Patient Health History Form

Patient Name:_____ DOB:_____ Age:_____

Reason for visit:_____

Patient Ocular History: Date of Last Exam: ___/___/___

Have you ever been diagnosed with any eye disorder: (I.e. Glaucoma, cataracts, Macular Degeneration or anything else:_____

_____

Do you wear glasses? Yes/ No Date of Prescription:_____ Use: Distance, Near, Computer

Do you wear contacts? Yes/ No Date of Prescription:_____ Type/Brand:_____

Do you sleep in your contacts? Yes/No How many hours do you wear your contacts?_____

How often do you change your contacts?_____ Solution Brand:_____

How many hours a day do you spend on the computer? _____

Patient Medical History:

Current Medication and milligram: _____

_____

Allergies to Medication:_____

Latex Allergy: Yes/No Other Allergies:_____ Smoker: Yes/No/Former How Long:_____

Health History: Please circle all that apply.

Seasonal Allergies Hypertension Heart Disease High Cholesterol Thyroid Disease Lupus Stroke Diabetes Other Health Issues (Please specify)_____

Are you pregnant or nursing? Yes or No

Family Medical History:

Hypertension: Relationship:_____

Diabetes: Relationship:_____

Thyroid Disease: High/Low: Relationship:_____

Cancer: Relationship:_____

Family Ocular History:

Glaucoma: Relationship:_____

Cataracts: Relationship:_____

Retinal Detachment: Relationship:_____

Macular Degeneration: Relationship:_____

Other Medical or Ocular history:_____

Eyes, etc. Taylor, MS

NOTICE OF PATIENT RESPONSIBILITY POLICY

FOR PATIENTS WITH INSURANCE PLANS

- **SERVICES PROVIDED WITH OR WITHOUT AUTHORIZATION**
  As a member of a vision program, I acknowledge for today's visit that I will assume full financial responsibility for services and/or material rendered to me, if for any reason, my vision plan carrier denies or does not cover my claim for these services or materials.
- **COPAYS**
  I understand that I am responsible to pay all co-payments at the time of service. Co-payments cannot be waived at any time by the providers of Eyes, etc.

FOR MEDICARE PATIENTS ONLY:

- **MEDICARE DEDUCTIBLES**
  If my insurance determines that I have not met my deductible, I understand that I will be fully responsible for payments in a timely manner, no more that 30 days after I have been notified by my insurance and/or my provider. Yearly deductibles cannot be waived at any time by the providers of Eyes, etc.
- **MEDICARE COVERAGE ALLOWANCES**
  Medicare reimburses our office at 80% of the approved amount for services. The remaining 20% is your responsibility. Our office may elect to bill you directly or bill your supplemental insurance plan.
- **MEDICARE REFRACTION INFORMED CONSENT:**
  THE REFRACTION is one of the most important parts of your eye exam today. This is the part of the exam by which the doctor will determine whether your vision can be improved in any way by a new eyeglass's prescription. The refraction is **NOT** covered by Medicare and many other insurance plans as they only cover medical services. These plans consider refraction a vision service and not a medical service. Our office fee for refraction is **$28.** Unless you have a supplemental plan that automatically covers the refraction fee, this fee is collected at the time of service. Should your plan pay us for the refraction, we will reimburse you accordingly.

Please check one:

____**I DO** want to have the refraction at this time and understand that I am financially responsible.

____**I DO NOT** want to have the refraction at this time. I understand that without the refraction, the doctor may not be able to fully assess the health and function of my eyes. As a result, I will not have a valid eyeglass prescription at the end of today's visit.

Please check one:

____**I AGREE TO PAY:** I have read the above and I acknowledge for today's visit that I will assume full financial responsibility for services and/or material rendered to me, if for any reason, my vision plan carrier denies or does not cover my claim for these services or materials.

____**I REFUSE SERVICE:** I have decided not to have the service/material rendered because the I am not willing to personally responsible for the payment.

Patient Name: (please print) _____

Patient Signature: _____ **Date:** _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____ I am a patient of Dr. Elizabeth M. Darby, Optometrist, PLLC

_____ I am a parent or legal guardian of _____ (patient's name) who is a patient of Dr. Elizabeth M. Darby, Optometrist, PLLC

I hereby acknowledge receipt of Dr. Elizabeth M. Darby, Optometrist, PLLC Notice of Privacy Practices with respect to the patient.

Name: _____ (please print)

Relationship to patient: ____ Self ____ Parent ____ Legal Guardian

Signature: _____ Date: _____

Please list any family members or other persons, if any, who we may inform about your general medical condition and diagnosis.

_____ _____

_____ _____

_____ _____

Please provide phone number where you want the receive calls about appointments, lab results, or other health information: _____. Please be aware that cell number is not secure and private.

Do we have permission to leave diagnostic test results or other health information on your answering machine/voicemail? _____ Yes _____ No

Patient Name: _____ (please print)

Signature: _____ Date: _____

Dr. Elizabeth M. Darby, Optometrist, PLLC d/b/a Eyes, etc.

504 Easel Street / P.O. Box 25

Taylor, MS 38673

Telephone: 662.234.9394 Fax: 662.234.9395

PERMISSION FOR DR. ELIZABETH M. DARBY, OPTOMETRIST, PLLC D/B/A EYES, ETC. TO RESPOND TO YOUR SOCIAL MEDIA POSTS/REVIEWS

I, _____, understand and acknowledge that due to the requirements of the Health Insurance Portability and Accountability Act (HIPAA), and the Health Information Technology for Economic and Clinical Health Act (HITECH) medical practices are not allowed to respond to any post or review I leave on their social media accounts, i.e., Facebook.

By signing this form, I grant **Dr. Elizabeth M. Darby, Optometrist, PLLC d/b/a Eyes, etc.**, its staff, and/or its physicians, permission to respond to any social media post or review I leave on any social media account they use for marketing purposes. By signing this form I understand that by granting such permission, any response that **Dr. Elizabeth M. Darby, Optometrist, PLLC d/b/a Eyes, etc.**, its staff, and/or its physicians make to my posts or reviews to their social media accounts is not a HIPAA/HITECH violation, and I will hold **DR. ELIZABETH M. DARBY, OPTOMETRIST, PLLC d/b/a Eyes, etc.**, its staff, and/or its physicians harmless.

I understand that I can rescind this permission at any time as long as I do so in writing and mail it to the address listed at the top of this form. I acknowledge that a copy of this form will remain in my chart, and is available to me upon request.

Patient Signature: _____ Date: _____

Signature of Personal Representative: _____

Authority of Personal Representative to Sign for Patient (Check one):

- o Parent
- o Guardian
- o Power of Attorney
- o Other: _____

Please Note: You are not required to sign this form. Doing so will only allow us to respond to any post or review, positive or negative, that you leave on our social media accounts.