Susan H. Eiland, M.D. PC.

- **Patient Information**

Name:_____ DOB:_____ Sex:_____ Race:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone: Primary _____ Secondary _____

SS#:_____ Email Address:_____

Employer:_____ Address:_____ City:_____ State:____ Zip:_____

Referring Physician:_____ Location:_____Phone:_____

Primary Care Physician:_____ Location:_____Phone:_____

- **Spouse's Information**

Name:_____ DOB:_____ SS#:_____

Phone (hm):_____ (wk):_____ (cell):_____

- **Insurance Information**

Company:_____ Name on Card:_____ Relationship to pt:_____

Policy holder's DOB:_____ SS#:_____

- **Emergency Contact**

Name:_____ Relationship to patient:_____

Phone (hm):_____ (wk):_____ (cell):_____

- **Pharmacy Information**

Name:_____ Address:_____ City:_____ Zip:_____

Phone:_____ Fax:_____

- **Contact Preference (Please check all that apply)**

Telephone message ___ Email ___ Text message ___

In the event the account is not paid in full within **90 days**, the undersigned agrees to pay all costs of collections (up to 33%) as well as any reasonable attorney's fees, and agrees to pay the legal rate of interest on the account until paid in full, and hereby waives all rights of exemption under the Constitution and laws of the State of Alabama.

Patient Signature:_____ Date:_____

Notice of Privacy Practices Acknowledge

Susan H. Eiland, M.D. Amanda Dinsmore, M.D. Lynne S. Stevens, O.D.

I, _____ acknowledge I have received a copy of the notice of privacy practices.

_____ _____ _____

Patient Signature Relationship to patient Date

Revised 05/25/2017

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date: _____ Date of last eye exam: _____

Do you wear **glasses**? YES NO

Do you wear or have you ever worn **contact lenses**? YES, in the past YES, current wearer NO

List any **medications** you are currently taking: (prescription medications, vitamins, herbal supplements and drops):

_____

_____

_____

Do you have any **allergies** to any medications: Yes No If YES, list the medications _____

_____

Circle all **major illnesses** you are being treated for: High Blood Pressure Diabetes High cholesterol Heart disease Stroke Thyroid problems Lupus Arthritis Asthma COPD Acid reflux Hepatitis HIV/AIDS Seizures Anxiety Depression Seasonal allergies Cancer List any others: _____

Have you ever had an eye injury? Yes No If YES, which eye, describe injury _____

Have you ever had any eye surgeries? Yes No If YES, list surgeries and year of surgery: _____

_____

Have you ever had any surgeries? Yes No If YES, list all surgeries you have had and year they were performed:

_____

_____

_____

Are you currently experiencing any eye symptoms? Please circle all that apply. Eye Pain Blurred vision Halos Eyelid crusting Flashes of light Floaters Discharge Light sensitivity Double vision Decreased vision

Family history: Has anyone in your family had any of the following diseases (e.g.: aunt, uncle, grandparent, mother, father, etc.). Please CHECK YES or NO & LIST WHO in your family has had the disease.

Or Family history is UNKNOWN. (Please circle if applicable)

DISEASE	YES	NO	FAMILY MEMBER
Amblyopia			
Blindness			
Cataracts			
Crossed Eyes			
Diabetic Retinopathy			
Glaucoma			
Macular Degeneration			
Retinal detachment			
Cancer			
Diabetes			
Heart disease			
High blood pressure			
Stroke			
Other:			

MEDICAL HISTORY QUESTIONNAIRE

Social History

Do you drink alcohol? YES NO If YES (circle one of the following): Rarely Socially

Do you smoke? YES NO If YES, how much? _____ How many years? _____

Do you drive? (Please circle) YES NO

Who do you live with? (Please circle)

Alone With Spouse With Spouse and kids In nursing home With family

OTHER: please specify _____

Are you married? (Please circle) YES NO

What is your current job? _____, or Are you retired? (Please circle) YES NO

Do you currently have any problems in the following areas? If YES, please provide additional information.

	Yes	No	Details
CONSTITUTIONAL (fever, weight loss, weight gain, fatigue)			
EARS, NOSE, THROAT (hard of hearing, sinusitis, chronic cough, dry mouth, etc.)			
CARDIOVASCULAR (hypertension, high cholesterol, heart disease, irregular rhythm, blocked arteries)			
RESPIRATORY (wheezing, short of breath, COPD, etc.)			
GASTROINTESTINAL (GERD, upset stomach, diarrhea, constipation, hernia, ulcers, etc.)			
GENITOURINARY (painful or frequent urination, impotence, etc.)			
OB-GYN (currently pregnant or breast feeding)			
MUSCULOSKELETAL (joint stiffness, swelling, arthritis)			
SKIN (growth, rashes, skin cancer, etc.)			
NEUROLOGICAL (headache, migraine, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, schizophrenia)			
ENDOCRINE (diabetes, thyroid problems, etc.)			
BLOOD/LYMPH (sickle cell, anemia, bleeding disorder)			
ALLERGIC/IMMUNOLOGIC (autoimmune diseases, seasonal allergies, sneezing, redness, itching, swelling, etc.)			

Patient signature _____ *Date* _____

Physician's signature _____ *Date* _____

Our Financial Policy

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. Payment is due at the time of service unless arrangements have been made in advance by our staff. We accept cash, check or Visa,Mastercard/AMX/Discover. Payments also refer to copays, deductibles or any non-covered services that are rendered to you on your visit today.

2. Please keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim, if we are contracted with your carrier and if you assign the benefits to the doctor, --- in other words, if you agree to have your insurance company pay the doctor directly. Otherwise, you will be responsible for filing any necessary claims to your carrier and paying the doctor at the time of your visit. If we do file the claim to your carrier and they do not pay the practice within a reasonable period of time, we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.

3. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them and you are required to pay your copayment/deductible or non-covered services at the time of your visit.

4. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

5. We will bill your insurance company for all services provided in the hospital. You are responsible for any balances due.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

_____ _____

Signature of patient (or responsible party, if minor) Relationship to the patient

_____ _____

Please print the name of the patient. Date

Medicare Part B

EXTENDED PATIENT SIGNATURE AUTHORIZATION

TO COMPLETED BY PROVIDERS OF SERVICE – Please PRINT or TYPE

Provider's Name (If you are a DMT supplier, please complete certification at bottom of page)	Provider's I.D. Code
Susan H. Eiland, M.D.	
Provider's Address (Street, City, State, ZIP Code)	
2700 10th Avenue S. Ste. 404, Birmingham, AL 35205	

TO COMPLETED BY BENEFICIARY OR AGENT – Directions For Payment Of Benefits And Release Of Medical Information

STATEMENT FOR PAYMENT OF MEDICARE BENEFITS	I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Susan H. Eiland or to Susan H. Eiland, MD, PC for any services or items furnished to me by the physician or supplier. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.
**********	
STATEMENT FOR PAYMENT OF MEDIGAP BENEFITS	I request that payment of authorized MEDIGAP benefits be made either to me or on my behalf to _____ for any services furnished to me by the physician/supplier. I authorize any holder of medical information about me to release to (name of MEDICAP insurer) _____ any information needed to determine these benefits or the benefits payable for related services.

X _____ Signature of Beneficiary or person signing for Beneficiary

X _____ Date signed

Address of Person Signing For Beneficiary (Street, City, State, Zip Code)	Relationship Of Agent To Beneficiary

Reason Beneficiary Is Unable To Sign

IMPORTANT INFORMATION FOR PHYSICIANS

In submitting claims under this procedure, PHYSICIANS undertake:

1. To complete and submit promptly the appropriate Medicare billing form for all services covered by the request for payment – even those in which the physician has not accepted assignment.
2. To incorporate, by stamp or otherwise, information to the following effect on any bills they send to Medicare patients: "DO NOT USE THIS BILL FOR CLAIMING MEDICARE BENEFITS. A CLAIM HAS BEEN OR WILL BE SUBMITTED TO MEDICARE ON YOUR BEHALF." This requirement is necessary to prevent patients from submitting duplicate claims.
3. To cancel the authorization on request by the patient.
4. To make the patient signature files available for carrier inspection upon request.

IMPORTANT INFORMATION FOR SUPPLIERS

1. Only use the extended patient signature authorization for assigned claims.
2. Renew the patient signature agreement if a new item is rented or purchased.
3. Place alongside the beneficiary's signature the following statement: "RESPONSIBLE FOR OVERPAYMENT ON ASSIGNED CLAIMS ACCEPTED."

DURABLE MEDICAL EQUIPMENT SUPPLIERS AGREEMENT

NOTE: THE FOLLOWING STATEMENT MUST BE SIGNED BY THE DME SUPPLIER PRIOR TO AUTHORIZATION OF PAYMENT FOR RENTAL OR DURABLE MEDICAL EQUIPMENT IN ASSIGNMENT CASES.

This supplier assumes unconditional responsibility for refunding of all overpayments for assigned claims for rental of durable medical equipment that may result from the failure of the Carrier to receive prompt notice of the return of, or the end of need for the rental of equipment, or the death or institutionalization of the Beneficiary.

_____ Signature of Durable Medical Equipment Supplier

_____ Date Signed

NON-COVERED ROUTINE SERVICES POLICY

There are certain services that are necessary for the maintenance of good healthy eyes that may not be covered by your Blue Cross contract. You will be expected to pay for these services in full. We will only perform tests as requested by the physician that are necessary for your treatment and care. You will be informed of these tests before they are performed.

If you have questions about whether or not your Blue Cross contract will cover a particular service, our staff will be happy to assist you. Thank you for your understanding.

Examples of non-covered services:

- Routine eye exams
- Refraction
- Ultrasound services

Please remember that these are just examples. Each contract is different.

I have read and understand the above. If Blue Cross/Blue Shield denies payment for services rendered on _____, I agree I will be responsible for any balances on the account.

X _____ X _____

PATIENT SIGNATURE DATE

SUSAN H EILAND MD PC

Signature on File, Assignment of Benefits, Financial Agreement

Beneficiary Name *(print)* _____ Insurance ID Number _____

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Susan H. Eiland, MD,PC for services furnished me by Susan H. Eiland, MD,PC. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable 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. Susan H. Eiland, MD accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2. **SECONDARY INSURANCE:** I understand that if other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Susan H. Eiland, MD,PC, if possible or otherwise to me.

3. **RELEASE OF INFORMATION:** Susan H. Eiland, MD,PC may disclose all or any part of my medical record, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV to any health care provider for continued patient care. Susan H. Eiland, MD,PC may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

4. **OTHER INSURANCE:** I understand that Susan H. Eiland, MD,PC maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office and that Susan H. Eiland, MD,PC has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Susan H. Eiland, MD if I belong to a plan that does not appear on the above mentioned list.

5. **NON-COVERED SERVICES:** I understand that Susan H. Eiland, MD,PC's contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Susan H. Eiland, MD to obtain necessary health care service plan authorizations.

6. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Susan H. Eiland, MD,PC, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Susan H. Eiland, MD,PC for payment. If an account is sent to an attorney for collection, I agree to pay collection fees (33% at present) and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Susan H. Eiland, MD,PC. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Susan H. Eiland, MD,PC. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

7. **COLLECTIONS:** You agree, in order for us to service your account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

X _____ _____

Beneficiary Signature or Authorized Party **Date**

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and care among multiple healthcare providers.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that Susan H. Eiland, M. D., P. C. has the right to change its *Notice of Privacy Practices* from time to time and that I may contact them at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

As provided for by HIPAA, and as described in the *Notice of Privacy Practices*, Susan H. Eiland, M. D., P. C. may use or disclose my health information for treatment, payment or healthcare operations. Therefore, unless I specifically object, Susan H. Eiland, M. D., P. C. may disclose to a member of my family, a relative, a close friend, caregiver or any other person I identify, my personal information that directly relates to that person's involvment in my care.

Please list those individuals below that you would wish to use as Contacts to discuss your care needed:

Contacts: (List by name)

- Spouse _____
- Mother _____
- Father _____
- Adult Children _____
- Other _____
- Other _____
- Other _____

Printed Patient Name _____ Signature _____

Date _____

Relationship if other than patient Signature _____

OFFICE USE ONLY

attempted to obtain the patient's signature in acknowledgement on the Notice of Privacy Practices Acknowledgement, ut was unable to do so as documented below:

Reason: _____

Date: _____ By: _____