

Patient Information

Name: _____ Sex: F M
Address: _____ Marital Status: S W D M
City: _____ State: _____ Zip: _____ Date of Birth: _____
SS#: _____ Co-Pay _____ Age: _____ Race: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Cell Carrier: _____ E-mail: _____

Person to notify in case of emergency:

Name: _____ Phone #: _____ Relation: _____

Responsible party

Name: _____ SS#: _____
Address _____ City/State/Zip _____ Phone # _____

Referring source: _____

1. List any family members that are patients here: _____
2. Nature of problem(s): _____
3. Employed by: _____

AUTHORIZATION TO RELEASE INFORMATION: I authorize INSTITUTE FOR TOTAL EYE CARE, P.C., to release any medical information necessary to process health insurance claims. I also authorize payment directly to the physician of the surgical and/or medical benefits, if any, otherwise payable to me for this service as described. **ACKNOWLEDGEMENT OF RESPONSIBILITY:** I understand that I am financially responsible to you for all professional services rendered, including but not limited to those services which are not covered by Blue Shield PMD/Medicare programs or other private and commercial insurance programs (co-payments, refractions, and/or deductibles). I also understand that if I have an HMO insurance and do not obtain the proper referral number prior to my visit, that I am financially responsible for any charges incurred. I understand that payments for these charges are due at the time of service. **AGGREEMENT TO PAY:** I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs. Also, I acknowledge receipt of ITEC's "Notice of Privacy Practices" and further authorize ITEC, its employees and or agents, to contact me at any/all phone numbers, including my cell phone I have provided and to discuss with any family members or care givers anything about my private health information insurance and payments.

You agree, in order for us to service your account or to collect monies you may owe our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

PATIENT/PARENT/GUARDIAN-SIGNED _____ **Date:** _____

04/04/17

Please Complete Entire Form Including Medication List

NAME: _____

CHART # _____

DATE: _____

YOUR PRIMARY CARE PHYSICIAN: _____

REVIEW OF SYSTEMS/PAST MEDICAL HISTORY:

DO YOU NOW HAVE/HAD PROBLEMS WITH ANY OF THE FOLLOWING? IF YES, EXPLAIN:

EYES ☐ NO ☐ YES _____
EARS, NOSE, THROAT ☐ NO ☐ YES _____
HEART, BLOOD, VESSELS,
HIGH BLOOD PRESSURE ☐ NO ☐ YES _____
LUNGS/ BREATHING ☐ NO ☐ YES _____
STOMACH, INTESTINES, LIVER ☐ NO ☐ YES _____
KIDNEYS, BLADDER, GENITAL ☐ NO ☐ YES _____
MUSCLES, JOINTS ☐ NO ☐ YES _____
SKIN / BREASTS ☐ NO ☐ YES _____
BRAIN, SPINAL CORD, NERVES ☐ NO ☐ YES _____
PSYCHIATRIC ☐ NO ☐ YES _____
DIABETES, THYROID ☐ NO ☐ YES _____
BLOOD PROBLEMS, SWELLING ☐ NO ☐ YES _____
ALLERGIES, IMMUNE ☐ NO ☐ YES _____
OTHER ☐ NO ☐ YES _____

PAST SURGICAL HISTORY: _____

PREVIOUS EYE PROBLEMS OR SURGERIES: _____

ARE YOU CURRENTLY WEARING: GLASSES? _____ SOFT CONTACTS? _____ HARD CONTACTS? _____
ARE YOU INTERESTED IN SOFT CONTACTS? _____ HARD CONTACTS? _____

MEDICATIONS YOU ARE TAKING: _____

DRUG ALLERGIES: _____
HAVE YOU EVER HAD A PNEUMONIA VACCINE?: ☐ NO ☐ YES
HAVE YOU HAD AN INFLUENZA (FLU) VACCINE THIS YEAR?: ☐ NO ☐ YES

SOCIAL HISTORY: MARITAL STATUS: ☐ M ☐ S ☐ W ☐ D
TOBACCO USE: ☐ NO ☐ YES - AMOUNT _____
DRINK ALCOHOL: ☐ NO ☐ YES - AMOUNT _____
CURRENT OCCUPATION: _____

FAMILY HISTORY - EYES: GLAUCOMA ☐ NO ☐ YES _____
CATARACTS ☐ NO ☐ YES _____
MACULAR DEGENERATION ☐ NO ☐ YES _____
OTHER ☐ NO ☐ YES _____

FAMILY HISTORY - GENERAL HEALTH:
HEART DISEASE ☐ NO ☐ YES _____
HIGH BLOOD PRESSURE ☐ NO ☐ YES _____
DIABETES ☐ NO ☐ YES _____
CANCER ☐ NO ☐ YES _____
OTHER ☐ NO ☐ YES _____

IF YES TO ANY OF THE ABOVE, EXPLAIN RELATIONSHIP TO PATIENT.

OFFICE USE ONLY

COUNSELLED ON TOBACCO
USE: ☐ NO ☐ YES

REVIEWED BY:

TECH _____

PHYSICIAN _____



Institute for Total Eye Care, P.C.

A PROFESSIONAL CORPORATION

James D. Izer, M.D.
Elizabeth K. Murphy, M.D.

Richard M. Murphy, O.D.
Ashley H. Ware, O.D.

Consent to the Use and Disclosure of Health Information For Treatment, Payment, or Healthcare Operations (TPO) Roger R. Yonker, Jr., Administrator

I, _____, understand that as part of my health care, Institute for Total Eye Care, P.C. (ITEC) originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment, which may include discussion with family members for emergency or medical necessity.
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals. If you wish to make any restrictions, please do so in the space below.

☐ I agree to allow Institute for Total Eye Care, P.C. (ITEC) to call for any matters related to my healthcare and leave a message if I am not available, either a voice message or with the person that answers the phone.

☐ I agree to allow Institute for Total Eye Care, P.C. (ITEC) to fax all documents pertinent to my healthcare to those entities that are part of my TPO. I understand that faxed documents cannot be encrypted and can be at risk for unintentional disclosure of my health and personal information.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures.* I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Institute for Total Eye Care, P.C. (ITEC) is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Institute for Total Eye Care, P.C. (ITEC) reserves the right to change their notice and practices prior to implementation, in accordance with section 164.520 of the Code of Federal Regulations.

* My signature indicates I understand the terms of this consent form.

Patient's Signature

Date

* **The Notice of Information Practices entitled Notice of Privacy Practices is located in the waiting room.**

** **Expiration date is 2 years from date signed**

4255 Carmichael Court North
Montgomery, Alabama 36106
(334) 277-9111
1-800-255-3012
FAX (334) 270-9359

Website: www.eyes-itec.com
E-mail: itecinfo@eyes-itec.com

8007 U.S. Highway 231
Wetumpka, Alabama 36092
(334) 567-9111
FAX (334) 567-8004



I, _____, give permission to my health care medical services provider to disclose and release my protected health information described below to:

Name(s):

Relationship:

Health Information to be disclosed (Check all that apply)

- ☐ My complete health record (including but not limited to diagnoses, lab tests, Prognosis, treatment, and billing, for all conditions) **OR**
☐ My complete health record as above, with the exception of the following information:

The authorization shall be effective until (Check one):

- ☐ All past, present, and future periods, **OR**
☐ Date or event: _____
unless I revoke it (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

Printed Name of Individual Giving this Authorization

Signature of Individual Giving this Authorization

Date