
- Difficulty Sleeping

ENDOCRINE
- Increased Thirst
- Increased Hunger
- Increased Urination
- Increased Sweating
- Fingernail Changes

BLOOD/LYMPH NODES
- Easy Bruising
- Gums Bleed Easy
- Prolonged Bleeding
- Heaving Aspirin Use

MUSCULOSKELETAL
- Stiffness
- Arthritis
- Joint Pain/Swelling

SKIN
- Rash/Sores
- Lesions
- Hives/Eczema

NEUROLOGICAL
- Seizures
- Weakness/Paralysis
- Numbness
- Tremors

IMMUNOLOGICAL
- Hives
- Itching
- Runny Nose
- Sinus Pressure

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A refraction is a measurement for glasses or other corrective lenses. Most medical insurance plans, including Medicare, do not cover routine refractions or routine eye examinations including Contact Lens Fitting. Contact lens fitting fees cover the extra measurements that are done only for patients requesting contact lens. The fitting fees also including one pair of trials and a month of followup visits if you are having problems with the contacts.

Medicare and most insurance plans require that we charge separately for these type of measurements.

Contact fitting fees are determined by the physician at the time of the exam and depend solely on the type of contacts needed. These fees can range from $50 to $350 in addition to the exam fees. You may discuss this with the technician and/or physician at the time of your exam.

Refraction fees are $30.

By signing below, I acknowledge that I have read and understand the refraction and/or contact lens fitting.

Signature _____ Date _____

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WHERE DID YOU HEAR ABOUT US?

Please let us know how you found out about us.

- [ ] Billboards
- [ ] Magazines
- [ ] TV
- [ ] Google
- [ ] Facebook
- [ ] Doctor Referral (please specify who so we can thank them)

- [ ] Family / Friend (please specify who so we can thank them)

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FINANCIAL POLICY

All patients must provide accurate and complete personal and insurance information prior to being seen by the physician, physician assistant, nurse practitioner or other medical care provider/practitioner.

Payment is required at the time of service if you are a self-pay patient. There will be a $35 fee for all returned checks.

It is your personal responsibility to understand the limitations and exclusions of your insurance plan as well as to understand your co-pays, deductibles, in-network and out of network coverage.

We understand situations arise that can cause you to miss your scheduled appointment. However, we will charge a $25 no show fee for the first missed appointment. Please call at least 24 hours prior to your appointment if you need to cancel or reschedule so that we can schedule another patient in the appointment slot.

Federal laws require that Shreveport Eye Specialists submit every claim to an insurance company accurately and report the exact services performed and the exact reason for performing them. It is insurance fraud to change this information in order to try to obtain payment on a claim from an insurance company.

I agree that in the event my insurance provider does not pay for some/all of the charges associated with and in curred for today's visit, I will pay any remaining balance due and that balance will be my personal financial responsibility. I understand that this Medical Treatment and Financial Agreement is and will be valid for any and all services prided by Shreveport Eye Specialists effective from the date this Medical treatment and financial Agreement is signed by me and does not expire unless and until I inform Shreveport Eye Specialists directly that I no longer with to have the agreement in effect.

Signature _____ Date _____

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CONSENT/RELEASE AUTHORIZATION TO PHOTOGRAPH AND/OR VIDEO

I, the undersigned, give permission to Shreveport Eye Specialists, and/or parties designated by Shreveport Eye Specialists to photograph/video me and use such photograph(s)/video(s) in all forms of media for all promotional purposes including advertising, display, audiovisual, exhibition or editorial use.

I further consent to the use of my name in connection with the photograph(s)/video(s) if needed by Shreveport Eye Specialists and/or parties designated by Shreveport Eye Specialists.

I understand and agree that I will not receive any payment for my time or expenses or any royalty for the publication of the photograph(s)/video(s) or the use of my name and I hereby release Shreveport Eye Specialists and/or any parties designated by Shreveport Eye Specialists from such claims.

I certify that I have read and fully understand this consent and release, and that all questions pertaining to this consent have been answered to my satisfaction.

Signature _____ Date _____

Print Name _____

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NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.
This notice describes how medical information about you may be used and disclosed and how you can get access to the information. Please review it carefully.

Your Rights. When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record.
- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record.
- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications.
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share.
- You can ask us not to use or share certain health information for treatment, payment or out operations. (We are not required to agree to your request, and we may say “no” if it would affect your care.)
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or out operations with your health insurer. (We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information.
- You can ask for a list (accounting) of the times we’ve shared your health information for six year prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice.
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you.
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

NOTICE OF PRIVACY PRACTICES

- We will make sure the person has this authority and can act for you before we take any action.

File a complain if you feel your right are violated.
- You can complain if you feel we have violated your rights by contacting us using the information in this packet.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/compaints/.
- We will not retaliate against you for filing a complaint.

Your Choices. For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in your care.
- Share information in a disaster relief situation
- Include your information in a hospital directory (If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and shred your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent thread to health or safety.

In these cases we never share your information unless you give us written permission:
- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:
- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures. How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you:
- We can use your health information and share it with other professionals who are treating you. (Example: a doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization:
- We can use and share your health information to run our practice, improve your care and contact you when necessary. (Example: We use health information about you to manage your treatment and services.)

Bill for your services:
- We can use and share your health information to bill and get payment from health plans or other entities. (Example: We give information about you to your health insurance plan so it will pay for your services.)

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How else can we use or share your health information? We are allowed or required to share your information in other ways - usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues:
- We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research:
- We can use or share your information for health research.

Comply with the law:
- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests:
- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director:
- We can share health information with a coroner, medical examiner, or funeral director with an individual dies.

Address workers' compensation, law enforcement, and other government requests:
- We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security and presidential protective services.

Respond to lawsuits and legal actions:
- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities. We are required by law to maintain the privacy and security of your protected health information.
We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
We must follow the duties and privacy practices described in this notice and give you a copy of it.
We will note use or share your information other than as described here unless you tell us we can in writing. If you tel us we can, you may change your mind at any time. Let us know in writing if you change your mind.

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For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Term of This Notice:
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

This Notice of Privacy Practices applied to the following organizations:

Shreveport Eye Specialists
8445 Line Avenue Suite 200 Shreveport, LA 71106
318-703-5655
https://www.shreveporteyespecialists.com/

I certify that I have read and fully understand this notice of privacy practices, and that all questions pertaining to this consent have been answered to my satisfaction.

Signature _____ Date _____

Print Name _____