Name: Age:

Chart: DOB:

Date: Referring Dr:

HAIK HUMBLE EYE CENTER

Patient Information

last name | first name | middle | maiden name | home phone

street address/p.o. box/route | city | state | zip | social security number | date of birth | age | sex ☐ M ☐ F

Race: ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Asian ☐ White ☐ Black or African American ☐ Other _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

cellular phone | email address | Primary Language: ☐ English ☐ Other _____ | employer name and occupation

employer address | city | state | work phone | workman's compensation? ☐ yes ☐ no

marital status | spouse's name | spouse's social security # | spouse's birthdate | spouse's work phone

spouse's employer and occupation | spouse's employer address | city | state | zip

Payment / Insurance Information

How will you pay for today's visit? ☐ Medicare ☐ Medical Insurance ☐ Vision Insurance ☐ Self-Pay ☐ Worker's Comp

medicare number | medicaid number | medicare supplement | policy number

insurance company | policy number | group number | name of insured

Guarantor Information (for children)

last name (father) | first name | middle | phone

billing address/p.o. box/route | city | state | zip | social security number | date of birth

employer | occupation | work phone number

last name (mother) | first name | middle | maiden name | phone number

billing address/p.o. box/route | city | state | zip | social security number | date of birth

employer | occupation | work phone number

Name of relative or friend (not in same household)

name | relationship to patient

address | city | state | zip | phone number

Referred By: Please indicate who referred you so we may thank them.

☐ Family/Friend ☐ Radio ☐ Newspaper ☐ Yellow Pages ☐ TV ☐ Billboard ☐ Website/Internet ☐ Direct Mail

☐ Doctor_____ ☐ Nurse Practitioner_____ ☐ Other_____

referring person or doctor's name

Has any member of your family ever been treated by our clinic? ☐ yes ☐ no ☐ don't know name(s): _____

Please read the following statements and sign:

I authorize release of medical information. I consent to photography. This authorization shall be binding indefinitely from the date of signature. A copy of this release will be as legal and binding as the original.

I understand all office visits are to be paid at the time services are rendered. I also realize that I am responsible for payment before filing my insurance. For any services rendered I request that payment of authorized Medicare, Medicaid, or insurance benefits be made to Eye Associates of Northeast Louisiana, Surgery Center of West Monroe, Raymond Haik MD, Joseph Humble MD, Thomas Parker MD, Baron Williamson MD, Ruben Grigorian MD, Jonathan Scogin OD, Jim Eaton OD, Robert Pierce OD, or Thomas Marsala, PA-C. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration, insurance company and its agents any information needed to determine these benefits or benefits for related services.

A monthly interest charge of 1 1/2% per month (18% annually) may be added to all past due accounts (over 60 days). Any account with a pending balance over 90 days may be referred for collection.

Due to danger to myself and others, I realize I should not drive while my eye is dilated, medicated, or patched.

Signature of patient or guardian: _____ Date: _____

Name: Age:
Chart: DOB:
Date: Referring Dr:

Any past eye problem? _____

Describe the reason for your visit today: _____

Family Doctor _____ Pharmacy/Street Address _____

Please mark Yes or No

Personal Medical History

Yes	No	
☐	☐	Diabetes
☐	☐	High Blood Pressure
☐	☐	Cataract
☐	☐	Stroke
☐	☐	Crossed Eyes
☐	☐	Arthritis
☐	☐	Asthma/Emphysema
☐	☐	AIDS
☐	☐	Cancer (including skin cancer)
☐	☐	Retinal Detachment
☐	☐	Heart Disease
☐	☐	Heart Attack
☐	☐	Tuberculosis (TB)
☐	☐	Glaucoma
☐	☐	Thyroid Problems
☐	☐	Cholesterol (High / Low)

Medications

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Personal Medical History

OTHER:

_____
_____

Living Conditions:

☐ Widowed
☐ Married
☐ Single
☐ Nursing Home

Family History

Yes	No	
☐	☐	Glaucoma
☐	☐	Cataracts
☐	☐	Macular Degeneration
☐	☐	Retina Disease
☐	☐	Diabetes
☐	☐	Cancer
☐	☐	Hypertension
☐	☐	Heart Disease

Alcohol

☐ Never
☐ Once a month or less
☐ 2 to 4 times a month
☐ 2 to 3 times a week
☐ 4 or more times a week

Smoking

☐ Never smoker
☐ Current every day smoker
☐ Current some day smoker
☐ Heavy tobacco smoker
☐ Light tobacco smoker
☐ Former smoker

Hobbies / Activities

☐ Golf ☐ Hunting / Fishing
☐ Water Sports ☐ Computer Work
☐ Tennis ☐ Needlepoint
☐ Reading
☐ Other _____

Past Eye Surgery

_____
_____
_____
_____
_____
_____

Other Past Surgeries

_____
_____
_____
_____
_____
_____

Are you interested in Lasik? ☐**Yes** ☐**No**
Are you interested in Contact Lenses? ☐**Yes** ☐**No**

Allergies to Medicine

_____
_____

Other Allergies

_____
_____

I authorize the request and use of my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

Signature of patient or guardian: _____ Date: _____

Name: Age:

Chart: DOB:

Date: Referring Dr:

EYE ASSOCIATES OF NORTHEAST LOUISIANA •• SURGERY CENTER OF WEST MONROE

NOTICE OF PRIVACY PRACTICES

This is only a summary of our Notice of Privacy Practices. We encourage you to read the full Notice posted in our lobby. If you would like a paper copy, please ask the receptionist.

HOW WE USE AND DISCLOSE YOUR INFORMATION

We will obtain your written authorization for any uses and disclosures of protected health information "PHI" not described in the Notice of Privacy Practices.

Treatment, Payment, and Health Care Operations. We may use your PHI in order to provide your medical care; to bill for our services and to collect payment from you or your insurance company; and for the general operation of our business.

Marketing, Fundraising, and Sale of PHI. We will obtain your prior written authorization before sending you certain marketing communications. We may use or disclose your demographic information in order to contact you for our fundraising activities, but you have the right to opt out of such communications. If you do not wish to be contacted, please contact our Privacy Officer. We will not sell your health information or otherwise use or disclose your medical information for marketing purposes without your prior written authorization.

We may use your PHI as otherwise authorized or required by law for such purposes as:

- public health reporting and oversight activities
- judicial, administrative, or law enforcement proceedings
- complying with workers' compensation laws
- communicating with your family or caregivers
- sending appointment reminders

YOU HAVE THE RIGHT TO:

- Request certain restrictions on our use and disclosure of your PHI.
- Request communications from us by specific means or locations.
- Receive an accounting of disclosures of your PHI by our practice.
- Inspect and copy your medical record.
- Ask us to correct the information in your medical record.
- Be notified in the case of a breach of unsecured PHI.

CONTACT US

Contact our Privacy Officer with any questions, comments, or complaints or to exercise any of your rights:

Mary Sue Jacka, Administrator
1804 N 7th Street • West Monroe, LA 71291 | Ph: (318) 325-2610

By signing this form, you acknowledge that you have been informed that Eye Associates of Northeast Louisiana and Surgery Center of West Monroe provide information about how we may use and disclose your protected health information.

Eye Associates of Northeast Louisiana and Surgery Center of West Monroe may use the following methods of communicaiton regarding information related to my personal health, treatment or payment for treatment. I acknowledge I am responsible for updating this information as necessary. This request supersedes any prior request for methods of communication I may have made.

☐ Contact me by phone at home_____ ☐ Work_____ ☐ Cell_____

☐ May leave a message on my voice mail/answering machine ☐ Email_____

☐ May speak to anyone who answers the phone

☐ May only speak to_____

☐ May leave a message for me at my work phone number.

Signature:_____ Date:_____

(Patient / Parent / Conservator / Guardian)

Practice Representative:_____