Account #_____

ALABAMA VISION CENTER

Price Kloess, M.D. | Andrew Velazquez, M.D. | Andrew Bartlett, M.D. | Jessica Duddleston, M.D.
Holly Young, O.D. | Kelsey N. McCluskey, 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

Ethnicity: White/African American/Other

WERE YOU REFERRED BY ANOTHER DOCTOR? WHO? _____

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 Center (AVC) 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 AVC 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.

YES_____ NO_____ - AVC has my permission to keep my credit card on file for refunds ONLY.

Sign Here: _____ Date: _____

Account #_____

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 send reminders/follow up to the numbers listed above

Cell Number: _____
___OK to leave message with detailed information
___OK to Text at the number listed above
___ Leave message with call back numbers only

E-mail me at:
_____
___ OK to send email and/or text correspondence regarding appointments, reminders or other office related business using communication methods listed
I understand and acknowledge that communications sent via unencrypted email over an open network are inherently insecure, and there is no assurance of confidentiality of information communicated in this manner. Nevertheless, I consent to allow EyeCare Partners LLC or its affiliates to use unsecure email to communicate with me regarding my health information.

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:** _____

Account #_____

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/City: _____ 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: **(attach list if applicable)**

_____

_____

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

Print Name: _____

Sign Here: _____ **Date:** _____