PATIENT REGISTRATION INFORMATION CHART#___________

Is this condition a result of an accident or injury? Y or N Date and description ______________________________

PATIENT PERSONAL INFORMATION

Name____ Date of Birth ___/___/_____

Permanent Address______________________City__________________State_____ Zip__________

Temporary Address______________________City__________________State_____Zip__________

Telephone # ( ) ______________ Cell # ( )________________ email______________________________

SS # _____-_____-______ Marital Status __Single __ Married __Divorced __Widowed

Do you have a living will? Yes or No

Patient Employer______________________________________Phone____________________

Referred by________________________ Other Physicians who care for you____________________

Which Pharmacy do you use?____

PATIENT/ RESPONSIBLE PARTY

Responsible Party____________________________(please do not list insurance) DOB ___/___/___

Relationship to Patient __Self __ Spouse __Other Please list how related__________________ SS# ____-____-_____

Address__________________________________ City__________________ State_____Zip__________

Telephone # ( )____________ Cell # ( )____________

Employer______________________________ Work # ( )______________ Occupation_____________

PATIENT/ RESPONSIBLE PARTY

Emergency Contact__________________________________Relationship:______________________

Address__________________________________City__________________ State______ Zip__________

Telephone # ( )______________ Cell # ( )_______________ Work # ( )______________________________

ASSIGNMENT OF BENEFITS/ FINANCIAL AGREEMENT

I certify that the information given by me in applying for payment under Title XVIII and Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf to Dr. Ganthier who accepts assignment.

I hereby assign to and authorize the doctor or its duly authorized agents and/or assign to take all necessary steps, without limitations to insure that any insurance benefits otherwise payable to me, or my estate, are paid directly to the doctor. This assignment of insurance benefits includes, but is not limited to, billing insurance filing petitions, filing suit, in my name or in behalf of the doctor filing proofs of claims and filing grievances and all other similar procedures, as may be amended from time to time with the applicable State Department of Insurance. I also agree to provide and sign any other documents that may be reasonably necessary to accomplish any of the above purposes.

I understand that I am financially and legally responsible for charges not covered in full by any third party. I further agree that should this account become delinquent and require collection efforts, I will pay costs of collection, including reasonable attorney's fees and cost, collection agency fees and costs, and interest which shall accrue at the maximum rate allowed by law.

I further agree that a photocopy of this agreement shall be valid as the original.

Date______________________ Signature____

PAYMENT IS EXPECTED AT TIME OF SERVICE – ARRANGEMENTS SHOULD BE MADE FOR EXCEPTIONS

HIGHLANDS EYE INSTITUTE, P.A.

R. GANTHIER, JR., M.D.

MEDICAL HISTORY CHECKLIST

(Please Print)

Please complete this medical history checklist.

Chart #:____________

Date:______________

Name:____Age:______________

Height:________ Weight:________ Sex: M or F Race:____________ Language Spoken:____________________

Drug Allergies:____

Circle the number(s) of the conditions that apply to you, whether you have them now or have had them in the past

1. Do you have any specific concerns about your vision?______________________________________
2. Diabetes?___________ Year diagnosed?________ How do you control it? (Please Circle)
   Insulin (______# of units) Medication Diet Exercise
3. Arthritis?___________ Collagen Disease?_______________ Skin Disorder?_____________________
4. Do you use aspirin? If yes, how often?_________________ Do you tend to bleed heavily when cut?________
5. Heart Attack?_________ When?_________________
6. Epilepsy/ Seizures?______ Prostrate/ Bladder Problems? ___________
7. Do you have a problem with anesthesia? ____ If yes, please explain:_________________________
8. Heart Disease or murmur?________ High Blood Pressure? _________
9. Have you ever had or do you have an infectious disease (such as shingles, etc.)?___________________
10. Hepatitis?______________ When?_________________ Type?____________________
11. Cancer? _____ Type?________________________ How/ when treated?____________________
12. Any nervous condition or taking any medication for same?___________________________________
13. Stroke or neurogenic disease? ______ When?___________ How affected?__________________
14. Respiratory disease (emphysema, COPD, asthma)?_______________________________________
15. Are you a smoker? ________, _____packs per day for _____years. Quit date:__________________
16. Tuberculosis? _____ Treated for it?__________ When?___________ For how long?______________
17. Do you wear contact lenses?___________ Do you have contact lenses in place now?______________
18. Do you have any other medical problems?______ Please explain:________________________________
19. Have you ever had surgery before? If so, what type and year, if known:

Type of Surgery	Any complications	Year

20. Have you received any blood transfusions?____________ When?_________________________________
21. Do you take any medications? ______ Please list below or provide a medication list.

Name of Medication	Dosage	Frequency	Injections

PLEASE BRING A LIST OF ALL OF YOUR MEDICATIONS EACH AND EVERY TIME YOU COME TO THE OFFICE!! THANK YOU.

HIGHLANDS EYE INSTITUTE
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 (HIPPA).

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 request was signed by: ______________________________ Date: __________

Printed Name – Patient or Representative

Witness: ______________________________ Date: __________

I authorize R. Ganthier, Jr., M.D. and medical staff to release my health care information to the following persons:

Spouse ______________________________

Family Member(s) ______________________________

Friend(s) ______________________________

Other ______________________________

Note: We will not release any information to anyone not listed above.

This information may be released to those listed above by:

❑ Phone
❑ Message on Answering Machine
❑ Fax
❑ Mail
❑ In Person
Other

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: __________ Initials: __________ Reason: ______________________________

FORM#C15

HIGHLANDS EYE INSTITUTE, PA
R. GANTHIER, JR., M.D.

FINANCIAL TERMS AND CONDITIONS

CO-PAYMENTS AND DEDUCTIBLES

Your insurance company requires that we collect your co-payment at the time of service. Patients with deductibles will be required to pay them at the time of service. Patients who are unable to make their co-payments or deductibles will not been seen and will need to reschedule their appointment.

MEDICAL RECORDS

Patients requesting copies of their medical records must sign a release form. The patient will be notified prior to records release of any charges for the records. **We require 72 hour notice** prior to the release of records.

NON-PARTICIPATING INSURANCE PLANS

We will file your claim with your insurance company as a courtesy to our patients. I understand that if I elect to be treated by Highlands Eye Institute, PA and they do not participate in my insurance plan I may incur higher costs in co-payments and deductibles.

MEDICARE AND MEDICARE SUPPLEMENTS

As a participating provider with Medicare Part B we are obligated to write off the difference between our usual and customary charge and what Medicare pays us for the services rendered to you (the allowed amount). Medicare pays 80% of the "allowed amount" to us directly. The remaining 20% coinsurance and your annual deductible are the patient's responsibility by federal law. We do file secondary insurance as a courtesy to our patients, however any balance after Medicare pays will become the patient responsibility if not covered or paid in a timely manner by your supplemental policy.

SURGERY PRE-PAYMENT

If surgical treatment is necessary you will be notified by our office the amount of your financial responsibility for Dr. Ganthier's services. Patients are required to pay their portion of surgical fees two (2) days prior to surgery unless other payment arrangements have been made with our billing department. If the patient is unable to meet their financial responsibility we will reschedule their surgery.

I, ____, have read, understand, and agree to the Terms and Conditions set forth above by Highlands Eye Institute, PA.

____   ______________________________

Signature   Date