Eye Specialists of Louisville
A proud member of UofL Health Care

William R. Nunery, MD

PATIENT INFORMATION

PATIENT'S FIRST NAME | MIDDLE INITIAL | LAST NAME

STREET ADDRESS | CITY | STATE | ZIP CODE

( ) HOME PHONE | ( ) WORK PHONE | ( ) MOBILE/ALT PHONE

SOCIAL SECURITY # | BIRTHDATE | RACE | MARITAL STATUS | GENDER

PATIENT'S EMPLOYER | ( ) EMPLOYER PHONE NUMBER | PATIENT'S OCCUPATION

SPOUSE'S FULL NAME (FATHER'S FULL NAME - IF MINOR) | SPOUSE'S EMPLOYER (FATHER'S EMPLOYER - IF MINOR)

MOTHER'S FULL NAME - IF MINOR | MOTHER'S EMPLOYER - IF MINOR

EMERGENCY CONTACT (NOT LIVING WITH YOU) | RELATIONSHIP | ( ) PHONE

PRIMARY CARE/FAMILY DR NAME | CITY | ( ) PHONE

EYE DR NAME | CITY | ( ) PHONE

REFERRING DR NAME | CITY | ( ) PHONE

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME

ID NUMBER / GROUP NUMBER

NAME OF INSURED

SOCIAL SECURITY # OF INSURED

SECONDARY INSURANCE COMPANY NAME

ID NUMBER / GROUP NUMBER

NAME OF INSURED

SOCIAL SECURITY # OF INSURED

PERSON RESPONSIBLE FOR PAYMENT | RELATIONSHIP | SOCIAL SECURITY #

( ) HOME PHONE | ( ) WORK PHONE | BIRTHDATE

SIGNATURE OF PATIENT OR LEGAL GUARDIAN | DATE

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Financial Policy

Thank you for choosing Eye Specialists of Louisville to participate in your healthcare. As a patient in our practice, it is important that you are aware of our financial policies. We ask that you carefully read this notice in its entirety and have any questions answered by our staff.

Insurance Filing – Prior to your appointment, please call your insurance carrier to confirm Eye Specialists of Louisville is a provider in your specific plan. Some insurance carriers require a written referral from your primary care physician (PCP) prior to seeing a specialist. We ask that you request such a referral directly from your PCP and bring to your scheduled appointment. If you do not obtain the proper referrals or authorizations you may be responsible for all charges. Eye Specialists of Louisville will promptly file a claim with your primary and secondary insurance carriers, provided we have a copy of your current insurance card, and necessary information on file. We expect your insurance carrier to pay us within 60 days. If your insurance carrier does not pay us within the 60 day period, you will be responsible for any balance due.

Payment Policy - All co-pays are due at the time of service. If you do not have insurance or do not have your insurance card we will require $100 at the time of your appointment. We accept cash, checks, Visa and Mastercard. Payment plans may be available with prior approval. In order to be of service to all patients, we ask that you inform us of cancellations 24 hours prior to your appointment. There is a potential charge of $35 for all no-show appointments and late cancellations. Scheduled surgeries cancelled less than 2 weeks prior to surgery will incur a $200 cancellation fee.

Medical Records and Forms - If you require a copy of your medical records a fee may be charged to offset our costs. The fee is $20 for the first 10 pages plus 50¢ for each additional page. All fees are payable prior to the release of records. Government regulation limits, but allows for, these fees and requires us to obtain a Medical Records Release Authorization form prior to release of your records. If you require FMLA, disability, or forms to be completed, a fee of $25 will be charged. All fees are payable at the time of request.

Collection Policy - If your account becomes delinquent and you have made no attempt to pay your bill or contact us, the account will be turned over to a collection agency. In that event, you will be responsible for all collection costs including attorney fees, court costs and interest.

Cosmetic Services - Some of the procedures performed by Eye Specialists of Louisville are considered cosmetic in nature and are not covered by insurance carriers. Full payment for cosmetic services is required two-weeks prior to surgery. We will assist you in coordinating prepayment of cosmetic services with the surgical facilities and anesthesia departments involved in your care; however, our office can only provide an estimate of expected facility and anesthesia fees. You are encouraged to verify directly how they handle cosmetic prepayments and your expected total liability for their services.

Photography Release – I consent that photographs may be taken in connection with the medical services I receive. I understand that such photographs shall be used in my medical record and may be shared with others, including but not limited to, my insurance carrier. I also give permission for these photographs and information relative to them and/or relating to my case to be published and republished for the purpose of medical research, education or science; and I specify that such publication of the photographs will not include my name. I understand that this release remains valid unless I revoke it myself.

I authorize Eye Specialists of Louisville to apply for benefits on my behalf for services rendered. I authorize disclosure of medical information to the extent necessary to determine liability for payment and to obtain reimbursement as well as disclosure to other physicians as needed for consulting. I request that payment from my insurance company, Medicare or Medicaid be made directly to Eye Specialists of Louisville.

I have read and understand this Eye Specialists of Louisville financial policy.

_____ _____

Signature of Patient or Responsible Party Date

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HIPAA Privacy Compliance

Authorization for RELEASE or USE and DISCLOSURE Of PROTECTED HEALTH INFORMATION

Patient Name: _____ **D.O.B.** _____
(Please Print)

Name of the Physician/Practice providing information: Eye Specialists of Louisville_____

_____

Name of Person(s) and/or Organization(s) who are being authorized to receive information:

_____

_____

_____

_____

_____

Limitations to this Authorization must be identified below. If this portion of the form is left blank, it is assumed that the information authorized for released is unrestricted.

Please describe below any restrictions you wish to place on this authorization. (Restrictions might include limitations as to type of information released; specific dates or period of time involved; or a specific purpose for which the release might apply.)

_____

_____

_____

_____

As a patient I understand and accept the following statements:

I may see and copy the information described on this form if I ask for it, and I can receive a copy of this form after I sign it if I request one.

Patient Initials: _____

If my physician has initiated this Authorization I understand that in most cases I will be treated regardless of whether I sign this authorization. However, if the purpose of the Authorization is to allow research-related treatment, I understand I will not be able to get that treatment without signing this form.

Patient Initials: _____

Signature: _____ Date: _____

HIPAA Privacy Compliance

Notice of Privacy Practices

As our patient, a copy of the Eye Specialists of Louisville Privacy Practices policy will be available at any time from our reception desk, or directly from our practice office, and can be shared with you at any time upon request.

COMPLAINTS/COMMENTS

If you have any complaints concerning our privacy practices, you may also contact the Secretary of the Department of Health and Human Services, at 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201 (e-mail: ocrmail@hhs.gov).

YOU WILL NOT BE RETALIATED AGAINST OR PENALIZED BY US FOR FILING A COMPLAINT.

To obtain more information concerning this notice, you may contact our Privacy Officer:

Eye Specialists of Louisville
Attn: Patient Privacy Request
301 E. Muhammad Ali Boulevard
Louisville, KY 40202

SIGNATURE REQUIRED

Your signature is required below indicating that the entirety of the Eye Specialists of Louisville Privacy Practices policy has been shared with you. By signing you also acknowledge that an actual copy of this entire policy has been offered to you as well. This signature page will be maintained in your medical chart, and a copy will be provided to you upon request.

_____ _____

Patient Signature Date

_____

Patient Name - Printed

Oculofacial Plastic & Orbital Surgery
Medical History

Name _____ Birthdate _____ Date _____

Name of physician referring you _____

Why did the physician refer you? _____

C.C. and P.I. (For Physician Use Only)

REVIEW OF SYMPTOMS

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

	YES	NO	EXPLANATION OF PROBLEM
Skin			
Rash, nodules, etc.	☐	☐	_____
Eyes	☐	☐	_____
Loss of vision	☐	☐	_____
Blurred vision	☐	☐	_____
Distorted vision	☐	☐	_____
Loss of side vision	☐	☐	_____
Double vision	☐	☐	_____
Dryness	☐	☐	_____
Mucous discharge	☐	☐	_____
Redness	☐	☐	_____
Itching	☐	☐	_____
Burning	☐	☐	_____
Excess tearing/watering	☐	☐	_____
Eye pain	☐	☐	_____
Chronic infection of eye or lid	☐	☐	_____
Lazy or crossed eyes	☐	☐	_____
Halos around lights	☐	☐	_____
Eye injuries	☐	☐	_____
Droopy eye lids	☐	☐	_____
Ears, Nose, Mouth, Throat	☐	☐	_____
Sinus congestion, runny nose	☐	☐	_____
Chronic cough, recent cold	☐	☐	_____
Respiratory (lungs/breathing)	☐	☐	_____
Asthma, emphysema,	☐	☐	_____
Coughing blood, tuberculosis	☐	☐	_____
Cardiovascular (heart/blood vessels)	☐	☐	_____
Chest pain, increased blood pressure	☐	☐	_____
Heart attack, irregular heart beat	☐	☐	_____

History Reviewed. Additions as noted above.

_____, M.D.

	YES	NO	EXPLANATION OF PROBLEM
Gastrointestinal (Stomach/Intestine)	☐	☐	
Ulcers, blood in stools	☐	☐	
Genitourinary	☐	☐	
Genitals, kidney, bladder,	☐	☐	
Prostate, stones	☐	☐	
OB-GYN	☐	☐	
Cancer, lumps in breast, abnormal	☐	☐	
Menstrual periods	☐	☐	
Bones, Joints, Muscles	☐	☐	
Muscle or joint pain	☐	☐	
Neurologic System	☐	☐	
Convulsions, stroke, paralysis	☐	☐	
Headaches	☐	☐	
Lymphatics	☐	☐	
Lymph nodes, swelling	☐	☐	
Blood	☐	☐	
Anemia, clots, excess bleeding	☐	☐	
Allergic/Immunologic	☐	☐	
Hay fever, other allergies	☐	☐	
Psychiatric	☐	☐	
Diabetes	☐	☐	
Thyroid	☐	☐	

PAST HISTORY

List ALL medications you are allergic to.

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Have you had any problem with Anesthetics (local or general)? ☐ YES ☐ NO

If YES, please describe _____

Are immunizations up to date? ☐ YES ☐ NO

If NO, please list _____

List all surgeries, including eye surgeries and date of each.

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

List all major illness. Give approximate year of onset.

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

List all medications, including aspirin containing compounds and dosage.

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

History Reviewed. Additions as noted above.

_____, M.D.

FAMILY HISTORY – Do any family members have the following?

Disease	YES	NO	EXPLANATION OF PROBLEM
Blindness	☐	☐	_____
Corneal Disease	☐	☐	_____
Glaucoma	☐	☐	_____
Lazy or Crossed Eyes	☐	☐	_____
Macular Degeneration	☐	☐	_____
Retinal Detachment	☐	☐	_____
Arthritis	☐	☐	_____
Cancer	☐	☐	_____
Diabetes	☐	☐	_____
Lupus	☐	☐	_____
Hearth Attack	☐	☐	_____
High Blood Pressure	☐	☐	_____
Kidney Disease	☐	☐	_____
Stroke	☐	☐	_____
Thyroid Disease	☐	☐	_____
Tuberculosis	☐	☐	_____
Any Inherited Disease	☐	☐	_____
Other	☐	☐	_____

SOCIAL HISTORY

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Current Occupation? _____

Do you drive? ☐ YES ☐ NO

Do you have visual difficulty when driving? ☐ YES ☐ NO

Do you have a problem with night vision? ☐ YES ☐ NO

Do you currently wear glasses or contact lenses? ☐ YES ☐ NO

If YES, how long? _____

Do you use street drugs? ☐ YES ☐ NO

If YES, please indicate _____

Do you drink alcohol? ☐ YES ☐ NO

If YES, how much per day? _____

Do you smoke? ☐ YES ☐ NO Quit Date _____

If YES, how much per day? _____

Have you ever had intimate contact with a person who may have been exposed to or is infected with a sexually transmitted disease? ☐ YES ☐ NO

Is there any other information that you want to make certain the physician knows?

_____

_____

History Reviewed. Additions as noted above.

_____, M.D.

Office Use Only – Do Not Write Below Line

RECAP – Past Eye History/Surgery (Dates, Diagnoses, Therapy, Surgery, M.D.)

RECAP – Eye Medications, Rx, Eye, Orders

_____ _____ Eye Orders _____

_____ _____ Eye Orders _____

_____ _____ Eye Orders _____

_____ _____ Eye Orders _____

Misc. _____

_____

_____

History Reviewed. Additions as noted above.

_____, M.D.