Ratchford Eye Center

Excellence in Eyecare

Mary Gina Ratchford, M.D.
Daniel W. Chin, M.D.
Brett W. Kjellen, O.D.

Name ______________________________ D.O.B. __________ Sex ______
Last First Middle Initial

Address ____________________ City ______________ State ______ Zip ______

Phone ( ) __________ Bus. Phone ( ) __________ E-mail ______________

Soc. Security # ______________ Employer ______________________

Address ____________________ City ______________ State ______ Zip ______

Occupation ____________________ Employed Since ______________

INSURANCE INFORMATION

Primary Insurance Co. ______________ Policy Holder __________ D.O.B. __________

Primary Holder's SS # or ID # __________ Group # __________ Employer __________

Secondary Insurance Co. ______________ Policy Holder __________ D.O.B. __________

Policy Holder's SS # or ID # __________ Group # __________ Employer __________

EMERGENCY CONTACT INFORMATION

Name ____

Relationship__________ Home Phone ( ) __________ Work Phone ( ) __________

Address ____________________ City ______________ State ______ Zip ______

REFERRAL INFORMATION

Name of Referring Party ______________________ Phone ( ) __________

Name of Primary Care Physician______________________ Phone ( ) __________

FINANCIALLY RESPONSIBLE PARTY – *Must be completed if patient under 18 or a student.*

Name ______________ Relationship ______________ Birth Date __________

Address ____________________ City ______________ State ______ Zip ______

Phone ( ) __________ Bus. Phone ( ) __________ Soc. Security # __________

AUTHORIZATION AND RELEASE: I hereby authorize payment directly to the doctor of any medical benefits otherwise payable to me. I understand I am financially responsible to him for charges not covered by this assignment. I authorize him to release any information requested to support my claim including any information which constitutes a psychiatric communication and/or relates to treatment of alcohol and drug abuse. If any disclosed information contains AIDS/HIV information, state law prohibits further disclosure without specific written consent.

FINANCIAL RESPONSIBILITY
This information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered including reasonable attorney's fees and costs of collection in the event of default.

SELF-REFERRAL ACKNOWLEDGMENT
I understand that if at any time my insurance plan may not cover my services and I agree to pay all charges.

______________________________ Signature ______________ Date

1.	SKIN	Itching or rashes, eczema, psoriasis, rosacea, other skin conditions	YES NO
2.	PSYCHIATRIC	Confusion, disorientation, hallucinations, other psychiatric disorder	YES NO
3.	MUSCULO-SKELETAL	Arthritis, weakness or numbness of arms or legs	YES NO
4.	GASTROINTESTINAL	Loss of appetite, nausea, vomiting, constipation, diarrhea, stomach/intestinal disorders	YES NO
5.	ENDOCRINE	Excessive thirst, Diabetes, thyroid disorder, heat or cold intolerance	YES NO
6.	RESPIRATORY	Shortness of breath, wheezing, coughing, COPD, Asthma, other lung disorders	YES NO
7.	CARDIOVASCULAR	High blood pressure, palpitations, swelling of ankles, history of heart attack, stroke, pacemaker	YES NO
8.	GENITO-URINARY	Problems urinating, pain, discharge or bleeding, other urinary disorder	YES NO
9.	NEUROLOGICAL	Numbness, tingling, paralysis, other neurologic disorder	YES NO
10.	HEMATO/LYMPH	Swollen glands, anemia, bleeding tendencies, any blood disorder	YES NO

Have **YOU** ever had – MRSA, Cancer, AIDS, HIV, Hepatitis, ears/nose/throat problems, mouth sores, difficulty swallowing, recent fever, recent weight gain/loss, IV drug use, allergy to Latex, recent hospitalizations.

If any answer is yes give details here____

____

Do you smoke? ____Packs per day?______ When did you quit? ______ Drink? _____ Daily? _____ Amt? _____Socially?___________

LIST ALL CURRENT MEDICATIONS:____

____

Any allergies to medications?____

____

EYE HISTORY: Do you have Cataracts______ Glaucoma ______ Macular Degeneration ________

Have you ever had eye surgery _____ Laser eye surgery _____ eye injury ______ "lazy eye" _____ temporary loss of vision _______

Details:____

How much reading do you do daily? ______Are you having difficulty reading? _____ What is your occupation? _______________Do you use a computer daily? ____How many hours per day? ____ Are you having difficulty driving?_____ Is driving more difficult at night?____ Do you participate in any hobbies or sports?____

Which range of vision do you use most often? Near (reading) ____ Intermediate (computer) ____ Distance (driving) ____

Do you have **FAMILY** history of Diabetes____Glaucoma____ Macular Degeneration ____ High Blood Pressure_____Retinal Detachment _____ Rheumatoid Arthritis _____ Cancer _____

PURPOSE OF YOUR VISIT TODAY____

REFRACTION SERVICE AND FEE: A refraction is the process of determining if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye exam and **necessary to write a prescription for glasses/lenses. Many insurance plans, including Medicare, do NOT cover refractions or routine eye exams.** Refraction is typically done every year or two. Our fee for a refraction is **$40.00.** Would you like a refraction knowing that this may be a **NON**-covered service with your insurance plan?.........
YES **NO**

Patient Name:________________________________Signature:________________________________Date:______

If patient is a minor - Parent/Guardian signature: ________________________________Date:________________

Date Reviewed/Updated: ___/___/___ Comments: ____

____

__________________ __________Tech init______ M.D. sign________________________________

Date Reviewed/Updated: ___/___/___ Comments: ____

____

__________________ __________Tech init______ M.D. sign________________________________

PATIENT HIPAA AWARENESS

With my permission, Ratchford Eye Center may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Ratchford Eye Center Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Ratchford Eye Center reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of Ratchford Eye Center may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my permission, the office of Ratchford Eye Center may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and or Confidential.

With my permission, the office of Ratchford Eye Center may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Ratchford Eye Center restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing Ratchford Eye Center to use and disclosure my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

____
Signature of Patient or Legal Guardian

____ ____________________
Print Name of Patient or Legal Guardian Date