TODAY'S DATE:

FOR OFFICE USE ONLY: MRN #

Joseph & Swan Eye Center, APMC

Jonathan M. Joseph, MD ~ Kevin R. Swan, MD ~ Alexandra F. Sellers, MD
~ Meaghan Cortez Aridi, OD

WELCOME TO OUR OFFICE ~ PLEASE PRINT CLEARLY

Last Name: _____First Name: _____Middle Initial: _____

Date of Birth: _____ SEX: M F MARITAL STATUS: _____

LANGUAGE: _____RACE: _____SOCIAL SECURITY #: _____

ETHNIC GROUP: (CIRCLE ONE)

unspecified, declined to specify, prohibited by state law, Hispanic or Latino, not Hispanic or Latino, unknown

HOME PHONE: _____CELL PHONE: _____ PREFERENCE: CELL OR HOME

EMAIL: _____IF NO EMAIL, CHECK HERE: _____

ADDRESS: _____

CITY: _____ STATE: _____ZIP: _____

EMERGENCY CONTACT:

NAME: _____ RELATIONSHIP: _____

PHONE NUMBER: _____ALTERNATE PHONE: _____

IF MINOR, LIST PARENT OR GUARDIAN'S NAME: _____

DOB: _____ RELATIONSHIP TO PATIENT: _____

***We do not accept Medicaid* please see front for ABN form/cash pricing**

AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION:

I give the Joseph & Swan Eye Center permission to release medical information to the following individuals:

Name: _____Relationship: _____Phone: _____

Name: _____Relationship: _____Phone: _____

PATIENT MEDICAL HISTORY QUESTIONNAIRE

PRIMARY CARE/CARDIOLOGIST: _____

DIABETIC PHYSICIAN: _____ YEARS DIAGNOSED AS DIABETIC: _____

A1C LEVEL: _____ FASTING BLOOD SUGAR: _____

CIRCLE: YES OR NO

ALCOHOL USE: YES OR NO TOBACCO USE: YES OR NO SMOKER: YES OR NO

PNEUMONIA VACCINE: YES OR NO CONTACT LENS WEARER: YES OR NO IF YES: HARD LENS OR SOFT

PREFERRED PHARMACY & LOCATION: _____

WRITE OR ATTACH LIST OF CURRENT MEDICATIONS (INCLUDE EYE): _____

_____

_____

_____

_____

MEDICAL (DIAGNOSED) CONDITIONS: _____

_____

LIST ANY SURGERIES: _____

_____

_____

PLEASE LIST ANY KNOWN ALLERGIES: _____

_____

WHAT EYE ISSUES DO YOU WANT TO DISCUSS WITH YOUR DOCTOR: _____

_____

_____

DILATION CONSENT

Dilation is necessary to perform a complete eye exam of the retina and back of the eye. This may reveal the presence of a serious systemic condition as well as eye conditions. You may require driving assistance until the drops wear off. Risks include blurred vision after dilation until drops wear off, glare and distorted vision until drops wear off, In rare cases extreme elevation of the eye pressure can occur, allergic reaction can occur, increased blood pressure, cardiac arrhythmias, tachycardia, dizziness, increased swelling.

Please inform us immediately if any of these rare side effects occur.

I authorize my physician and staff to administer dilating eye drops.

PLEASE INITIAL: _____

REFRACTION

An essential piece of medical information that is used to assess your eyes and search for medical conditions and vision problems. It can also be used to provide a current eyeglass prescription, if necessary. The doctor determines if a refraction is needed. This is a non-covered service by Medicare and many other insurance plans.

By initialing I accept full responsibility for this service and the $45 fee is collected at the time of service.

PLEASE INITIAL: _____

DISCLOSURE OF FINANCIAL INTEREST

(As Required by R.S. 37:1744 and LAC: XLV.4211-4215)

Louisiana Law requires physicians and other health care providers to make certain disclosures to a patient when they refer a patient to a facility in which the physician has a significant financial interest. We may refer you, or the named patient for whom you are legal representative, to:

Southcity Optical, L.L.C.
214 Southcity Pkwy, Ste 102 Lafayette, LA 70503

To obtain the following health care services or products: Prescription lens, contact lens, frames and other eyewear. We have a financial interest in Southcity Optical, L.L.C. to whom we are referring you, or to whom we may refer you in the future, the nature and extent of which are as follows:

Southcity Optical, L.L.C., is wholly owned by Joseph & Swan Eye Center, A Professional Medical Corporation.

By initialing I acknowledge being informed of the Financial Interest.

PLEASE INITIAL: _____

NOTICE OF PRIVACY POLICIES: I HAVE READ AND BEEN OFFERED A COPY OF THE NOTICE OF PRIVACY PRACTICES LOCATED IN THE MAIN LOBBY.

NOTICE OF AUTHORIZATION TO RELEASE INFORMATION/PAYMENT AGREEMENT/FINANCIAL AGREEMENT: I HAVE READ AND BEEN OFFERED A COPY OF THE NOTICE OF AUTHORIZATION TO RELEASE INFORMATION/ PAYMENT AGREEMENT/FINANCIAL AGREEMENT IN THE MAIN LOBBY.

By initialing I acknowledge being informed of Privacy Policies, Authorization to release information/payment/financial agreement.

PLEASE INITIAL: _____

BY SIGNING BELOW, I ACKNOWLEDGE ALL THE ABOVE INFORMATION PROVIDED ON THESE DOCUMENTS IS COMPLETE AND ACCURATE:

_____ _____

Signature of Patient or Patient's Representative Date

Welcome

Our mission is to set a standard of excellence and provide a full range of quality eye care to all patients who use our eye center. Our priority is the satisfaction of patients and referring doctors. We will hold ourselves to the highest standard of integrity and treat all people with respect, dignity, kindness, and compassion striving to continuously understand their needs and exceed their expectations.

We are glad you chose us for your vision needs.

JOSEPH & SWAN
EYE CENTER

southcity optical

In Appreciation we want to offer you a special discount:

- **30% Discount on Optics (Eyeglasses)**
- **10% Discount on Contact Lenses**

Some exclusions may apply.

Please bring this flyer to our Optical for your discounts

Joseph, & Swan Eye Center, APMC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health records and other Protected Health Information (PHI) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse PHI. We have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your PHI.

Joseph & Swan Eye Center, APMC (JSEC) has adopted reasonable policies and procedures for administration of its programs, services, and activities. If any State or Federal laws or regulations, or order of court having appropriate jurisdiction imposes as stricter requirement upon any JSEC policy regarding the privacy or safeguarding of information, JSEC shall act in accordance with that stricter standard.

Without specific written authorization, we are permitted to use and disclose your health care records for the purpose of treatment, payment, and health care operations. **Treatment** means providing, coordinating, or managing health care and related services by one or more healthcare providers. Examples of treatment would include eye exams and surgery procedures; **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your insurance company for services; **Health Care Operations** include the business aspect of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example of this would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (electronically or by mail) or provide you with information about treatment options or other health related services including release of information to friends and family members that are directly involved in your care or assist in taking care of you. We will use and disclose your PHI when we are required to do so by federal, state, or local laws. We may disclose your PHI to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court order or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or obtain an order protecting the information the party has requested. We will release your PHI if requested by law. We may release your PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. We may release PHI to organizations that handle organ, eye, or tissue donation and transplantation if you are an organ donor. We may use and disclose PHI when necessary to reduce or prevent a serious threat to your health and safety of another individual or to the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PHI if you are a member of U.S. or foreign military (including veterans) and if required by an appropriate intelligence and national security activities authorized by law. We may disclose your PHI to federal officials to protect the President, other officials or foreign heads of state, or conduct investigations. We may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary for the institution to provide health care services to you, for the safety and security of the institution, and to protect your health and safety or that of other individuals or the public. We may release your PHI for worker's compensation and similar programs. We may disclose your PHI with disaster relief organizations to coordinate care and or locate family members in the event of a disaster. Any other uses and disclosures, including marketing, fundraising, notes pertaining to psychotherapy, or any sale of PHI, will be made only with your authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights regarding your PHI: **The right** to request restrictions on certain uses and disclosures of payment and Health Care Operations in your PHI, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. (The practice does not require you to agree with said restriction except for those for whom healthcare is being paid out of pocket.) **The right** to elect to pay "out of pocket" for medical services and request that we not disclose the related information to your health plan. Such a request would be honored unless we are required by law to disclose the information. **The right** to request to receive confidential communications of PHI from us by any alternative means or at alternative locations. **The right** to access, inspect, and copy your PHI. **The right** to request an amendment to your PHI. **The right** to receive an accounting of disclosures of PHI outside of treatment, payment, and healthcare operations. **The right** to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to notify you if a breach of confidentiality occurs involving your PHI. We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new provisions effected for all PHI that we maintain. Revisions will be posted on the effective date, and you may request a written copy of the Revised Notice from this office. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health and Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

A full explanation of the regulations can be obtained by contacting our privacy officer.

Joseph & Swan Eye Center, APMC
214 Southcity Pkwy, Ste 101
Lafayette, LA 70503-5718
(337) 981-6430

For more information about our Privacy Practices, HIPAA or to file a complaint: Please contact our Privacy Officer

The U.S. Dept. of Health & Human Services
Office of Civil Rights
200 Independence Ave. S.W.
Washington, D.C. 20201 Toll Free (877) 696-6775

AUTHORIZATION TO RELEASE INFORMATION
PAYMENT/FINANCIAL AGREEMENT

In connection with the medical services currently received from Joseph & Swan Eye Center, APMC, ("the practice"), the undersigned hereby agrees as follows:

Authorization to Release Information: Insurers and managed care companies occasionally review medical charts to ensure compliance with the company procedures. I understand that my chart may be selected for such review and that the confidentiality of this information in my chart will be preserved and I hereby consent to such review and release the physician and such insurer or managed care company for liability for any reasonable review of my chart.

Payment agreement: I request that payment of authorized medical benefits be made on my Behalf to the Practice or any physician in their association or employ, for services furnished by said physician. I further understand that I will be solely responsible for any deductibles, co-insurance and/or non-covered services not payable by my insurance plan. I further understand that most insurance companies will not pay for an examination for glasses or contact lens or change of lenses and that I will be asked to pay for this service at the time the service is done. I authorize the release of medical information about me to my insurance carrier and its agents needed to determine the benefits payable for related services. In the event I am not covered by an insurance plan to which Joseph & Swan Eye Center, APMC belong to at the time of my visit, I understand that I am responsible to pay for services provided at standard clinic charge amounts.

Medicare Signature Authorization: Medicare *does not* pay for services provided if there is no medical eye disease or medical eye problem. If you are here to have your eyes examined for glasses only, you will be responsible for full payment because Medicare does not cover a standard eye exam for eyeglasses. Medicare has made it very clear that this is not a covered service, just as standard dental work is not a covered service. If you are here for problems with your eyes (blurry vision, red eyes, swollen eyes, glaucoma, cataracts, etc.) Medicare will cover the visit; however, they will not cover the refraction. Most Medicare supplements will also not pay. I request payment of authorized Medicare benefits to be made to the Practice for any services furnished to me by the Practice. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related service.

No Insurance Coverage: I understand that should I not have insurance coverage, I am fully responsible for payment of services provided by the Practice to me or my dependents, AT THE TIME SERVICES ARE RENDERED, unless other financial arrangements have been made with the practice PRIOR to being seen by my physician.

Financial Agreement: I understand that Joseph & Swan Eye center, APMC will file a claim on my behalf for the services rendered at the time of service and I authorize Joseph & Swan Eye Center, APMC to receive payment from my insurance company. Should it be determined that my insurance is not valid when my insurance company receives and presses the claim, I understand that I will be fully responsible for all charges incurred on the date of services.

CANCELLATION AND 'NO SHOW" FEE POLICY: We reserve the right to charge a fee of $50 for all missed appointments (No Shows) and appointments which are not cancelled with a 24-hour advances notice. This fee is not covered by insurance and MUST be paid prior to your next appointment being scheduled. Multiple "no shows" in any 12-month period may result in termination from our practice.

Patient copy

Updated: 9/05/2024