CULLMAN PRIMARY CARE, PC

EYECARE CULLMAN

PATIENT INFORMATION/ UPDATE SHEET

Patient's Name: _____

Date of Birth: _____ Social Security # _____

Mailing Address: _____Email Address:_____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Marital Status: (Circle One) Single Married Divorced Widowed

Current Employer: _____ Work Phone: (_____) _____-_____

Emergency Contact Outside of Your Household:

Name: _____ Phone: (_____) _____-_____

Primary Care Doctor: _____

***Please present your Insurance card(s) and Photo ID when turning in this update sheet.**

I authorize Cullman Primary Care, PC to release any information requested by my Insurance Company including diagnosis and records of any treatment or surgical services. I also authorize and request that my Insurance Company pay directly to Cullman Primary Care, PC the amount due in my pending claim for services rendered to me. I understand I am also responsible for any amount that my Insurance does not pay and for any fees or charges accrued in the process of collecting past due amounts on my account, including attorney's fees in the event my medical/surgical bills are placed with an attorney or other third party.

Patient/Guarantor Signature: _____ Date: _____

Insurance:

Primary: _____ Secondary: _____

Cardholder's Name as shown on card: Cardholder's Name as shown on card:

_____ _____

Cardholder's Date of Birth: Cardholder's Date of Birth:

_____/_____/_____ _____/_____/_____

CPC-EyeCare Cullman

HEALTH HISTORY FORM

Name _____ Date of Birth _____ Date _____

Yes	No		Yes	No	
☐	☐	Asthma/Bronchitis/Emphysema	☐	☐	Heart or vascular disease
☐	☐	Arthritic disorder	☐	☐	High blood pressure
☐	☐	Kidney disease	☐	☐	Stroke
☐	☐	Diabetic ☐ Oral Medication ☐ Insulin Dependent	☐	☐	Hepatitis
☐	☐	Migraines	☐	☐	(Women) are you pregnant
☐	☐	Psychiatric disorder	☐	☐	Other diagnosed major health problems
☐	☐	Neurological condition			List _____
☐	☐	Gastric ulcer			_____

CURRENT MEDICATIONS (NAME AND DOSAGE)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

DRUG ALLERGIES

MAJOR SURGERY

YOUR OCULAR HISTORY (Have you been treated for any eye disorders not including corrective lenses?)

_____
_____

EYE SURGERY ☐ Yes ☐ No

List if yes _____
_____

SOCIAL HISTORY (Do you smoke or use any tobacco products?)

☐ Yes ☐ No

IMMEDIATE FAMILY EYE HISTORY OF GLAUCOMA OR INHERITED OCULAR DISORDER

☐ Yes ☐ No

List if yes _____
_____

CULLMAN PRIMARY CARE

EYECARE CULLMAN

Patient Consent Forms

I understand that as part of the provision of healthcare services, CULLMAN PRIMARY CARE, P.C. creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care of treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practice and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, and healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organizations is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent in writing, except where disclosures have already made in reliance on my prior consent.

This consent is give freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy of fax of this consent is valid as this original.
3. I may revoke this consent at any time, except where information has already been released. This consent is valid until revoked by me in writing.
4. I have the right to request that the use of my Protected Health Information which is used or Disclosed for the purposes of treatment, payment or health care operations be restricted. Cullman Primary Care, P.C., is not bound by the restriction unless it is in agreement with the restriction.

CULLMAN PRIMARY CARE, P.C.

**Communications Regarding My Accounts

Until my accounts are finally settled, I give my direct consent to receive communications regarding my accounts from any servicers and any collectors of my accounts, through various means such as (1) any cell, landline, or text number that I provide, (2) any email address that I provide, (3) auto dialer systems, (4) voicemail messages, and other forms of communications.

If your Insurance requires a referral for you to see a Cullman Primary Care, P.C. provider, it is your responsibility to provide our office with the referral. If your insurance company denies payment, **DUE TO NO REFERRAL, you the patient agree to pay Cullman Primary Care, P.C. in full for any charges incurred during your visit.

REFRACTION, IS THE PROCESS OF DETERMINING THE EYE'S REFRACTIVE ERROR AND IS NECESSARY TO PRESCRIBE GLASSES OR CORRECTIVE LENSES. IT IS AN ESSENTIAL PART OF AN EYE EXAMINATION, BUT IS NOT COVERED SERVICE BY MEDICARE OR MOST ANY OTHER INSURANCE COMPANIES. OUR OFFICE FEE FOR THE REFRACTION IS $25.00 AND THIS FEE IS DUE AT THE TIME OF SERVICE IN ADDITION TO ANY COPAYMENT ACCORDING TO YOUR INSURANCE.

I have read the above information and understand that I am responsible for any referral or outstanding balance with Cullman Primary Care, P.C. I understand that the **REFRACTION** is a **NON-COVERED** service. I also understand that I am responsible for any copayment/deductible these are separate from and not included in the Refraction Fee.

(Patient's Name Printed)	(Date)
(Patient's Signature or Guardian, If Minor)	(SSN#)
(Witness)	(Date)

CULLMAN PRIMARY CARE

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PRIVACY COMPLIANCE

Please list family member or other person, if any, we may inform about your general medical condition and your diagnosis which might include medical history, treatment, laboratory reports, x-rays, and treatment and/or reference to any mental or nervous disorders, drug and/or alcohol abuse, or sexually transmitted disease.

_____Relationship, _____Phone_____

_____Relationship, _____Phone_____

_____Relationship, _____Phone_____

_____Relationship, _____Phone_____

Please list the family members or other persons, if any, we may inform about your general medical condition and your diagnosis only in an emergency situation.

_____Relationship, _____Phone_____

_____Relationship, _____Phone_____

_____Relationship, _____Phone_____

Please print the telephone number, if any, where you want to receive calls about your appointments, lab, x-ray results, and/or any other health information, if other than your home phone number: _____

Can confidential messages be left on your home answering machine or cell phone voicemail?

_____YES _____NO

_____ _____ _____

Patient or Guardian Signature Birthdate Date