ALABAMA VISION& HEARING CENTER

Price Kloess, M.D. | Andrew Velazquez, M.D. | Andrew Bartlett, M.D.
Brittany Mitchell, O.D. | Holly Young, O.D.

PATIENT INFORMATION

Name: ______________________________ DOB: ___________ Age:_____ Gender: M / F

Address: __________________________ City:_______________ State:______ Zip:_________

Home Phone: ________________ Cell Phone________________ Work Phone________________

Email: __________________________ SSN: ___________________

Occupation: ______________________ Status: Single /Married / Widowed / Divorced / Other

EMERGENCY CONTACT

Name: ______________________________Phone________________ Relationship___________

MEDICAL INSURANCE

Insured's Name: ____

D.O.B. ______/_____/______ Relationship to Patient: _____________ SSN: ____-____-______

Insurance Provider: ____

Contract #: _____________________________________ Group #: ________________

Secondary Insurance Company: ____

Contract #: _____________________________________ Group #: ________________

Do you have a specific vision insurance coverage plan? YES / NO

Provider: ______________________________ Insured Name__________________________

Insured SSN______________________________ Insured DOB__________________________

PLEASE READ AND SIGN THE BELOW AGREEMENT:

I understand that the charges made by the Alabama Vision& Hearing Center (AVHC) for professional services may not be covered in full by any insurance covering such services to the patient. The patient and/or party responsible for payment of fees for services rendered to the patient agrees to make in full to the AVHC in such cases. The undersigned accepts the fees charged as a lawful debt and promises to pay said fee including up to 35% of the debt for the cost of collection, in addition to attorney's fees, and court costs if necessary, waiving now and forever the right to claim exemption under the constitution and laws of the state of Alabama or any other state. I understand that I am required to pay any health insurance deductibles, co-insurance, co-payments or any other charges incurred which are not paid by insurance. I understand that Medicare, Blue Cross and other insurances may or may NOT cover refractions, after hour services or other services that the doctor feels necessary for the treatment of my condition and/or maintenance of good health. If I receive a refraction, receive care after hours or other non-covered service by my insurance today and future visits, I agree to pay for these services in full. I authorize the release of any medical information necessary to process an insurance claim and wish to receive updates in medical information via email.

ALL PAYMENTS ARE DUE AT THE TIME SERVICES ARE RENDERED.

Sign Here: ______________________________ Date: ______________

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

Request to Receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby authorize the Practice to communicate with me by the alternative means that I have listed below.

PLEASE CHECK ALL THAT APPLY

Home Phone Number: ___________________________

___OK to leave message with detailed information

___Leave message with call back numbers only

___OK to Fax to the number listed above

E-mail me at: ________________________________

___ OK to send email correspondence regarding appointments, reminders or other office related business.

Cell Number: _______________________________

___OK to leave message with detailed information

___OK to Text at the number listed above

___Leave message with call back numbers only

Other:

____

How did you hear about us? Circle one

Friend Family Newspaper Magazine Internet search Phonebook

Facebook Event Insurance Other___________________________________

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

Acknowledgement of Practice's Notice of Privacy Practices:

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

Name of Patient____ Date of Birth ______________________________

Signature of Patient/Parent/Guardian__________________________________ Date ________________________

Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain of my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my health care. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Print Name:____ Relationship:____

Print Name:____ Relationship:____

Print Name:____ Relationship:____

MEDICAL CONDITIONS

(Please check any that apply.)

CARDIOVASCULAR:
- ☐ Abnormal Valve
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Murmur

ENDOCRINE:
- ☐ Diabetes Type l
- ☐ Diabetes Type II
- ☐ Thyroid Disease

ENT:
- ☐ Deafness
- ☐ Sinus Problems

EYES:
- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Double Vision
- ☐ Dryness
- ☐ Flashes of Light
- ☐ Floaters
- ☐ Glaucoma
- ☐ Injury
- ☐ Itching
- ☐ Infection
- ☐ Poor Night Vision
- ☐ Redness
- ☐ Tearing

GENERAL:
- ☐ Fatigue
- ☐ Fever
- ☐ Loss of Appetite
- ☐ Weight Gain

GASTROINTESTINAL:
- ☐ Acid Reflux
- ☐ Cancer
- ☐ Hepatitis
- ☐ Hernia
- ☐ Ulcer

GENITOURINARY:
- ☐ Cancer
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Prostate Disease

HEMATOLOGY:
- ☐ AIDS
- ☐ Anemia
- ☐ Bleeding Disorder
- ☐ HIV

MUSCOSKELETAL:
- ☐ Arthritis
- ☐ Lupus
- ☐ Muscle Aches
- ☐ Rheumatic Disease

NEUROLOGICAL:
- ☐ Headache
- ☐ Migraine
- ☐ Seizure
- ☐ Stroke
- ☐ Vertigo

PSYCHIATRIC:
- ☐ Anxiety
- ☐ Depression

RESPIRATORY:
- ☐ Allergies
- ☐ Asthma
- ☐ Sleep Apnea
- ☐ Shortness of Breath

SKIN:
- ☐ Itching
- ☐ Rash
- ☐ Redness
- ☐ Shingles

MEDICAL HISTORY

Primary Care Physician: ______________________________ Phone #: _________________________

Pharmacy Name: ____________________________________ Phone #: _________________________

Drug Allergies: ____

Use of Alcohol: Yes / No Use of Tobacco: Yes / No

Prior Surgeries: ____

I have a Family History of (please check)**: If checked, please indicate which family member.**

____ Cancer ____ Eye Disease ____ Diabetes ____ Heart Disease

________________ ________________ ________________ ________________

Medication/Dosage:____

____

____

Have you had: **Pneumonia Vaccination Yes / No** **Influenza Vaccination Yes / No**

____

Print Name: ____

Sign Here: ____ **Date:** ___________________

Hearing Health

The Alabama Vision & Hearing Center includes a full hearing evaluation as part of the total care package that we offer our patients. During your exam, you will have a hearing screening performed ***at no charge***. If the doctor feels you need a further evaluation, we can schedule a visit with our Audiologist who specializes in hearing care.

1. Do others complain that you watch television with the volume too high? Yes No

2. Do you frequently have to ask others to repeat themselves? Yes No

3. Do you have difficulty understanding what is being said in groups or noisy settings? Yes No

4. Do you sit up front in meetings or social gatherings to understand the speaker? Yes No

5. Do you have difficulty understanding women or young children? Yes No

6. Do you have trouble knowing where sounds come from? Yes No

7. Are you unable to understand when someone talks to you from another room? Yes No

8. Have others told you that you don't seem to hear them? Yes No

9. Do you avoid family gatherings or social situations because you can't understand? Yes No

10. Do you have ringing or noises (tinnitus) in your ears? Yes No

Sign Here: ______________________________ **Date:** ______________

For Administrative Use Only

(Please Circle Frequencies Missed)

Patient Name: ______________________ Account #: ______________

______ Doctor	Pass	R	500	1000	2000	4000
______ Technician	Fail	L	500	1000	2000	4000
______ Appointment	Office:	Greystone		Mountain Brook		Shelby County

Notes____

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