Account #: _____
Name: _____
D.O.B.: _____

Southern Eye Consultants

1406 McFarland Blvd N
Suite 1-B
Tuscaloosa AL 35406
Phone: 205-752-5551
Fax: 205-831-8370
Max Musharoff, MD Bret Fisher, MD

Name: _____

Date of Birth: _____

SSN: _____

Address:

_____

_____

Cell Phone: _____

Home Phone: _____

Email: _____

Medical Insurance Type & Plan Number:

_____

_____

Vision Insurance Type & Plan Number:

_____

_____

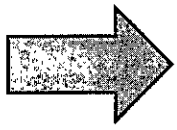
Emergency Contact Name, Relationship, & Phone Number:

_____

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:

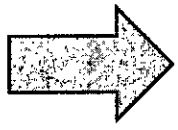
I understand that the charges made by Tuscaloosa Ophthalmology for professional services may not be covered in full by any insurance covering such services to the patient. The patient and/or responsible party for payment of fees for services rendered to the patient agrees to make in full to Tuscaloosa 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 he 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: _____