GADDY EYE CLINIC PATIENT INFORMATION SHEET

Last Name: _____ Marital Status: _____

First Name: _____ Employer: _____

Middle Initial: _____ Suffix: _____ Sex: _____ Email: _____

Phone: _____ Work Phone: _____

Soc. Sec. # _____ Race: _____ Language: _____

Date of Birth: _____ Age: _____ Ethnicity: (please circle) Hispanic / Non-Hispanic

Street Address: _____

City, State, Zip: _____

INSURANCE INFORMATION:

Primary Insurance: _____

Policy Holder's Name: _____

Policy Number: _____

Policy Holder's SSN#: _____ Policy Holder's DOB: _____

Policy Holder's Employer: _____

Secondary Insurance: _____

Policy Holder's Name: _____

Policy Number: _____

Policy Holder's SSN#: _____ Policy Holder's DOB: _____

Policy Holder's Employer: _____

In Case of Emergency: _____ Phone: _____

SIGNATURE ON FILE:

I authorize payment benefits to be made payable to Dr. Gene Gaddy. My authorization is hereby given to Dr. Gene Gaddy to submit any claims to my insurance carrier in my behalf. I understand that I am responsible for **deductible amount and the percent that my insurance does not cover.**

_____ _____

Policy Holder/Patient **Date**

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Social Security: _____ **Date of Birth:** _____

SECTION B: TO THE PATIENT: PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of consent: By signing this form, you will consent to our use of disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of privacy practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, healthcare operations, and of the uses and disclosures we may make of your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our policy practices as described in our Notice of Privacy Practices. If we change our primary practices, we will issue a revised Notice of Privacy Practices, which will contact the changes. Those changes may apply to any of your Protected Health Information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person:	Privacy Officer
Telephone:	(228) 539-7762
Address:	Gaddy Eye Clinic Gene Gaddy III, M.D. 10051 Lorraine Road, Suite A. Gulfport, MS 39503

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE:

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use of disclosure of my Protected Health Information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

_____

Personal Representative's Name Relationship to Patient

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Gaddy Eye Clinic

Financial Policy

Effective immediately:

Payment is expected in full for services rendered at the time of your visit should you not have any insurance coverage at all. Those with insurance any and all co-pays and co-insurance amounts are due at the time of service.

As a courtesy Gaddy Eye Clinic will be happy to file your ophthalmology visit with your insurance company(s) to assist you in lower up front out of pocket expenses. However it is YOUR responsibility to provide the accurate up to date information at each visit. Gaddy Eye Clinic will not refile any claim(s) after a denial due to inaccurate information or patient error.

Gaddy Eye Clinic will also only carry an account balance without payment from patient or insurance for 90 days from the date of service before it will be placed for outside collection if patient has not made valid arrangements with our office. Gaddy Eye Clinic will be happy to provide a receipt for you to work with your insurance company to obtain reimbursement should you choose once account is paid in full.

Surgery that is scheduled with Dr. Gaddy at Gulf South Surgery Center is billed by both parties separately so you will receive two separate billing notices. It is our policy and intention to discuss your share if any is due before your scheduled surgery if at all possible. Your cost share is expected in full in our office before your surgery for Dr. Gaddy's fees. Should we not collect or expect anything due by you before and a balance remains after insurance payment is received it is your responsibility to pay such balance within 30 days or make arrangements with our billing department.

Vision Optique requires all glasses paid in full before glasses are picked up, however as a courtesy we will allow payment to be broken down into payments of no less than half at the time order is placed and the remaining balance at time of pick up. Glasses will not be held more than 30 days without payment.

By signing below you understand our office policy and agree to such terms.

_____ _____

Patient or Guardian **Date**

This written notice posted in the office will serve as notice to policy change

1-2020

REFRACTION:

Refraction - Is a ***NONCOVERED*** Service by most insurance policies.

The Refraction; is a ***MANDATORY*** test Dr. Gaddy requires each patient to have at least once a year during your annual exam. This is a valuable test in which allows him to properly diagnose, treat and determine any changes that have occurred since last exam.

A Refraction is the determination of an eye's refractive error and the best corrective lenses to be prescribed; series of test lenses in graded powers are presented to determine which provide sharpest, clearest vision.

Eyeglass prescriptions as well as contact lens prescriptions are only good for one year. Should you need a new pair of glasses or your vision has changed you will need to have a current prescription on file. The only way to receive a prescription is by having a Refraction.

The charge for a Refraction in our office is $30.00, paid by you prior to the service rendered.

In the event you desire to be fitted with contact lenses there will be additional fees. The charge for an initial contact lens fitting is $75.00 and a follow up and/or annual refitting is $35.00 which is generally ***NOT*** a covered benefit under insurance.

The total charge will be determined by the type of contact lens used. Most spherical (nonastigmatism) lenses can be fitted with only one follow up visit. Bifocal and Toric (astigmatism) contact lenses can take several follow up visits to complete the fit.

By signing below it means that you understand your insurance coverage and financial obligation.

_____ _____

Patient Signature **Date**

1-2020

Name: _____

D.O.B: _____

HISTORY INTAKE FORM

****CIRCLE ALL THAT APPLY ABOUT YOU****

PAST MEDICAL HISTORY:

Anxiety
Arthritis
Asthma
A-Fibrillator
BPH (enlarged prostate)
Bone Marrow Transplant
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
If yes, AIC _____ Sugar _____
Who is your primary physician treating your diabetes?
_____
End Stage Renal Disease
GERD / REFLUX

Hearing Loss
Hepatitis
High Blood Pressure
If yes, last blood pressure reading _____/_____
HIV/AIDS
High Cholesterol
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
NONE
Other – Please list

_____

PAST SURGICAL HISTORY:

Appendix Removed
Bladder Removed
Breast: Biopsy, Lumpectomy, Mastectomy
Colon: Cancer, Diverticulitis, Colostomy
Gallbladder Removed
Heart: Valve replacement/Coronary Artery Bypass
Heart: PTCA (coronary angioplasty)
Heart: Transplant
Joint Replacement, **Knee** – Right / Left
Joint Replacement, **Hip** – Right / Left
Kidney: Biopsy, Stone Remove, Transplant

Liver: Shunt, Transplant, Hepatectomy
Ovaries: Endometriosis, Cancer, Cyst, Tubal
Pancreas: Pancreatectomy
Prostate: Biopsy, Cancer, TURP
Rectum: APR, Resection
Skin: Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Hyperthyroidism
Spleen Removed
Testicular Surgery
Hysterectomy: Fibroids, Cancer
C- Section
Valve Replacement
NONE
OTHER- Please list any other surgery within the last year

_____

_____

PHARMACY: (location)_____ _____

Date updated

Who is your primary care provider? _____

Do you consent Gaddy Eye Clinic to import your current prescribed medications from your primary care physician into your medical chart from your pharmacy? If you consent, there is no need to complete the list of meds, as we will import them from your pharmacy directly into your chart. YES/NO

MEDICATIONS: PLEASE LIST BELOW WITH milligrams, INCLUDE EYE DROPS

(You can provide us with list of your medications)

_____ _____

_____ _____

_____ _____

_____ _____

ALERTS:

Do you have or have you ever had one of the following?

____ Blood Thinners ____ Artificial Heart Valve ____ Defibrillator

____ Pacemaker ____ MRSA

ALLERGIES: (circle all that apply)

NKDA (No Known Drug Allergies)

	REACTION	SEVERITY
Sulfa	_____	MILD – MODERATE- SEVERE
Codeine	_____	MILD – MODERATE- SEVERE
Penicillin	_____	MILD – MODERATE- SEVERE
Adhesive	_____	MILD – MODERATE- SEVERE
Lidocaine	_____	MILD – MODERATE- SEVERE
OTHER:	_____	MILD – MODERATE- SEVERE
	_____	MILD – MODERATE- SEVERE
	_____	MILD – MODERATE- SEVERE

SOCIAL HISTORY:

Cigarette Smoking:

Never smoked
Former Smoker
Current Smoker

Alcohol Use:

None
Social (less than 1 a day)
1-2 Drinks a day
3 or more Drinks a day

FAMILY HISTORY: **PARENTS, GRANDPARENTS, SIBLINGS, AUNTS, UNCLES**

Glaucoma _____
Macular degeneration _____
Retinal detachment_____
Diabetes _____
Stroke _____
Heart disease _____
Cancer _____
Thyroid _____
Arthritis _____
Other: _____

REVIEW OF SYSTEMS:

****CIRCLE ALL THAT APPLY****
IF YOU HAVE ANY OF THESE SYMPTOMS OR CONDITIONS AT THIS TIME
-----**some may be the same as medical history**-----

EYES: Change in vision, Pain, Tearing, Redness, Jaw Pain, Scalp Tenderness, Sudden vision loss

ENDOCRINE: Diabetes, Thyroid

RESPIRATORY: Shortness of breath, Congestion, Wheezing

CARDIOVASCULAR: High Blood Pressure, Cough, Rapid Heart Beat

CONSTITUTIONAL: Sudden Weight Loss, Fever, Chills

NEUROLOGICAL: Headaches, Seizure, Stroke, Paralysis

MUSCULOSKELETAL: Arthritis, Joint Pain, Stiffness

PSYCHIATRIC: Anxiety, Depression, Insomnia

ENT/ MOUTH: Stuffy nose, Earache, Dry mouth

GASTROINTESTINAL: Upset stomach, Diarrhea, Constipation

GENITOURINARY: Burning Urination, Urinary Frequency, Incontinence

INTEGUMENTARY: Rash, Changing Moles

HEMATOLOGIC: Anemia, Bleeding

IMMUNOLOGIC: Hay fever, Hives

OCULAR HISTORY:

Allergic Conjunctivitis
Amblyopic (Lazy Eye)
Blepharitis
Cataract – Right/ Left
Contact Lens
Corneal Dystrophy – Right/ Left
Diabetic Retinopathy (background) Right/ Left
Diabetic Retinopathy (proliferative) Right/ Left
Dry Eyes
Glasses
Glaucoma -- Right/ Left
Macular Degeneration – Right/ Left
Macular ERM – Right/ Left
Narrow Angles – Right/ Left
Ocular Hypertension—Right/ Left
Ocular Migraine
Foreign Body Removal
Retinal Tear – Right/ Left
Strabismus
PVD –Right/ Left
Vitreous Floaters – Right/ Left

NONE:
Other:

_____

_____

OCULAR SURGERY:

Blepharoplasty – Right/ Left
Cataract Surgery – Right/ Left
Corneal Transplant – Right /Left
DSAEK – Right/ Left
Eye Muscle Surgery
Intravitreal Injections – Right/ Left
LASIK – Right/ Left
LPI—Right/ Left
LTP – Right / Left
PRK – Right/ Left
Ptosis Repair – Right/ Left
Punctal Plugs – Right/ Left
Strabismus Surgery
Retinal Laser – Right / Left
Trabeculectomy – Right/ Left
Tube Shunt – Right/ Left
YAG Capsulotomy – Right/ Left

NONE:
Other:

_____

_____