Clarity
EYE CARE & SURGERY

New Patient Information

Date_____

Name (Last, First, Initial):_____ Age: _____

Address: _____Email:_____

City: _____ State: _____ Zip: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____ Message Phone: _____

Patient Status: ☐ Married ☐ Single ☐ Other
☐ Separated ☐ Divorced ☐ Widowed

Birthdate: _____ Sex: _____ Social Security#: _____

Emergency Contact: _____ Phone: _____

Referred by:_____ Primary Care Doctor: _____

Primary Insurance: _____ Policy No: _____

Secondary Insurance: _____ Policy No: _____

Employment Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Student

Employer's Name: _____ Phone: _____

Please list the name and cross streets of your pharmacy:_____

Refraction Fee:
A refraction is the test done to determine your eyeglass prescription***. Most medical insurance plans, including Medicare do not cover this service.*** The refraction is not a medical service, it is a routine service.

We will be happy to perform the refraction on any patient requesting the service; however, there will be a **$30.00 charge** that you the patient will be responsible for.

The choice to have the refraction done is yours. If you feel you are not seeing as well as you used to, if things seem blurry or if you want to update your lenses or frames it is advised that you choose to have the refraction performed.

If you decide against having the refraction done, your decision will in no way affect the medical portion of your exam.

Please select one of the options below and initial next to your choice: Please Initial

☐ Yes, I would like to have a refraction done today. _____
☐ No, I do not want the refraction done today. _____
☐ I am unable to have the refraction done today, but would like to have it done at my next visit. _____

Receipt of Notice of Privacy Practices Acknowledgment
I acknowledge that I have received the Notice of Privacy Practices from Kristin Carter, M.D., which sets forth the ways in which my personal health information may be used or disclosed by Kristin Carter, M.D., and outlines my rights with respect to such information.

Patient's Signature: _____ Date: _____

I will be assessed a $25.00 charge if I fail to show for my appointment or do not give 24 hour notice prior to cancelling my appointment.

Assignment of benefits, financial responsibility, and release of information:
I hereby assign my insurance benefits to be paid directly to Kristin Carter, M.D. I am financially responsible for non-covered services. I understand and agree that if I do not pay my account in a timely fashion and collection steps become necessary, I will be responsible for all collection costs including, but not limited to, attorney fees and court costs. I also authorize the office of Kristin Carter, M.D. to release any information required to process this claim.

Patient's Signature: _____ Date: _____

New Patient Health History Questionnaire

Patient's Name_____ Date of Birth _____ Family Physician_____

Reason for your visit: _____

List all prior **EYE** surgeries:

Type of **Eye** Surgery	Date	Surgeon	Which Eye

List all **OTHER** surgeries:

Type of Surgery	Date

Please **circle** any of the following medical or eye conditions listed below that **you** have been diagnosed with:

Glaucoma	Macular Degeneration	Stroke	High Cholesterol	COPD	HIV/Aids
Cataracts	High Blood Pressure	Diabetes	Thyroid Disease	Asthma	Emphysema
Arthritis	Heart Attack/Disease	Eye Trauma	Cancer / What type?_____		

Other_____

Please list:

Eye Medications	Dose	Frequency

Other Medications	Dose	Frequency

Please list **ALL** allergies to medications:

_____ _____ _____ _____

_____ _____ _____ _____

Have you or a family member ever had an allergic reaction to general anesthesia? YES ◯ NO ◯

Family History

Please **circle** any of the following eye conditions your **family members** have had, and state which family member.

Glaucoma_____ Macular Degeneration_____ Corneal Disease_____

Retinal Detachment_____ Other_____

Social History

Have you ever smoked? Yes ◯ No ◯ Do you still smoke? Yes ◯ No ◯ If so, how much and for how long?_____

Do you drink alcohol? Yes ◯ No ◯ If so, how much, how often and for how long?_____

Do you or have you used recreational drugs? : Yes ◯ No ◯

Occupation_____ Retired Unemployed Marital status: (circle one) Single Married Divorced Widowed Other

Do you live: (circle one) Alone With spouse Other_____

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STANDARD AUTHORIZATION OF USE & DISCLOSURE PHI

Information to be Used or Disclosed
The information covered by this authorization includes: Personal Medical Information

Purpose of the Disclosure: Leave messages on patient's voicemail or give information to approved person(s).

Will this information be used for marketing? Yes____ No__X__

Has this information been previously de-identified? Yes____ No__X__

Persons Authorized to Use or Disclose the Above Information: Clarity Eye Care and Surgery
(Name of person or organization)

Persons and Phone Numbers to Whom Information May Be Disclosed:_____

_____

My Personal Phone Numbers Where Voicemail May Be Left:_____

_____

Expiration Date of Authorization
This authorization is effective through (check one) ☐ _____/_____/_____ or ☐ NO Expiration, unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to our office. You should contact the HIPAA Compliance Officer to terminate this authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be re-disclosed by the person or organization to which it is sent. The privacy of this information may not be protected under the Federal Privacy Rule depending on whom the information is disclosed to.

Our practice will not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization.

_____
Name of patient (Type/Print)

_____
Signature of Patient Date

_____
Signature of Patient Representative (if applicable)

_____
Relationship of Patient Representative to Patient (if applicable)