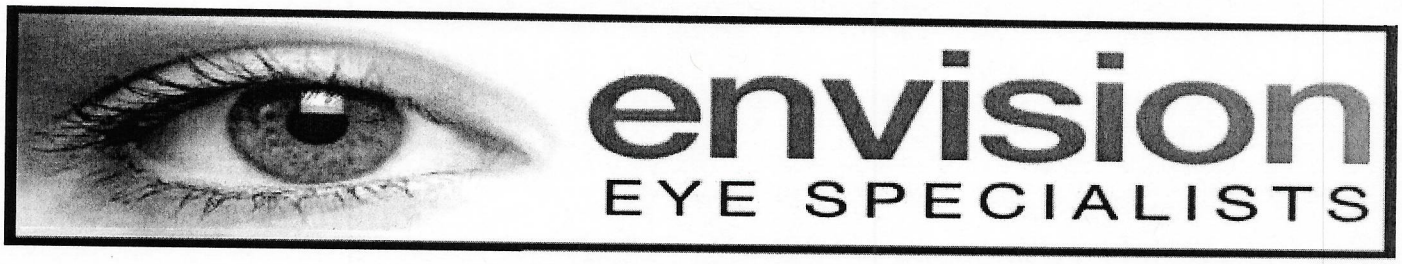


Envision Eye Specialists Patient Information

Patient Name:_____Date_____

Address:_____

City:_____State:_____Zip Code:_____

Home Phone ( )-_____Work/Cell Phone( )-_____

Sex: [ ]Male [ ]Female Marital Status: [ ]Single [ ]Married [ ]Divorced [ ]Widowed

Social Security#:_____Date of Birth: _____

Patient Occupation: _____

Family Doctor:_____ Phone ( )_____

Emergency/Secondary Contact

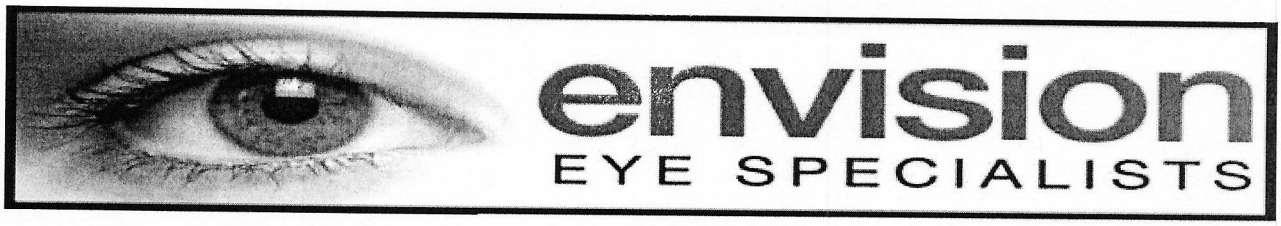
Spouse's/Partner's:_____ Phone ( )-_____

Closest Relative/Friend:_____Phone ( )-_____

How did you hear about our Practice? Doctor/Friend/Family/Insurance/Other: _____

Payment from insurance company requires the collective effort of the patient and the Doctor; Envision Eye Specialists will bill and collect payment from participating insurance companies. Any unpaid balance after insurance becomes the responsibility of the patient. If a referral for a visit is required; the patient should contact their primary care physician for necessary paperwork prior to the exam. Patients who do not obtain prior approval will be responsible for all balances if the Insurance Company denies the visit. I authorize the release of any medical information necessary to process and collect all claims; to coordinate care and I provide medical information to other Doctors.

Patient or Guarantor's Signature **Date**



LIFETIME AUTHORIZATION

NAME OF PATIENT:.....

(Please Print)

I request that payment of authorized Medicare, Medicaid, or private insurance benefits to be made to Joseph Ross, M.D., FACS, for any service furnished.

I authorize any holder of medical or other Information pertaining to the patient to hereby release to the Health Care Financing Administration and its agents; to CHAMPUS and Its agents; or to any private Insurance company all information required in determining their benefits or in determining their benefits for related services.

PATIENT'S SIGNATURE: _____

I am responsible for all financial obligations of health services for the above named patient, and for reimbursement and payment of claims from the patient's Insurance company. If, for any reason the account should become delinquent, I agree to pay for all rebilling charges, Interest charges, collection costs, and reasonable legal fees.

I agree and consent to the Practice releasing information to me in the following alternative manners:
(Please initial the appropriate selection below)

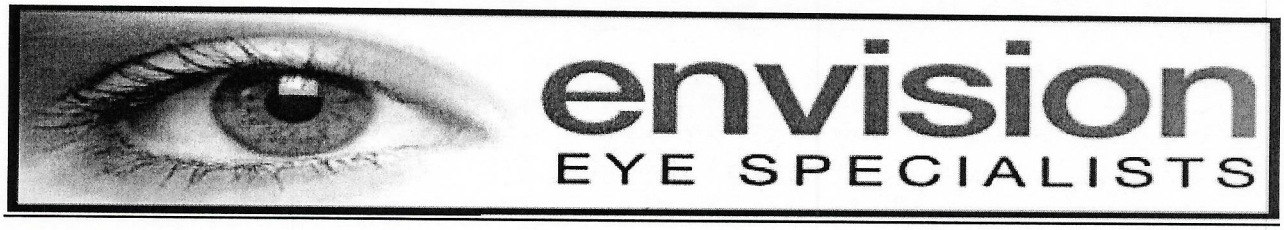
___ Via Email to Patients designated email address:_____

_____Via regular mail, with any envelope marked "Personal and Confidential" and addressed to me.

___ Via telephone, if I contact the practice and provide appropriate information i.e., name, social security number and account number.

SIGNATURE OF RESPONSIBLE PARTY:_____

RELATIONSHIP TO PATIENT: _____



AUTHORIZATION TO RELEASE OR USE INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS.

I hereby authorize the release of my individually identifiable health information (PROTECTED HEALTH INFORMATION) and medical record information by Envision Eye Specialists in order to carry out treatment, payment, or healthcare operations. You should review the Notice of Privacy Practices for a more complete description of the potential release and use of such information. You have the right to review such Notice prior to signing this consent form.

We reserve the right to change the terms of our Notice of Privacy Practices at any time. If we do make changes to terms of the Notice of Privacy Practice, you may obtain a copy of the revised Notice.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or healthcare operations. Our Practice is not required to agee to such requested restriction(s), however, if we do agree to your requested restriction(s), such restrictions are then binding on the practice.

I acknowledge and agree the Envision Eye Specialists may disclose my protected health information and medical record information to the following individuals who are either my family member, legal representatives, guardians, healthcare surrogates, or those who have power of attorney on my behalf:

Name of Authorized Representative(s):_____

_____

I agree and consent to the Practice releasing information to me in the following alternative manners:
(Please initial the appropriate selections below.

_____ Via e-mail to Patient's designated e-mail address:_____

_____ Via regular mail, with any envelope being marked "Personal and Confidential" and addressed to me.

_____ Via telephone, if I contact the Practice and provide appropriate information i.e., name, Social security number and account number.

At all time I retain the right to revoke this consent. Such revocations must be submitted to the Practice in writing. The revocation shall be effective except to the extent that the Practice has already taken action based on prior consent.

The Practice may refuse to treat you if you (or an authorized representative) do not sign this Consent Form. If you (or your authorized representative) sign this Consent, and then revoke it, the Practice has the right to refuse to provide further treatment to you as of the time of revocation (except to the extent of Practice is required by law to treat individuals).

Please initial each comment below:

_____ I HAVE READ AND UNDERSTANDTHE INFORMATION IN THE CONSENT.
_____ I HAVE RECEIVED A COPY OF THIS CONSENT.
_____ I AM THE PATIENT OR THE AUTHORIZ PARTY TO ACT ON BEHALF OF THE PATIENT TO SIGNT THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE TERMS.

_____ _____

Signature of Patient or Authorized Representative Date

MEDICAL HISTORY

NAME _____ DATE _____

DOB _____ AGE _____ HEIGHT _____ WEIGHT _____ M F

PLEASE INDICATE BY A CHECK [√] YOUR ANSWER TO EACH QUESTION. **COMPLETE ALLERGY VERIFICATION / MED. FORM.**

	Y	N	PHYSICIAN
Any Heart Disease			
Specify: Bypass - Stent(s) Valve - Atrial Fibrillation			
Do you have a pacemaker or automatic defibrillator?			
High Blood Pressure			
Bleeding Disorder			
Respiratory / Lung Disease			
Specify: COPD - Asthma Emphysema - Cancer			
Do you use oxygen? _____Liters/min.			
Diabetes: Insulin Oral Meds			
Hypoglycemia (Low Blood Sugar)			
Parkinson's Disease Other Neurological Disease			
GI Disease: GERD REFLUX			
Liver Disease			
Specify: Jaundice - Cancer Cirrhosis			
Kidney Disease			
Thyroid Condition			
Muscle Disease			
Hiatal Hernia			
Claustrophobia			
Any unusual reaction to anesthesia			
Specify:			
Ocular / Head Trauma			
Hearing Problems – HOH Do you wear Hearing Aides?			

	Y	N	
Stroke or paralysis			
TIA (mini stroke)			
Seizures			
Motion sickness/ Nausea			
Arthritis			
Back pain			
Capable of laying flat			
Decreased Memory			
Dementia			
Alzheimer's POA / HC Surrogate			
Depression			
Anxiety			
Drink alcohol			Daily__ Occasionally__
Do you Smoke			Former Smoker? ___
Are you allergic to			**Reaction**
Sulfa drugs			
Eggs _____ Soy	_		
Betadine (Iodine)			
Shellfish			
Latex (Y-complete assessment)			
Have you ever had:			**When**
Tuberculosis			
MRSA (severe Staph. inf.) Hepatitis	_		
Sleep apnea: Use CPAP machine?			
Contact lenses?			
If in a wheel chair can You transfer unassisted?			

Past Eye Problems/Surgeries:

Previous Major Surgeries: List dates & procedures:

Significant Family History:

**Have you traveled outside US in past 30 days? N Y
If Yes, have you had fever or cough? Has anyone close to you traveled outside US in past 30 days? N Y

Occupation: ____Retired ____Work FT / PT

Living with: ____ Spouse, ____Family, ____Friend, ____Alone, ____ACLF, ____Nursing Home, ____Other

-------FOR OFFICE USE ONLY-------

Reviewed/verified w/patient: _____ Date:_____

Reviewed/updated w/patient: _____ Date:_____

ALLERGY / MEDICATION VERIFICATION RECORD	
ALLERGIES: Include Drugs, Food and Environmental	**Sensitivity / Reaction to allergy**
[ ] No Known Allergies	

MEDICATIONS: Include pills, liquids, drops, patches, vitamins, herbal medications *(Per Patient)*		
Medication	**Dose**	**Frequency**

* All medications, vitamins & supplements with their corresponding dosage and frequency should be recorded. This information is necessary regarding your anesthesia care.

A. Notifier: Envision Eye Specialists

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Insurance doesn't pay for **D. Item below** below, you may have to pay. Insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Insurance may not pay for the **D. Item below** below.

D. Refraction	E. Reason Insurance May Not Pay:	F. Estimated Cost
Refraction is the process of determining your best corrected vision and if there is a need for corrective lenses. It is an essential part of the eye exam and is necessary to write a prescription for glasses or contact lenses and to determine the power of an implant used in surgery.	Insurance considers a refraction a vision service and not a medical service. This will cause the claim to deny as not medically necessary.	$35.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D. Service** listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Insurance cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D. Service** listed above. You may ask to be paid now, but I also want Insurance billed for an official decision on payment, which is sent to me on a Explanation of Benefits (EOB). I understand that if Insurance doesn't pay, I am responsible for payment, but I can appeal to Insurance by following the directions on the EOB. If Insurance does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D. Service** listed above, but do not bill Insurance. You may ask to be paid now as I am responsible for payment. I cannot appeal if Insurance is not billed.

☐ **OPTION 3.** I don't want the **D. Service** listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Insurance would pay.

H. Additional Information:

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date: