THE OFFICE OF

WALLY EL-HITAMY, O.D.

CONFIDENTIAL PATIENT INFORMATION

Date _____/_____/_____

PLEASE PRINT

Dr. Mr. Mrs. Ms. Miss _____ Male Female

Address: _____ City/State:_____ Zip: _____

Home Phone: _____ Cell Phone/Pager:_____

Work Phone: _____ Email: _____

Age: _____ Date of Birth: _____/_____/_____ SS #:_____-_____-_____ Driver's License #:_____

Marital Status: _____ Education: _____

Employer: _____ Occupation: _____

Spouse's Name: _____ Occupation: _____

Cell Phone: _____ Work Phone: _____ Employer: _____

In Case of Emergency, Contact: _____ Phone: _____

Primary Care Physician: _____ Date of Last Visit: _____

Referred by: ☐ at&t Yellowpages ☐ Lakeway Directory ☐ Other Directory ☐ Insurance ☐ School ☐ Drive by

☐ Newspaper_____ ☐ Patient _____ ☐ Doctor _____

☐ Internet Search / Website _____

Please list hobbies_____

If patient is a child or adolescent, please complete the following:

Mother's Name: _____ Occupation: _____

Cell Phone: _____ Work Phone: _____ Employer: _____

Father's Name: _____ Occupation: _____

Cell Phone: _____ Work Phone: _____ Employer: _____

Legal Guardian's Name: _____ Occupation: _____

Cell Phone: _____ Work Phone: _____ Employer: _____

Child's School: _____ Grade: _____

As a courtesy, we will file most primary insurance claims for you if we have the following information:

1. ***Photocopies of the front and back of your valid, insurance ID card(s).***
2. ***Authorization to file insurance claims and receive direct payment for services.***
3. ***Notification of changes in your insurance coverage, address or phone number.***

Primary Medical Insurance: _____ **Phone #:** _____

Name of Policy Holder: _____ Relationship to Patient: _____

Policy Holder Date of Birth: _____ Employer: _____ PCP Referral Required? Yes No

Policy #: _____ Group #: _____ PCP:_____

Vision Plan: _____ **Phone #:** _____

Name of Policy Holder: _____ Relationship to Patient: _____

Policy Holder Date of Birth: _____ Employer: _____

Policy #: _____ Group #: _____

INFORMED CONSENT & TREATMENT AUTHORIZATION

The law requires that we make every effort to inform you of your rights related to your personal health information.

- I have read or had explained to me the *Notice of Privacy Practices* for Wally El-Hitamy, O.D. and agree to continue my care with Wally El-Hitamy, O.D. under said terms.
- I was given the opportunity but declined to read the *Notice of Privacy Practices,* for Wally El-Hitamy, O.D. but wish to continue my care with Wally El-Hitamy, O.D. under the terms of his privacy policies.
- I have read or had explained the *Notice of Privacy Practices* for Wally El-Hitamy, O.D. and do not wish to continue my care with Wally El-Hitamy, O.D. under said terms.
- The *Notice of Privacy Practices* could not be read due to the emergent nature of the care or the reason described as:

  _____

- I (do) ____ (do not) ____ authorize Wally El-Hitamy, O.D., or his staff to leave a message with available persons at my home phone number, on my answering machine or with the emergency contact listed above.
- I (do) ____ (do not) ____ authorize Wally El-Hitamy, O.D., or his staff to leave a message at my place of employment.

I hereby authorize Wally El-Hitamy, O.D. to provide a diagnosis & optometric treatment to my child or me. I further authorize the release of Protected Health Information to additional physicians or optometrists in order to facilitate continuity of care. I have read & understand the above information & am signing this form voluntarily.

_____ _____

Patient or Legal Guardian's Signature Date

FINANCIAL & INSURANCE FILING POLICY

- *All charges are your responsibility, whether or not your insurance company pays. Not all services are covered in all contracts. Some insurance companies arbitrarily select certain services they will not cover. We cannot become involved in disputes between you and your insurer regarding covered charges, deductible, or copay*
- *If your insurance company does not pay your claim within 30 days, it is your responsibility to contact them to expedite payment. If your insurance company refuses to pay, you are responsible for payment.*
- *If your insurance company does not pay within 45 days, we will require you to pay the balance by cash, check, money order, Visa or Mastercard.*
- *Payment for copay and/or deductible is due at the time services are rendered.*
- *We accept cash, checks, money orders, Visa and Mastercard.*
- *Canceled or rescheduled appointments are subject to a fee if we do not receive 24 hours advance notice.*
- *In the event that refraction is not covered by your insurance you will be charged a fee in addition to your copay and/or deductible.*

AUTHORIZATION TO RELEASE HEALTH INFORMATION & ASSIGN BENEFITS

I _____, authorize the release of all necessary Protected Health Information & assign all medical & vision benefits to Wally El-Hitamy, O.D. I also request that payment of authorized Medicare (if applicable) benefits be made on my behalf to Wally El-Hitamy, O.D. for any services furnished to me by Wally El-Hitamy, O.D. I authorize any holder of medical information related to me to release to the Centers for Medicare & Medicaid Services (CMS) & its agents, any information needed to determine these benefits or the benefits payable to related services. I understand that my signature requests that payment be made & authorizes release of medical information necessary to pay the claim. If item 12 of the CMS 1500 claim form is completed, my signature authorized releasing of the information to the insurer or agency shown. In Medicare assigned cases, the supplier agrees to accept the charge determination of the Medicare carrier as the full charge, & the patient is responsible only for the deductible, copay, & non-covered services. Copay & deductible are based upon the charge determination of the Medicare carrier. I understand that I am ultimately responsible for any bill incurred in this office. Should this account become delinquent, I will be responsible for any & all legal fees, court costs, & collection charges. There will be a service charge for each returned check. This authorization & assignment will remain in effect until revoked by me in writing. A photocopy of this authorization & assignment is to be considered as valid as the original. I request that you file my insurance & I have agreed to & completed all of the conditions listed above. I accept financial responsibility for all charges. I have read & understood this information & I am signing voluntarily.

_____ _____

Patient or Legal Guardian's Signature Date

Medical Information

Date_____/_____/_____

Please circle Y/N on the following:
Do you currently have problems with:

Yes	No	
☐	☐	Fever
☐	☐	Weight loss/poor appetite
☐	☐	Fatigue easily
Eyes		
☐	☐	Vision loss
☐	☐	Distorted vision
☐	☐	Double vision
☐	☐	Floating objects in vision
☐	☐	Flashing lights
☐	☐	Dryness
☐	☐	Redness
☐	☐	Itching
☐	☐	Burning
☐	☐	Excess Tearing
☐	☐	Glare/Light Sensitivity
☐	☐	Eye pain
☐	☐	Lazy Eye
☐	☐	Past eye injury/surgery
		Type _____Date_____
Ears, Nose, Mouth, Throat		
☐	☐	Recent viral infection
☐	☐	Sore throat
☐	☐	Loss of hearing
☐	☐	Dryness of mouth
Allergic		
☐	☐	Hay Fever Symptoms
☐	☐	Allergies List _____
☐	☐	Medication Allergies _____
		_____

Yes	No	
Skin		
☐	☐	Easy bruising
☐	☐	Rashes
Neurological		
☐	☐	Headaches
☐	☐	Numbness of extremities
☐	☐	Seizures
☐	☐	Depression
☐	☐	Anxiety
Cardiovascular		
☐	☐	Chest pain
☐	☐	High blood pressure
Respiratory		
☐	☐	Emphysema
☐	☐	Chronic Cough
☐	☐	Shortness of Breath
Gastrointestinal		
☐	☐	Stomach Pain
☐	☐	Diarrhea
Genitals,Kidney,Bladder		
☐	☐	Burning with urination
☐	☐	Kidney infection or bleeding
Musculoskeletal		
☐	☐	Muscle or neck pain
☐	☐	Back pain or stiffness
☐	☐	Joint pain or stiffness
Endocrine		
☐	☐	Thyroid Problems
☐	☐	Diabetes; Type_____

List and explain other medical conditions_____
_____

Current medication(s)_____
Have you had any operations? Y/N Kind?_____When? _____
Do you use cigarettes/tobacco? Y/N alcohol? Y/N Other substances_____

Family History	**Yes**	**No**	
High blood pressure.....	☐	☐	Relation_____
Diabetes	☐	☐	Relation_____
Macular degeneration	☐	☐	Relation_____
Glaucoma.....	☐	☐	Relation_____
Retinal detachment.....	☐	☐	Relation_____
Cataracts.....	☐	☐	Relation_____

Other eye conditions....Y/N _____Relation_____

Date of last eye exam: _____ was this for ☐ Glasses ☐ Contacts ☐ Both

I, (sign here) _____have received a copy of the Spectacle/Contact Lens Policy for Lakeway Eye Center.
09/07 Doctor's initials _____