

Account #: \_\_\_\_\_

Name: \_\_\_\_\_

D.O.B.: \_\_\_\_\_

**Tuscaloosa Ophthalmology**

535 Jack Warner Pkwy NE

Suite B-1

Tuscaloosa AL 35404

Phone: 205-556-2121

Fax: 205-831-8370

E. Van Johnson, MD Timothy V. Johnson, MD Michaele Snyder, OD

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

SSN: \_\_\_\_\_

Address:

\_\_\_\_\_  
\_\_\_\_\_

Cell Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Medical Insurance Type & Plan Number:

\_\_\_\_\_  
\_\_\_\_\_

Vision Insurance Type & Plan Number:

\_\_\_\_\_  
\_\_\_\_\_

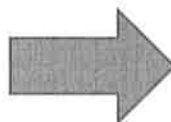
Emergency Contact Name, Relationship, & Phone Number:

\_\_\_\_\_

PLEASE SIGN HERE STATING THE ABOVE INFORMATION IS ACCURATE:

\_\_\_\_\_

**\*\*\*PLEASE READ AND SIGN NEXT PAGE\*\*\***



Account #: \_\_\_\_\_  
Name: \_\_\_\_\_  
D.O.B.: \_\_\_\_\_

Please read and sign the below agreement:

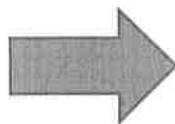
I understand that the charges made by Tuscaloosa Ophthalmology for professional services may not be covered in full by any insurance covering such services to the patient. The patient and/or responsible party for payment of fees for services rendered to the patient agrees to make in full to Tuscaloosa Ophthalmology in such cases. The undersigned accepts the fees charged as lawful debt and promises to pay said fee including up to 35% of the debt for the cost of collection, in addition to any attorney fees, and court costs if necessary, waiving now and forever the right to claim exemption under the constitution and laws of the state of Alabama or any other state. I understand that I am required to pay any health insurance deductibles, co-insurance, co-payments or any other charges incurred which are not paid by insurance. I understand that Blue Cross and other insurances may or MAY NOT cover refractions, after hours services or other services that the doctor feels necessary for the treatment of my condition and/or maintenance of good health. If I receive a refraction, receive care after hours or other non-covered service by my insurance today and future visits, I agree to pay for these services in full. I authorize the release of any medical information necessary to process an insurance claim and wish to receive updates in medical information via email.

ALL PAYMENTS ARE DUE AT THE TIME OF SERVICES RENDERED.

YES \_\_\_\_\_ NO \_\_\_\_\_ - TUSCALOOSA OPHTHALMOLOGY HAS MY PERMISSION TO KEEP MY CREDIT CARD ON FILE FOR REFUNDS ONLY.

SIGN HERE: \_\_\_\_\_

\*\*\*PLEASE FILL OUT AND SIGN NEXT PAGES\*\*\*



Account #: \_\_\_\_\_  
Name: \_\_\_\_\_  
D.O.B.: \_\_\_\_\_

**PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM**

**Request to Receive Confidential Communications by Alternative Means:**

As provided by Privacy Rule Section 164.522(b), I hereby authorize the Practice to communicate with me by the alternative means that I have listed below.

**PLEASE CHECK ALL THAT APPLY**

Home Phone Number: \_\_\_\_\_

- OK to leave message with detailed information
- Leave message with call back numbers only
- OK to send reminders/follow up to the numbers listed above

Cell Number: \_\_\_\_\_

- OK to leave message with detailed information
- OK to Text at the number listed above
- Leave message with call back numbers only

E-mail me at: \_\_\_\_\_

OK to send email and/or text correspondence regarding appointments, reminders or other office related business using communication methods listed.

I understand and acknowledge that communications sent via unencrypted email over an open network are inherently insecure, and there is no assurance of confidentiality of information communicated in this manner. Nevertheless, I consent to allow EyeCare Partners LLC or its affiliates to use unsecure email to communicate with me regarding my health information.

**How did you hear about us? Circle one**

- |          |        |           |             |                 |
|----------|--------|-----------|-------------|-----------------|
| Friend   | Family | Newspaper | Magazine    | Internet search |
| Facebook | Event  | Insurance | Other _____ |                 |

**PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM**

**Acknowledgement of Practices Notice of Privacy Practices:**

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

Signature of Patient/Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Name of Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:**

I agree that the practice may disclose certain of my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my health care. In that case, the Physician Practice will disclose only information that is directly relevant to the persons involvement with my health care or payment relating to my health care.

Print Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Print Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Print Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Account #: \_\_\_\_\_  
Name: \_\_\_\_\_  
D.O.B.: \_\_\_\_\_

## Medical Conditions

(Please check any that apply.)

### CARDIOVASCULAR:

\_\_\_\_\_ Abnormal Valve  
\_\_\_\_\_ Heart Attack  
\_\_\_\_\_ High Blood Pressure  
\_\_\_\_\_ High Cholesterol  
\_\_\_\_\_ Heart Murmur

### ENDOCRINE:

\_\_\_\_\_ Diabetes Type I  
\_\_\_\_\_ Diabetes Type II  
\_\_\_\_\_ Thyroid Disease

### ENT:

\_\_\_\_\_ Deafness  
\_\_\_\_\_ Sinus Problems

### EYES:

\_\_\_\_\_ Blurred Vision  
\_\_\_\_\_ Cataracts  
\_\_\_\_\_ Double Vision  
\_\_\_\_\_ Dryness  
\_\_\_\_\_ Flashes of Light  
\_\_\_\_\_ Floaters  
\_\_\_\_\_ Glaucoma  
\_\_\_\_\_ Injury  
\_\_\_\_\_ Itching  
\_\_\_\_\_ Infection  
\_\_\_\_\_ Poor Night Vision  
\_\_\_\_\_ Redness  
\_\_\_\_\_ Tearing

### GENERAL:

\_\_\_\_\_ Fatigue  
\_\_\_\_\_ Fever  
\_\_\_\_\_ Loss of Appetite  
\_\_\_\_\_ Weight Gain

### GASTROINTESTINAL:

\_\_\_\_\_ Acid Reflux  
\_\_\_\_\_ Cancer  
\_\_\_\_\_ Hepatitis  
\_\_\_\_\_ Hernia  
\_\_\_\_\_ Ulcer

### GENITOURINARY:

\_\_\_\_\_ Cancer  
\_\_\_\_\_ Kidney Disease  
\_\_\_\_\_ Kidney Stones  
\_\_\_\_\_ Prostate Disease

### HEMATOLOGY:

\_\_\_\_\_ AIDS  
\_\_\_\_\_ Anemia  
\_\_\_\_\_ Bleeding Disorder  
\_\_\_\_\_ HIV

### MUSCOSKELETAL:

\_\_\_\_\_ Arthritis  
\_\_\_\_\_ Lupus  
\_\_\_\_\_ Muscle Aches  
\_\_\_\_\_ Rheumatic Disease

### NEUROLOGICAL:

\_\_\_\_\_ Headache  
\_\_\_\_\_ Migraine  
\_\_\_\_\_ Seizure  
\_\_\_\_\_ Stroke  
\_\_\_\_\_ Vertigo

### PSYCHIATRIC:

\_\_\_\_\_ Anxiety  
\_\_\_\_\_ Depression

### RESPIRATORY:

\_\_\_\_\_ Allergies  
\_\_\_\_\_ Asthma  
\_\_\_\_\_ Sleep Apnea  
\_\_\_\_\_ Shortness of Breath

### SKIN:

\_\_\_\_\_ Itching  
\_\_\_\_\_ Rash  
\_\_\_\_\_ Redness  
\_\_\_\_\_ Shingles

## Medical History

Primary Care Physician: \_\_\_\_\_ Phone # \_\_\_\_\_

Pharmacy Name/City: \_\_\_\_\_ Phone # \_\_\_\_\_

Drug Allergies: \_\_\_\_\_

Use of Alcohol: Yes / No      Use of Tobacco: Yes / No

Prior Surgeries: \_\_\_\_\_

I have a Family History of (please check): If checked, please indicate which family member.

\_\_\_\_\_ Cancer      Family Member \_\_\_\_\_

\_\_\_\_\_ Eye Disease      Family Member \_\_\_\_\_

\_\_\_\_\_ Diabetes      Family Member \_\_\_\_\_

\_\_\_\_\_ Heart Disease      Family Member \_\_\_\_\_

Medication/Dosage: (attach list if applicable) \_\_\_\_\_

Have you had:    Pneumonia Vaccination Yes / No      Influenza Vaccination Yes / No

Print Name: \_\_\_\_\_

Sign Here: \_\_\_\_\_ Date: \_\_\_\_\_