MONTGOMERY LASIK & EYE CARE CENTER

Patient Policy

PATIENT NAME: ______________________________ D.O.B.: _______________

PLEASE READ & INITIAL AFTER EACH

(1) All Doctor's services are charged to the patient. **Both medical and vision insurance information must be presented in order to file insurance claims.** The patient is responsible for prior authorizations or other requirements regarding any insurance coverage. There may be services, such as a refraction, which are not covered by insurance. Insurance eligibility is NOT a guarantee of payment.

INT______

(2) **ALL payments are due at the time services are rendered. If the doctor should discover any medical issues, it would fall under medical insurance and the patient is responsible for that co-pay.** I, the undersigned, accept the fee charged for medical services rendered and/or products sold, as a legal and lawful debt and agree to pay said fees, including any/all collection agency fees, (33.33%), (33.33%), attorney fees and/or court costs, if necessary. I waive now and forever my right of exemption under the laws of the Constitution of the State of Alabama and any other state. You agree, in order for us to service your account or to collect monies you may owe, Montgomery LASIK & Eye Care Center and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We and/or our agents may also contact you by sending text messages or emails, using any email address you have provided to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

INT______

(3) Effective August 1, 2023 any patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24 hours' notice will be considered a No Show, after 1 No Show the patient(s) will be charged a $50.00 fee. The fee is charged to the patient, not the insurance, and is due when received or at the time of the patient's next appointment. As a courtesy, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.

INT______

(4) Outside and Online glasses: If you need your pupillary distance measurement, you will be charged a fee of $50.00. This comes as a package including the verification of your prescription, adjustments, repairs, and cleanings. If you have issues with the glasses, we will also be happy to troubleshoot any issues.

INT______

____

Signature (Patient or Parent/Guardian if a minor) DATE

MONTGOMERY LASIK & EYE CARE CENTER

HIPAA ACKNOWLEDGEMENT

PATIENT NAME: ______________________________ D.O.B.: ____________

PRIMARY TELEPHONE: ______________________________

EMAIL: ______________________________

I acknowledge that I have received, read, and understand the HIPAA privacy policies of Montgomery Lasik & Eye Care Center. I understand that the physicians and staff of Montgomery Lasik & Eye Care Center will not discuss my health information to anyone other than what is allowed by the HIPAA privacy policies unless I have authorized them to do so. **I HEREBY CONSENT THAT MEDICAL INFORMATION AND TEST RESULTS CAN BE DISCUSSED WITH THE FOLLOWING PERSONS:**

______________________ ( ) ______________________

Name Phone Number Date

______________________ ( ) ______________________

Name Phone Number Date

____

Signature (Patient or Parent/Guardian if a minor) Date

MONTGOMERY LASIK & EYE CARE CENTER

Personal Information ☐ Male ☐ Female

Last Name *First Name* *MI* ☐ Single ☐ Married ☐ Divorced ☐ Widow

Street Address *City* *State* *Zip*

(____) *Home Phone* (____) *Cell Phone* _____ \ _____ \ _____ *Date of Birth* _____ - _____ - _____ *Social Security Number*

Employer/Name of School (if student) *Occupation* (____) *Work Phone*

E-mail Address *Spouse or Parent(s) Name* *DOB*

Person Responsible for Account *Social Security # of Person Responsible for Account*

Address of Person Responsible for Account (____) *Telephone #*

Emergency Contact (____) *Emergency Phone*

How were you referred to our office? Phone Book Radio Insurance listing LED Sign (outside) Patient Other________

Doctor________________ Address________________________________

Insurance Information

*Name of **Primary** Medical Insurance Company* *Address* (____) *Telephone #*

Insured's Last Name *Insured's First Name* *MI* *Insured's Date of Birth*

Insured's Identification Number *Group Number*

Patient Relationship to Insured
Self Spouse Child Other

*Name of **Secondary*** Medical *Insurance Company* *Address* (____) *Telephone #*

Insured's First Name *MI* *Insured's Last Name* *Insured's Date of Birth*

Insured's Identification Number *Group Number*

Patient Relationship to Insured
Self Spouse Child Other

Vision Insurance Company Name Insured's Social Security #

Signature (Patient or Parent/Guardian if minor) Date

PATIENT HEALTH HISTORY QUESTIONNAIRE
Please answer all questions.

NAME: ____________________ Today's Date: ______________
AGE: ____________________ DATE OF BIRTH: ______________

MEDICAL INFORMATION

Do you have problems with any of these systems? (Please **circle yes or no.**)

		Pregnant/Nursing	Yes/No
DIABETES	Yes / No	GASTROINTESTINAL	Yes / No
HIGH BLOOD PRESSURE	Yes / No	EARS/NOSE/THROAT	Yes / No
HEART DISEASE	Yes / No	CARDIOVASCULAR	Yes / No
ARTHRITIS	Yes / No	RESPIRTORY	Yes / No
CANCER	Yes / No	GENITOURINARY	Yes / No
DERMATOLOGIC	Yes / No	KIDNEY STONES	Yes / No
STEROID USE	Yes / No	BLOOD/LYMPH	Yes / No
HEADACHES	Yes / No	OTHER ILLNESS	Yes / No

Allergies to Medications: Yes / No Please List: ______________________________
____

Current medications please List: ______________________________
____

Eye Medications: ______________________________

Do you use Alcohol? Yes / No How much in one week? ______________
Do you use Tobacco? Yes / No How much in one week? ______________

FAMILY HISTORY

High blood pressure	Yes / No	Relation ______________
Diabetes	Yes / No	Relation ______________
Macular degeneration	Yes / No	Relation ______________
Glaucoma	Yes / No	Relation ______________
Retinal detachment	Yes / No	Relation ______________
Cataracts	Yes / No	Relation ______________
Blindness	Yes / No	Relation ______________
Other	Yes / No	Relation ______________

PERSONAL EYE HISTORY

Have you had any eye injury? Yes / No What Kind? ______________ Date ________
Have you had any eye operations? Yes/No What Kind? ______________ Date ________

(Please circle.)

Do you have Glaucoma? Cataracts? Retinal detachment? Macular degeneration?
Dry Eyes? Blurred Vision? Lazy Eye/Crossed Eye
Do you wear glasses? Yes/No Do you wear Contacts? Yes/No

UPDATED ______________
UPDATED ______________