Mulqueeny EYE CENTERS
- your sight solution

(*Office Use Only*) MRN: _____

NAME		DATE
STREET ADDRESS	APT. #	SOCIAL SECURITY #
CITY, STATE, ZIP		

RACE	SPECIAL NEEDS
☐ AMERICAN INDIAN ☐ ALASKAN NATIVE ☐ BLACK OR AFRICAN AMERICAN ☐ WHITE ☐ DECLINE ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	☐ WHEELCHAIR ☐ HEARING IMPAIRED ☐ WALKER ☐ TRANSLATOR ☐ OTHER

PREFERRED LANGUAGE	BIRTH DATE	AGE	ETHNIC ORIGIN	SEX
			☐ HISPANIC OR LATINO ☐ NON- HISPANIC OR LATINO ☐ DECLINE	☐ M ☐ F

HOME PHONE	WORK PHONE	MARITAL STATUS
		☐ S ☐ M ☐ D ☐ W
EMPLOYER NAME/ADDRESS		POSITION/DEPARTMENT
SPOUSE'S NAME		SPOUSE'S WORK PHONE ( )
EMERGENCY CONTACT – NAME AND PHONE NUMBER		YOUR E-MAIL ADDRESS

BILLING

GUARANTOR (FINANCIALLY RESPONSIBLE PERSON) NAME_____ SOCIAL SECURITY # – –	RELATIONSHIP TO PATIENT ☐ SELF ☐ PARENT ☐ SPOUSE ☐ OTHER
STREET ADDRESS	BIRTH DATE PHONE / / ( ) -
CITY	STATE ZIP
SEND WORKERS COMP BILL TO	AUTHORIZED BY NAME PHONE ( ) -

REFERRAL

WHOM MAY WE THANK FOR TELLING YOU ABOUT OUR PRACTICE? PHONE ( )	☐ FRIEND/FAMILY ☐ NEWSPAPER ☐ M.D. ☐ RADIO ☐ OPTOMETRIST ☐ TELEVISION ☐ YELLOW PAGES ☐ OTHER		
STREET ADDRESS	CITY	STATE	ZIP CODE
PRIMARY CARE DOCTOR	PHONE ( ) -		
STREET ADDRESS	CITY	STATE	ZIP CODE

Continued on back ➔

Agreement of Responsibility

I understand that professional services are rendered to the patient and the patient is responsible for charges incurred for these services. Payment for annual deductibles and co-insurance may be collected at the time of service. I understand that I am financially responsible for charges not covered by my insurance company.

Consent to Treat

I voluntarily consent to such care and treatment as prescribed by the physician as is necessary in his/her medical judgment.

Release of Information/Assignment of Benefits

I authorize use of this form on all my insurance submissions and authorize release of information needed to process a claim to all my insurance companies. I permit a copy of this authorization to be used in place of the original. I authorize the provider to act as my agent in helping me obtain payment from my insurance companies. I understand the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement on disputed claims. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand I will receive a monthly statement for any balance due by me.

This Agreement is in effect until revoked in writing by the patient.

Signature: _____ Date: _____/_____/_____

Medicare Authorization Medicare No. _____

I request payment of authorized Medicare benefits be made on my behalf to SureVision Eye Centers – Midwest, LLC for any services furnished me by that physician/supplier. I authorize the holder of medical information about me to release to Medicare and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and the uncovered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Medigap Authorization Insurance Co._____

Policy No._____

Fill out if you have a Medigap insurance policy for which you wish to assign benefits. A Medigap or Medicare Supplemental policy is a health insurance policy or other health benefit plan, offered by a private company, to those entitled to Medicare benefits. It is designed to pay certain costs that Medicare does not pay. By law, this excludes a policy or plan offered by an employer to employees or former employees, as well as a policy or plan offered by a labor organization to members or former members.

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PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

This Consent was signed by: _____

Signature — Printed Name – Patient or Representative

Relationship to Patient (if other than patient): _____

Date: _____/_____/_____

Witnessed by: _____

Printed Name – Practice Representative

I agree to have my health information disclosed to the following person(s):

_____ _____

Name — Relationship to Patient

_____ _____

Name — Relationship to Patient

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Name: **Today's Date:**

Birth Date:

FAMILY DOCTOR:

Address:

City: State: Zip:

Telephone:

REFERRING DOCTOR:

Address:

City: State: Zip:

Telephone:

HEALTH HISTORY (Please check all that apply to you):

__ Diabetes
__ Hypertension
__ Heart Disease
__ Arthritis
__ Lung Disease
__ Kidney Disease
__ Stomach/Colon Disease
__ Liver Disease
__ Seizure Disorder
__ Cancer (*Type:* _____)
__ Autoimmune Disease
__ Thyroid/Gland Disease
__ Skin Disease
__ HIV Positive
__ Claustrophobia

Have you had a Pneumococcal (pneumonia) shot? Yes or No

Do you have an Advanced Care Plan? Yes or No

SURGICAL/HOSPITALIZATION HISTORY (Please list all surgeries or hospitalizations AND the year)

EYE HISTORY / SURGERY OF THE EYE (Please list all EYE conditions and surgeries)

FAMILY HISTORY (Please *WRITE FAMILY MEMBER* next to all that apply):

_____Glaucoma _____Crossed Eyes _____Retinal Disease _____ Macular Degeneration
_____Diabetes _____Corneal Disease _____Heart Disease _____ Stroke/TIA

SOCIAL HISTORY (Please check all that apply):

Are you a… ___Nonsmoker ___Former Smoker ___Current Smoker (___ *Cigarettes/Day*)

Do you drink alcohol? ___No ___Yes (How *much?* _____ *How often?* _____)

Do you abuse drugs? ___ No ___ Yes

Have you fallen in the last year? ___No ___Yes if yes, how many times? _____

DRUG ALLERGIES:

CURRENT MEDICATIONS (Write out or attach a list, PLEASE INCLUDE ALL EYEDROPS):

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Optomap®

Retinal Exam

We all want to protect our gift of sight. That is why it is important to have annual eye health examinations. Annual check-ups not only allow Dr. Mulqueeny to improve the quality of your vision but it also provides the opportunity to determine the overall health of your eye –from the clear window of the eye (cornea) to the very back (retina).

Dr. Mulqueeny highly recommends that you have an Optomap® Retinal Exam, a comprehensive method of evaluating, monitoring and helping treat various eye conditions. Another benefit to consider –this technology allows you to have your annual eye health exam without having your eyes dilated.

The Optomap® takes just minutes to perform and retinal analysis is an essential part of your annual eye exam. If you choose the advanced technology of Optomap® instead of dilation, the cost to you is $40.00. Depending on your eye health history, the doctor may be able to submit to your insurance company; however, you will be responsible for any deductible and/or co-pay.

I understand the above and choose to:

_____ **Accept test** ***some circumstances require medical necessary dilation.**

_____ **Decline test**

QuantifEye® MPOD Test

Age Related Macular Degeneration Risk Factors

Age-Related Macular Degeneration (AMD) is the leading cause of vision loss in adults. Its effect may be permanent and irreversible. Dr. Mulqueeny strongly recommends the QuantifEye® macular pigment optical density (MPOD) measurement to determine the density of the pigment in your macula. This information will allow him to assess your risk of AMD in the future. This measurement is not covered by insurance, the cost to you is $20.00 and there is a discount if you choose to pay out of pocket for the Optomap® as well.

AMD Risk Factors (please check all that apply)

___ Age (over 50)

___ Low macular pigment

___ Cardiovascular disease

___ Caucasian

___ Overweight

___ Discomfort due to glare, night or day

___ Family history of macular degeneration

___ Smoker (current or prior)

___ Light colored eyes

___ Female

___ Night driving difficulty

___Sensitivity to bright lights

___ Difficulty seeing objects against their background (contrast sensitivity)

I understand the above and choose to:

_____ **Accept test**

_____ **Decline test** **Patient Signature** _____ **Date** _____