Please complete this authorization form carefully. The following in-depth information will enable us to provide you with complete, quality eyecare.

FULL NAME _____ TODAY'S DATE _____

SSN # _____ MARITAL STATUS: SINGLE ___ MARRIED ___ DIVORCED ___ OTHER ___

STREET ADDRESS _____

CITY _____ SPOUSE NAME _____

STATE _____ ZIP _____ SSN # _____ BIRTHDATE _____

HOME PHONE _____ SPOUSE'S EMPLOYER _____

SEX ___ MALE ___ FEMALE BIRTHDATE _____ ADDRESS _____

EMPLOYER _____ EMPLOYER ADDRESS _____

WORK PHONE _____

EMERGENCY CONTACT _____

RESPONSIBLE PARTY, IF OTHER THAN ABOVE

FULL NAME _____ SSN # _____ BIRTHDATE _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ RELATIONSHIP TO PATIENT _____

EMPLOYER _____ WORK PHONE _____

INSURANCE INFORMATION

Our office will file your PRIMARY & SECONDARY INSURANCES for you. If we have not received payment within 3 weeks after filing your second insurance, you are responsible for your entire balance.

Primary Insurance _____ Secondary Insurance _____

Referring Physician _____ Pharmacy Name _____

Whom may we thank for referring you to this office? _____

Acknowledgement of Financial Responsibility: this information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered, including reasonable attorney's fees and cost of collection in the event of default.

Notice of Privacy Practices for Protected Health Information

If you consent, the office is premitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care options. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for these services.

You have the right to review this Notice before signing the consent authorizing use and disclosure of your protected health information for treatment, payment, and health care operations purposes. If you would like a copy of this 6 page privacy notice, please ask our receptionist.

By signing this form,-I CONSENT TO TREATMENT for myself and/or on behalf of the Minor for which this information pertains. I GIVE PERMISSION for the doctor(s) to examine, diagnose and initiate treatment as deemed appropriate. I further attest that I am the Parent or Legal Guardian of the Minor and have the authority to authorize care and treatment.

Patient/ Parent or Guardian,Signature Today's Date

Cape Regional Eye Center, PLLC

CREDIT POLICY

SERVICES:

1. PAYMENT IS REQUIRED ON THE DAY OF SERVICE WITH THE FOLLOWING EXCEPTIONS:

   A. SPECIAL ARRANGEMENTS HAVE BEEN MADE WITH THE ACCOUNTS MANAGER, OR

   B. THE PATIENT HAS MEDICARE OR MEDICARE/MEDICAID.

      1. **MEDICARE DEDUCTIBLE:** MEDICARE REQUIRES YOU TO PAY A FEE EACH YEAR

      2. **MEDICARE CO-PAY:** MEDICARE REQUIRES YOU TO PAY 20% OF YOUR APPROVED CHARGES AFTER YOUR DEDUCTIBLE HAS BEEN MET.

   C. THE PATIENT HAS COMMERCIAL INSURANCE, PAYS ALL CHARGES FOR THE DAY UP TO $100.00, ASSIGNS BENEFITS TO THE PHYSICIAN AND AGREES TO PAY THE REMAINING BALANCE NOT PAID BY INSURANCE 30 DAYS FROM THE DATE INSURANCE IS FILED BY OUR OFFICE.

2. ANY BALANCE REMAINING AFTER INSURANCE SHOULD BE PAID IN FULL WITHIN 30 DAYS OF THE DATE OF SERVICE. IF THE PATIENT OR RESPONSIBLE PARTY IS UNABLE TO PAY THE ACCOUNT IN FULL, THEY SHOULD CONTACT OUR ACCOUNTS MANAGER IMMEDIATELY FOR **CONVENIENT TERMS**. (ANY ACCOUNT BALANCE REMIANING UNPAID AFTER 90 DAYS FROM THE INITIAL BILLING DATE WILL BE SUBJECT TO TRANSFER TO A COLLECTIONS AGENCY. THE PATIENT OR RESPONSIBLE PARTY WILL BE REQUIRED TO PAY ANY EXPENSES INCURRED DURING THIS COLLECTIONS PROCESS.)

3. PATIENTS SHOULD ALSO UNDERSTAND THAT THE PHYSICIAN HAS THE RIGHT TO REFUSE FURTHER TREATMENT OF CLIENTS THAT REFUSE TO HONOR THEIR FINANCIAL RESPONSIBILITIES WITH THE CLINIC.

4. THE RESPONSIBLE PARTY WILL ACCEPT FULL RESPONSIBILITY IF THE PATIENT IS A MINOR (UNDER 18 YEARS OF AGE).

I HEREBY REQUEST THAT PAYMENT OF THE AUTHORIZED INSURANCE BE MADE DIRECTLY TO CAPE REGIONAL EYE CENTER. I AUTHORIZE CAPE REGIONAL EYE CENTER TO ACT AS MY AGENT TO HELP ME DETERMINE AND OBTAIN BENEFITS FROM MY INSURANCE COMPANY. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO MY INSURANCE COMPANY, ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS. I **AGREE TO PAY ALL** COLLECTION EXPENSES INCURRED IN CONNECTION WITH THIS ACCOUNT.

CONTACTS:
ALL ORDERS MUST BE **PAID IN FULL** BEFORE DELIVERY.

I HAVE RECEIVED A COPY OF THIS CREDIT POLICY AND AGREE TO COMPLY WITH ALL POLICIES. I AGREE TO PAY ALL COLLECTION EXPENSES INCURRED IN CONNECTION WITH THIS ACCOUNT.

_____ _____

PRINT NAME DATE

CAPE REGIONAL EYE CENTER, PLLC

AUTHORIZATION

Patient Name_____ Chart #_____

Social Security_____ DOB_____

By signing this authorization, I permit Cape Regional Eye Center, PLLC to contact:

Name_____

Address_____

City_____ State_____

Phone Number_____

for the purpose of notifying me of my protected health information such as test results, appointment dates and times, or other necessary contacts. This person or persons will only be notified when I cannot be reached.

I understand that my home answering machine, voice mail messaging, and/or office may be called in the normal course of business

-to remind me of appointments,
-to leave messages thet the physician or nurse needs to speak with me,
-to initiate other necessary contacts.

I also understand that this contact has the potential to break confidentiality to which I agree.

NOTE: If you do not agree to the above terms, you may make arrangements to have all contacts regarding medical issues conducted at our office.

_____ _____

Signature of Patient Date

_____ _____

Signature of Witness Date

ALFORD PRINTING INC. 731-[illegible]

CAPE REGIONAL EYE CENTER, PLLC

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGMENT FORM

I, _____, HAVE RECEIVED A COPY OF CAPE REGIONAL EYE CENTER'S NOTICE OF PRIVACY PRACTICES.

_____ _____

SIGNATURE OF PATIENT DATE

PATIENT HISTORY QUESTIONNAIRE

NAME_____ AGE_____ TODAYS DATE_____

REFERRING DOCTOR_____ ADDRESS_____

PRIMARY CARE DOCTOR_____ ADDRESS_____

Have you ever been treated for any of the following: (Please circle all that apply to your health history)

AIDS	ARTHRITIS	ASTHMA
CANCER	DIABETES	EMPHYSEMA
HEART ATTACK	HEART FAILURE	HEPATITIS
HIGH BLOOD PRESSURE	LEUKEMIA	LUPUS
LYMPHOMA	STROKE	THYROID DISORDER
TUBERCULOSIS		

LIST ANY OTHER MAJOR ILLNESSES:_____

Do you have any drug allergies: (Please circle any that apply to your health history)

PENICILLIN ASPIRIN IODINE SULFA CIPRO TETRACYCLINE

Other Drug Allergies_____

LIST ALL MEDICATIONS YOU ARE CURRENTLY USING:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

LIST ANY SURGERIES:_____

_____

REVIEW OF SYSTEMS: (Please circle all that you have presently or in the past)

Fever - Chills - Weight loss - Fatigue - Night Sweats
Sinus Congestion - Sore throat - Runny Nose - Cold Sores Lip/Mouth
Chest pain - Rapid Heartbeat - Heart Skips Beat - Shortness of Breath when walking
Cough - Difficulty breathing - Asthma Attacks - Seasonal allergies
Blood in urine - Burns to urinate - Sores on genitals - Kidney stones
Diarrhea - Constipation - Blood in bowels - cramps/pain
Tick Bites - Rashes - Sores
Loss of balance - Headaches - Weakness arm/leg - Nausea/vomiting - Numbness arm/leg
Anemia(low blood count) - Abnormal white blood cells - Swollen lymph nodes

SOCIAL HISTORY: (Please circle all that apply to you)
Married Single Widowed Divorced Separated
Do you Smoke? Yes - No
Do you Drink Alcohol? Yes - No

FAMILY HISTORY: (Please circle all that apply to your family) Cancer - Diabetes - Heart Attacks
High Blood Pressure - Stroke - Tuberculosis

PATIENT EYE HISTORY QUESTIONNAIRE

WHEN WAS YOUR LAST EYE EXAMINATION:_____

WHO WAS THE EXAMINING EYE DOCTOR:_____

DO YOU CURRENTLY SUFFER FROM ANY OF THE FOLLOWING:

Loss of Vision?	**Yes/No**	**For how long?**_____	**Which eye?**_____
Blurred Vision?	**Yes/No**	**For how long?**_____	**Which eye?**_____
Halo's in vision?	**Yes/No**	**For how long?**_____	**Which eye?**_____
Loss of side vision?	**Yes/No**	**For how long?**_____	**Which eye?**_____
Double vision?	**Yes/No**	**For how long?**_____	**Which eye?**_____
Dry eyes?	**Yes/No**	**For how long?**_____	**Which eye?**_____
Mucous discharge?	**Yes/No**	**For how long?**_____	**Which eye?**_____
Redness?	**Yes/No**	**For how long?**_____	**Which eye?**_____
Sandy/gritty feeling?	**Yes/No**	**For how long?**_____	**Which eye?**_____
Itching/burning?	**Yes/No**	**For how long?**_____	**Which eye?**_____
Foreign body sensation?	**Yes/No**	**For how long?**_____	**Which eye?**_____
Excess watering?	**Yes/No**	**For how long?**_____	**Which eye?**_____
Eye pain or soreness?	**Yes/No**	**For how long?**_____	**Which eye?**_____
Eye Surgery?	**Yes/No**	**What type?**_____	**Which eye?**_____
		When?_____	**What doctor?**_____

FAMILY HISTORY: (Please circle all that apply to your family)

BLINDNESS **GLAUCOMA** **MACULAR DEGENERATION** **RETINAL DETACHMENT**