FAGADAU, HAWK & SWANSON
Eye Physicians & Surgeons

It is important that you complete all the following:

Patient Name:_____DOB:_____ F ___ M ___ SSN: _____
MD_____ Mr.____ Mrs.____ Ms.___Miss___ Other_____

Address:_____ City:_____ State: _____ ZIP:_____

Employer:_____ Occupation: _____ Work Phone:_____

Home Phone: _____ Cell Phone:_____ E-Mail: _____

Spouses Name:_____ Spouse's Employer:_____ Spouse's SSN:_____

Primary Care Physician:_____PCP Ph # _____Pharmacy:_____Phn#_____

Emergency Contact: _____
(Name) (Phone) (Relationship)

RESPONSIBLE PARTY:

Name: _____DOB:_____ SSN:_____ Home Phone:_____

Address:_____ City:_____ STATE:_____ ZIP:_____

Employer:_____ Work Phone: _____Relationship to Patient_____

Who Referred You?___Website___Patient___Friend___Employee___Physician_____Other:_____
(Please List Referring Doctor above)

Are You Interested in a LASIK Consultation? _____Yes _____No

Are You Interested in Contact Lenses? _____Yes _____No

(Please present your insurance cards for scanning)

MEDICAL INSURANCE:

Primary: _____Subscriber:_____ID#:_____Grp#_____
Secondary:_____Subscriber:_____ID#:_____ Grp#_____
Worker's Comp: Date Occurred:_____ Ins. Co._____ Claim #_____

All professional services rendered are charged to the patient or responsible party. We will file claims with the patient's insurance carrier; however, the patient is responsible for all fees, co-payments, and/or insurance deductibles, as well as any amount not covered by insurance. **Payment of co-payments and insurance deductibles is expected when services are rendered unless other arrangements have been made with our business office in advance.**

I request that payment of authorized Medicare benefits be made either to me or to the provider named above for any services furnished me. I authorize any holder of medical or other information about me to release to CMS and its agents any information needed to determine these benefits or benefits for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. The Provider accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

I further give my permission for the release of information regarding my diagnosis, test results and/or prescriptions to anyone answering at my home telephone number or for the leaving of that information on my home answering machine and I permit the use of my e-mail address to contact me.

I hereby assign to the physician, if assignment is taken, all payments for medical services rendered.

I have been offered the HIPAA Privacy Practices.

I consent to monitoring and/or recording of consultation and/or meeting with doctor or staff employee for quality control and training purposes.

Date:_____ Signature:_____

Printed Name: _____

10/14/2013

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FINANCIAL POLICY:

Fagadau, Hawk & Swanson is a professional office that renders quality care to our patients. The following explains our practice's policy and procedure regarding patient billing.

- **Payment is expected at the time services are rendered unless arrangements have been made prior to treatment.**
- **As a courtesy to our patients, our office will file insurance claims for Drs. Fagadau, Hawk & Swanson. However, our doctors are not contracted, nor participating with discount vision plans. (ex: VSP, Spectera) Each patient is responsible for knowing their individual policy and limitations and we recommend that you familiarize yourself with the specifics of your plan prior to your visit. (ex: co-payments, deductibles, routine eye coverage) Please be aware that some insurance plans do not allow routine eye care and payment for non-covered services are expected at the time of visit.**
- **Non-Payment by Insurance Company: You are responsible for payment for any services that your insurance company determines to be "non-covered benefits" or any services that are not covered or not payable to Drs. Fagadau, Hawk & Swanson.**
- **Steve Fitzpatrick and Claire Shaw are not contracted medical providers, and therefore we will not be filing insurance for them. Payment is expected at the time of service. We will provide a receipt so that you are able to file for personal reimbursement.**
- **HMO insurance policies do require a referral from the primary care physician which the patient is responsible for obtaining prior to the visit.**
- **Any outstanding balances more than 120 days will be forwarded to our collection agency unless payment arrangements have been made with our Billing Manager. You will be responsible for all fees charged by the collection agency.**

_____ _____

Patient/Guarantor Signature **Date**

If there are any questions or concerns, please contact our Billing Department.

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Health History Form

Patient Information			
Name		Primary Care Physician	
Date of Birth / Age		Pharmacy & phone#	
Occupation		**Allergies (list all):** Medications or Latex	
Interests / Hobbies			
Visit Date			

Eye History:	Right	Left	Medications (list all):	Eye Medications (list all):
Cataract				
Glaucoma				
Lazy eye/Amblyopia				
Iritis				
Cataract surgery				
Other eye surgery				**Major Surgery (last 10 years):**
Eye injury				
Macular Degeneration				
Retinal problems				
Refractive surgery				

MEDICAL HISTORY

Social	Yes	No	1st use?
Tobacco use?			
Alcohol use?			
Drug use (recreational)?			
Do you drive?			

Do you have or have you ever had:

Cardiovascular	Yes	No	When?
Heart Attack			
Chest Pain			
Angina			
Congestive Heart Failure			
Irregular Heart Beat			
High Blood Pressure			
Low Blood Pressure			
Pacemaker			
Defibrillator			
High Cholesterol			
Respiratory			
Asthma			
Emphysema			
COPD			
Bronchitis			
TB: Positive Test? Treated?			
Genitourinary			
Incontinence			
Prostate Treatment (ever used):			
Proscar, Flomax, Tamsulosin			
ENT			
Sinus Congestion			
Cancer			
Type?			
Treatment: Chemo / Radiation			

MEDICAL HISTORY (CONT'D)

Endocrine	Yes	No	When?
Diabetes: Circle – Type 1 / Type 2			
Thyroid Disease			
Kidney Problems			
Kidney Stones			
Neurological			
Parkinson's			
Stroke/TIA			
Multiple Sclerosis			
Chronic Headache			
Dementia / Alzheimer's			
Hard of Hearing / Deaf			
Musculoskeletal			
Osteo / Rheumatoid Arthritis			
Joint Pain			
Gastrointestinal			
Crohn's / Ulcerative Colitis			
Hepatitis A / B / C or Jaundice			
Allergic/Immunologic			
HIV			
Persistent Infections			
Hem/Lymph			
Anemia / Bleeding / Bruising			
General			
Night Sweats / Unexplained Fever			
Are you pregnant?			

Family History	Yes	No	Who?
Diabetes			
Glaucoma			
Macular Degeneration			

Other Medical Conditions Not Listed

Date: _____ M.D.: _____ Tech: _____ | Date: _____ M.D.: _____ Tech: _____ | Date: _____ M.D.: _____ Tech: _____ | Date: _____ M.D.: _____ Tech: _____ | Date: _____ M.D.: _____ Tech: _____ | Date: _____ M.D.: _____ Tech: _____ | Date: _____ M.D.: _____ Tech: _____

Revised: 09/28/11

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NAME:_____ Date:_____

Please circle *yes* or *no* if you have had any of the following symptoms in the last 6 months:

Eyes feel dry	yes	no
Eyes feel teary or wet	yes	no
Red or "bloodshot"	yes	no
Burning	yes	no
Sandy or gritty	yes	no
Feels like something in eyes	yes	no
Tired or fatigued	yes	no
Feels strained	yes	no
Feels like pressure	yes	no
Need to blink often to focus	yes	no
Feels like film over eyes	yes	no
Itchy	yes	no
Double vision at times	yes	no
Eyes ache	yes	no
See shadowing on letters	yes	no
Headaches	yes	no
Trouble with reading	yes	no
Vision blurring at times	yes	no
Discharge or matting	yes	no
Sticky sensation	yes	no

Are any of the symptoms worse in the morning? yes no

Do the symptoms get worse as the day goes on? yes no

How long have you lived in the Dallas area? _____

Have you had any of the Following:

Blepharoplasty	yes	no
Chemotherapy	yes	no
Facial Surgery	yes	no
Lasik	yes	no
PRK	yes	no
Hysterectomy	yes	no
Botox	yes	no

If yes to Botox, when was last injection? _____

Do you take diuretics (water pills) or use a diet pill? yes no

Do you see a rheumatologist for any reason such as: Rheumatoid arthritis, Lupus, Sjogren;s syndrome, Scleroderma ? yes no

Do you have Bell's palsy? yes no

Do you use a CPAP at night? (breathing machine) yes no

Do you sleep under a moving fan or floor fan? yes no

Do you have Dry mouth ? yes no

Do you have trigeminal neuralgia (fifth nerve problem)? yes no

Do you use supplemental oxygen? yes no

Do you have a parotid tumor? yes no

Do you have a skin disorder ? yes no

Do you have a thyroid disease? yes no

FOR CONTACT LENS WEARERS ONLY:

Are they colored? yes no

Do they stick to your eyes? yes no

Do they pop out? yes no

Do they get protein deposits? yes no

Do you sleep in them? yes no

Do you have to order them more frequently than expected? yes no

Do you have days when you cannot put them in or have to remove them earlier than you would like to? yes no

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Patient Preference Regarding Communication of Health Information

In order to better protect your privacy under HIPAA, and to comply with all HIPAA regulations, we have created this consent form for releasing medical information to family members and other people of choosing. This will also be used for consent to leave detailed phone messages at the mentioned phone numbers, mail any test results to your personal email address and/or home address.

Many times we have patient's family members call requesting medical information and/or appointment information. We are not allowed to release this information without the patient's written consent.

The purpose of this document is to protect your privacy.

Communication to Family Members, Spouses or Other :

I, _____ DOB _____, hereby give my permission for the release of medical information regarding appointments and questions about my condition and treatments to the following person:

Name: _____ Relationship:_____ Phone:_____

Name: _____ Relationship:_____ Phone:_____

Name: _____ Relationship: _____ Phone:_____

____ Check here if you do not give permission for any additional family members, relatives or close personal friends to have access to any information regarding your medical condition (s).

Electronic Communication via Email

In choosing to allow us to communicate with you via email, please consider privacy implications; for example, any other person that may have access to your email or any other person, such as your employer, that may have the right and/or ability to review all email received at your work address.

_____ Check here if you prefer email to be the primary source of contact by our office.

_____ Check here if you choose to not be contacted by email.

If you choose to allow us to contact you by email, please enter in the space below the email you would like us to use.
Email Address: _____

Communication via the Telephone:

Detailed messages regarding my health information, appointments, etc may be left on voicemail at the following numbers:

_____(work/ cell/home) _____ (work/ cell/home)

Consent and Agreement

I have carefully reviewed this document and our Notice of Privacy Practices (NPP) and agree to fully comply with the guidelines defined herein for the communication of my health information.

Signature :_____ Date : _____