FAGADAU HAWK & SWANSON M.D. | Vision. For Life.

It is important that you complete all the following: (Please see new office policies effective 3/1/2020)

Patient Name:_____DOB:_____ F ___ M ___ SSN: _____

MD_____ Mr.____ Mrs.____ Ms.___Miss___ Other_____ Married: YES NO

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

Employer:_____ Occupation: _____ Work Phone:_____

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

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

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

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

RESPONSIBLE PARTY (Complete if the patient is under 18 years of age or has a legal guardian):

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:_____Sub. DOB_____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 to 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: _____

FAGADAU HAWK & SWANSON M.D. | Vision. For Life.

We would like to thank you for choosing Fagadau, Hawk, & Swanson M.D. as your eye care professionals. This information is meant to keep you informed of our current office policies and procedures.

Office Hours: We are open Monday through Thursday: 8:00 a.m.– 5:00 p.m. & Fridays 8 a.m.- 4:00 p.m.

Appointments: We see patients by appointment only. Same day appointments may be available for urgent eye related emergencies. Please contact the office to speak with a technician for urgent eye related emergencies.

****EFFECTIVE 3-1-2020: Missed and no show appointments will be subject to a $25 fee. ****

**** Walk-ins will be subject to a $25 fee for non-scheduled appointments. ****

After Hours and Emergencies: For a serious emergency call 911 right away. For an urgent eye related issue, please give symptoms and duration to the receptionist and a technician will call you back. Please be aware that we will be working you into our schedule and there may be a wait. Also, you may not be able to see your regular ophthalmologist and may be scheduled with one of our other physicians that is available at that time.

**** After hours week/ weekend appointments will be subject to a $50 fee. ****

If your emergency occurs after hours, please contact our answering service at **214-360-5673** and they will page the provider on call.

**** Consultation fees may apply ****

Running on Time: We know your schedule is busy and that your time is valuable. Please let us know if you have been waiting more than 30 minutes to be called for your appointment so we can confirm that you have been properly checked in. **Remember that our providers have several different schedules. If someone who arrived after you is called before you are, they may be seeing one of our other providers.**

Treatment of Minors: Patients under the age of 18 must be accompanied by a parent or legal guardian for every appointment. If a parent is unable to accompany the child, they may be seen with a written permission for treatment from a parent or legal guardian for that date of service only.

Requesting to Speak to a Technician: If you call our office during normal business hours with a non-emergency medical request such as a prescription refill, a glasses or contact lens prescription, or a question regarding eye drops, please leave a message with one of our receptionists and a good contact number so that a technician can return your call as soon as possible. Please keep in mind that the technicians are with other patients and we will do our best to return your call in a timely manner.

Prescription Samples: We often provide medication samples so that the doctor can see if the medication will work for you. Remember that samples are not a long term way to fill your prescription and we may not always have samples of your medications. **Please do not rely on samples for medications you take long term.**

Contact Lens Samples: If you need sample contacts to hold you over until your contact lens order arrives, please feel free to call our office to see if we have your prescription in stock. However, please keep in mind that these samples are primarily used for new contact lens wearers and we are not provided many trials of the same prescription to keep in stock. We encourage you to place a contact lens order before you use your last pair or open your last box. **Please visit our new online ordering website which you can access at www.fagadauhawk.com to take advantage of our convenient online ordering and delivery service for your contact needs.**

Billing/Collecting policies:

Type of Payments Accepted: Cash, Check, Visa or MasterCard are all acceptable forms of payment. **We do not accept *American Express* or *Discover*.**

Collection of copayments/co-insurance: Payment is required at the time of service, unless you have made prior arrangements with our billing department.

Referrals / Authorizations: If your insurance requires a referral to be processed through your insurance company, please have your primary care physician contact your insurance company to process the referral prior to your appointment. We must have this information before your appointment time in order to collect for services based on your in-network benefits.

Medicare Only Patients: Refractions are not considered a covered benefit by Medicare. The fee for this service is $60 and is due at the time of service. The results of this test help the doctor to determine the health of your eye and cannot be refused.

Other Policies:

Cell Phone Policy: During your appointment we kindly request that you refrain from cell phone use. If you need to take a phone call we ask that you do so in the atrium area located right outside of the office.

Food/ Beverages in the Back Office: Due to testing equipment and electronic devices that are used to complete your eye exam, we ask that all beverages and/or food be enjoyed only in the front waiting are. We only allow bottled water to be taken back with you during your appointment.

I acknowledge that I have received and agree to the office and financial policies. Signature:

_____ Date: _____

FAGADAU HAWK & SWANSON M.D. | Vision. For Life.

FINANCIAL POLICY:

Fagadau, Hawk & Swanson, M.D. 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 Dr. Fagadau, Dr. Hawk, Dr. Swanson & Dr. Mirza. However, our doctors are not contracted, nor participating with discount vision plans. (ex: VSP, Spectera, Davis Vision) 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 & Mirza. (ex. Repeat testing, refractions, & surgery kit fees)**
- **Patients who schedule appointments for a refraction will be billed the refraction fee of $60 and an office visit fee of $40. This will be due at the time of service.**
- **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. Please contact your insurance company to confirm if a referral is required by your insurance company to see a specialist.**
- **Any outstanding balances more than 120 days will be forwarded to our collection agency unless payment arrangements have been made with our billing department. 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.

FAGADAU HAWK & SWANSON M.D. | Vision. For Life.

Health History Form

Patient Information			Today's Date:	
Legal Name			Treating Physician(s): (ex. PCP or Intenist)	
Date of Birth / Age			Pharmacy & Phone #	
Occupation			Allergies (list all): Medications or Latex	
Interests / Hobbies				
Date of Visit				

Eye History:	Right	Left
Cataract		
Glaucoma		
Lazy eye/Amblyopia		
Iritis		
Cataract surgery		
Other eye surgery		
Eye injury		
Macular Degeneration		
Retinal problems		
Refractive surgery		
Keratoconus		
Dry Eye		

Medications (list all):Including Eye med

Ocular:

Systemic:

Over the Counter:

Received Flu Vaccine? **Y or N**

Received Pneumococcal Vaccine? **Y or N**

Are you pregnant? **Y or N**

Major Surgery/Procedures:

Ocular:

Other:

MEDICAL HISTORY

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

Do you have or have you ever had:

Cardiovascular	Yes	No	When?
Heart Attack			
Chest Pain			
High Cholesterol			
Congestive Heart Failure			
Irregular Heart Beat			
High Blood Pressure			
Low Blood Pressure			
Pacemaker			
Defibrillator			
Respiratory			
Asthma			
Emphysema			
COPD			
Bronchitis			
Do you sleep with a CPAP?			
Genitourinary			
Incontinence:			
Prostate Treatment (ever used):			
Proscar, Flomax, Tamsulosin			
ENT			
Seasonal Allergies			
Allergy Shots?			
Cancer			
Type?	Year:		
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/Migraine			
Dementia / Alzheimer's			
Hard of Hearing / Deaf			
Musculoskeletal			
Osteo / Rheumatoid Arthritis			
Joint Pain			
Gastrointestinal			
Crohn's / Ulcerative Colitis			
Hepatitis A / B / C or Jaundice			
Immunologic			
HIV/AIDS			
Hem/Lymph			
Anemia / Bleeding / Bruising			
Auto Immune D/O			
Lupus			
Sjogren's Syndrome			

Family History	Yes	No	Who?
Diabetes:			
Glaucoma:			
Macular Degeneration:			
Retinal Detachment:			
Keratoconus:			
Skin Cancer:			

Other Medical Conditions Not Listed

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**
Eyes feel irritated	**yes**	**no**
Do your eyes sting?	**yes**	**no**
Are any of the symptoms worse in the morning?	**yes**	**no**
Do you have a thyroid disease?	**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:

Do they pop out?	**yes**	**no**
Blepharoplasty	**yes**	**no**
Chemotherapy	**yes**	**no**
Facial Surgery	**yes**	**no**
Lasik	**yes**	**no**
PRK	**yes**	**no**
Hysterectomy	**yes**	**no**
frequently than expected?		
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**

FOR CONTACT LENS WEARERS ONLY:

Are they colored?	**yes**	**no**
Do they stick to your eyes?	**yes**	**no**
Do they get protein deposits?	**yes**	**no**
Do you sleep in them?	**yes**	**no**
Do you have to order them more	**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**

FAGADAU HAWK & SWANSON M.D. | Vision. For Life.

Patient Preference Regarding Communication of Health Information

The purpose of this document is to protect your privacy.

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, _____ (parent/legal guardian) hereby give my permission for the release of Medical information regarding appointments and questions regarding conditions and treatments for my minor child _____ DOB _____ to the following person (s) :

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 and/or Text

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

Email is required if you would like to receive updated appointment information.

_____ Check here if you choose to be contacted by email or text.

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

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 phone 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: _____

FAGADAU HAWK & SWANSON M.D. | Vision. For Life.

PREAUTHORIZATION TO TREAT MINORS CONSENT FORM

DATE OF SERVICE: _____

FOR FAMILIES WHO ARE ONGOING PATIENTS OF:

_____

(Pediatrician or Health Care Facility)

It may be more convenient to have prior authorization in place so that medical care may be delivered directly to minors if a parent or legal guardian cannot be present prior to treatment. Please review the following authorization for treatment and complete the information if you want to authorize such treatment for your minor child(ren) in advance. Be advised that protected patient health information may be shared with the proxy to whom the right to consent has been delegated to facilitate informed decision making.

AUTHORIZATION

I (we) have the legal right to preauthorize this facility to deliver medical treatment to my /our child(ren).

I (we) request and authorize_____ (ophthalmologist and/or contact lens specialist in the healthcare facility)

And its personnel to deliver medical care to my (our) child(ren) listed below:

Name: _____DOB: _____
Name: _____DOB: _____

LIMITATIONS OF TREATMENT (choose one):

_____ I do not want to limit the type of treatment. I will let the ophthalmologist decide what treatment my child needs that day. The providers of care will **NOT** do any procedure(s) without the presence of a parent or guardian.

_____I want to limit the treatment. The ophthalmologist cannot:
_____

PLEASE CONTACT ME IF YOU HAVE QUESTIONS

I want you to call me if my child has a serious condition.

Parent Name: _____ Cell Phone: _____

EXECUTED BY: _____ DATE: _____
(Parent or Legal Guardian)

This consent form will expire 90 days from date of service