Today's Date: _____ / _____ / _____

Name: Mr. Mrs. Miss Ms. Dr. _____
Last First MI

Date of Birth: _____ /_____ /_____ Marital Status: _____ Social Security #: _____- _____- _____

Do you live □ Alone □ With Spouse/Family □ Care Center Spouse's Name: _____

Address: _____
Street/PO Box City State Zip Code

Phone #: Cell _____ Home _____ Work _____

Email: _____ Occupation (if retired, list previous occupation)_____

Preferred Pharmacy: _____ Primary Physician: _____

How did you hear about us? (check one of the following boxes)

□ Other_____

□ Patient Referral □ Trejo's □ Good Eats Menu _____

□ Passer By □ Website □ Willis-Knighton Site □ Health Insurance

□ Yellow Pages □ User Friendly Book □ Physician Referral Name: _____

Please check the appropriate box to indicate whether you now have, or have ever had, any of the following:

YES	NO		YES	NO		YES	NO	
□	□	Glaucoma	□	□	Cataracts	□	□	MacularDegeneration
□	□	Diabetes	□	□	Thyroid	□	□	High Blood Pressure
□	□	Heart Attack	□	□	Heart Failure	□	□	Irregular Heartbeat
□	□	Stroke	□	□	Cancer	□	□	Multiple Sclerosis
□	□	HIV Positive	□	□	AIDS	□	□	Rheumatoid Arthritis

Please check the appropriate box to indicate whether your BLOOD relatives have or had any of the following:

Father	Mother		Father	Mother		Father	Mother	
□	□	Glaucoma	□	□	Stroke	□	□	High Blood Pressure
□	□	Cancer	□	□	Migraines	□	□	Retinal Detachment

Please list any surgeries you have had:

_____ _____ _____

_____ _____ _____

Please list any medications along with dosage and frequency, including over-the-counter, that you are taking:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please list any allergies to medications:

_____

Do you drink alcohol? □Yes □No If yes, how often?_____ **Do you smoke?** □Yes □No Cigarettes per day?_____

Emergency Contact Name: _____ Relation:_____ Phone #: _____

FINANCIAL AGREEMENT AND LIFETIME SIGNATURE AUTHORIZATION

▪ Bossier Eye Institute (BEI) is a privately-owned medical facility that provides medical services on a fee-for-basis. BEI relies solely on insurance reimbursement and patient payment(s) for services rendered in good faith. BEI receives no federal, state, or other third-party funding; as such, BEI does not have provision for providing on-going indigent care. The following Financial Agreement is developed in accordance with the Office of Inspector General (OIG) guidelines as well as all applicable State and Federal reimbursement guidelines.

▪ Upon obtaining a copy of your insurance card(s), BEI will verify your eligibility with your health insurance company, and BEI will submit claims for all medically necessary services to your health insurance company. Please note that payment is ultimately due from you in the event that your insurance company denies payment for any service(s); i.e. termination of coverage, coordination of benefits, non-payment of premium, etc…

▪ Copayments, deductibles, coinsurances, and any non-covered services are the responsibility of the patient. To the extent possible and feasible, all patient financial responsibilities are payable at the time of service. Not all health insurance companies publish their allowable fee schedule; therefore coinsurance percentages cannot always be accurately calculated for pre-payment. A BEI statement will be sent to you after your health insurance has processed your claim(s); the balance due will compare to the Explanation of Benefits you will receive from your health insurance company. Should you dispute any amount on your Explanation of Benefits/BEI statement, please contact your health insurance company member services for clarification of your benefits.

_____	_____	_____
Insured's Name	Insured's Date of Birth	Insured's Social Security Number
_____	_____	_____
Insurance Plan Name	Insurance ID Number	Insurance Group Number

▪ Self-Pay: In the event that (1) you are uninsured, (2) BEI does not have a participating relationship with your health insurance plan(s), or (3) you elect to have non-covered medical services (i.e. cosmetic or other services determined by your health insurance plan to be "not medically necessary", etc.) BEI accepts self-pay patients with this signed agreement that payment is due on the day services are rendered or in the case of surgical procedures, payment is due prior to the surgical procedure(s).

▪ For your convenience, BEI accepts cash, checks, money orders and credit cards. In addition, BEI offers financing options through CareCredit.

I understand all of the terms defined above; I consent to receiving treatment under the stated terms and I agree to honor all my financial obligations to Bossier Eye Institute. I authorize my insurance benefits to be paid directly to the physician/BEI. I also authorize Wally R. Nawas, MD/BEI or my insurance company to release any information required to process my claims. . My signature below constitutes my Financial Agreement and Lifetime Signature Authorization.

_____	**X**_____
Print Patient Name **Date**	**Patient Signature** **Date**
_____	**X**_____
BEI Employee Name **Date**	**BEI Employee Signature** **Date**

Failure to honor your financial obligations to BEI in accordance with this signed Agreement will result in your account being referred to Collections and possible termination of the treatment relationship in accordance with the regulations that govern ethical medical care.

PATIENT NAME: _____ DATE: _____

(Please Print Patient Name)

Bossier Eye Institute strives to maintain the highest standards in providing patient service. Bossier Eye Institute is required by the Louisiana Agency for Health Care Administration to report the following information to maintain State accreditation.

Bossier Eye Institute maintains strict privacy of you medical records and related personal information as required by the Federal HIPAA Privacy Rule. We may also use and/or disclose your information to authorized agencies in accordance with federal and state laws.

Please take a minute to enter your name and date at the top of this form and answer the two questions below:

Race (check one):

□ American Indian or Alaskan Native
□ Asian
□ Black or African American
□ Native Hawaiian or other Pacific Islander
□ White
□ Other

Ethnic Origin (check one):

□ Hispanic or Latino
□ Non-Hispanic or Latino

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION TO A DESIGNATED PERSON

This authorization allows our staff members to speak only with an individual you designate in the event you are available or if you have an adult member that helps coordinate your medical care. Please do not designate your primary care physician or other medical care givers.

_____ I do not authorize anyone to receive information regarding my medical care.

_____ I authorize my physician and the employees of Bossier Eye Institute to speak with:

Name: _____ Phone# _____

Relationship: _____ Phone# _____

Name: _____ Phone# _____

Relationship: _____ Phone# _____

This authorization will remain in effect unless changed by me while I am a patient at this office. It is my responsibility to notify this office of changes and to complete a new form. A copy of the Notice of Privacy Policies for Bossier Eye Institute is available upon request. I agree that should I desire to revoke this authorization, I will give written notice.

X_____ _____

Signature of Patient/Responsible Party **Date**