For Our New Patients

Welcome to Southern Eye Associates—Southaven!

This packet is provided to help you prepare for your upcoming visit with us. Please take a moment to fill out all information included so that we may better serve you.

Inside this packet you will find:

- Welcome letter with helpful tips and information
- Patient Registration Form
- Patient Responsibility and Assignment Form
- Patient Medical History and Questionnaire
- Notice of Privacy Practices
- Activities of Daily Living Questionnaire
- Map and Directions to our clinic

If you have any questions, feel free to speak with one of our friendly staff members by calling us at **(662) 548-2190**. Remember to bring your current medications and your insurance cards to each visit.

We look forward to serving you!

SOUTHERN EYE

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New Patient Information

SOUTHERN EYE *of Southaven*

Today's Date: _____ Your Appointment is Scheduled: _____ at _____.

Dear Patient,

Welcome to Southern Eye Associates! Your doctor has recommended a visit with us, and we are looking forward to seeing you. Southern Eye Associates works closely with your local optometrist to provide you the most advanced eye care available in a friendly and caring atmosphere.

In order to lessen your wait time before your examination, **please complete the enclosed forms and bring them with you for your appointment**:

- Patient Registration Form
- Patient Responsibility and Assignment Form
- Patient Medical History and Questionnaire

Please remember to bring:

- Your current medications that you are taking
- Your most current eyeglasses
- A referral, if it is required by your insurance (this is your responsibility)

If you are a new patient to Southern Eye Associates:

- Plan to spend approximately 2-3 hours with us. This time may vary according to the tests being performed.
- Your eyes may be dilated. Therefore, please bring a companion with you to drive you home.
- You may see more than one of our doctors at any visit. Our doctors function as a single team in order to provide you with the best possible care.
- ***For Cataract Patients: If you are a soft contact lens wearer, you need to stop wearing them 7-10 days prior to your visit. If you are a hard contact lens wearer, you need to stop wearing them 30 days prior to your visit.***

Financial Responsibility:

You are responsible for any unmet deductibles and/or co-payments at the end of your visit. If you have any questions, please do not hesitate to call and speak with one of our patient service representatives or patient account representatives. We look forward to seeing you and providing you with service you deserve!

Sincerely,

M. Cathleen Schanzer, MD
Medical Director

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Patient Registration Form

SOUTHERN EYE *of Southaven*

Chart #: _____

LAST Name: _____ FIRST Name: _____ M.I._____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____)_____ DOB: ___/___/___ Age: _____ ☐ Female ☐ Male

Cell Phone: (____)_____ E-Mail: _____

Pharmacy Name: _____ ***Pharmacy Phone #:*** _____

Pharmacy Address: _____

Marital Status: ☐ Single ☐ Married SSN:_____ Race: _____

Employer's Name: _____ Work Phone: (____)_____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Responsible Party's Name: _____ Relationship: _____

Responsible Party's Address: _____

City: _____ State: _____ Zip: _____

Resp. Party's Employer: _____ Work Phone: (____)_____

Is your insurance under your spouse, parent, or guardian? If yes, please list their DOB: ___/___/___

Emergency Contact: _____ Relationship: _____

Contact's Home Phone: (____)_____ Contact's Work Phone: (____)_____

Were you referred to Southern Eye Associates by an **Optometrist**? ☐ Yes ☐ No

If yes, what is their name? _____ Their Location: _____

Request for Care and Consent for Treatment

I am requesting medical services by **Southern Eye Associates, PLLC,** located at **5350 Poplar Avenue Suite 950, Memphis, Tennessee 38119**, and consent to such care and treatment as is ordered by the treating physician.

Authorization to Release Medical Records and Information

This authorizes you to release to **Southern Eye Associates, PLLC**, located at **5350 Poplar Avenue Suite 950, Memphis, Tennessee 38119,** their agents or representatives, full and complete medical records, reports, evaluations, consultations or information (hereinafter collectively referred to as "medical records") you may have in custody concerning the undersigned patient. The undersigned represents and warrants that he/she has full authority to request said records and to agree to all the conditions recited herein.

The undersigned expressly releases and forever discharges and agrees to indemnify and hold harmless **Southern Eye Associates, PLLC**, its directors, officers, agents, employees, successors and assigns from any and all claims, damages, actions, causes of action or suits of any kind or nature whatsoever arising out of, or from, the release of any medical records pursuant to this authorization.

_____ _____ _____

Signature of Patient/Responsible Party **Signature of Witness** **Date**

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Patient Privacy Questionnaire

SOUTHERN EYE *of Southaven*

Patient's Name: _____ Chart # _____

Please list the family member(s) or other persons, if any, whom we may inform about your eye medical condition and your diagnosis (including treatment, payment, and health care operations):

_____ _____/_____
Person's Name Relationship to Patient / Telephone Number

_____ _____/_____
Person's Name Relationship to Patient / Telephone Number

_____ _____/_____
Person's Name Relationship to Patient / Telephone Number

Please print the address of where you would like your billing statements and/or correspondence from our office to be sent, if other than your home:

_____ _____ _____
Street Address City Zip Code

Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other eye care information, **if other than your home telephone**:

Phone number: (_____)_____

I am fully aware that a cell phone is not a secure and private line. _____
Your Signature

Can confidential messages (i.e. appointment reminders) be left on your answering machine or voicemail?

☐ Yes ☐ No

Pharmacy Name: _____ Pharmacy Phone #: _____

_____ _____
Signature of Patient or Guardian **Date**

_____ _____
Signature of Witness **Date**

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Acknowledgement of Receipt of Privacy Notice

SOUTHERN EYE *of Southaven*

I, _____, hereby acknowledge receipt of the Notice of Privacy Practices given to me by Southern Eye Associates, PLLC.

_____ _____

Signature of Patient/Guardian **Date**

For Office Use Only

If not signed, please note the reason why acknowledgement was not obtained:

_____

_____

_____

_____ _____

Person Seeking Acknowledgement **Date**

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your personal health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operation.

Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this would include referring you to a retina specialist.

- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.

- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.

- The practice may also disclose your PHI for law enforcement and other legitimate reasons although we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

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You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You may have the following rights with respect to your PHI.

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alterative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.

The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your Protected Health Information and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice if effective as of September 16, 2013 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with the office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Administrator for more information, in person or in writing.

Lori Jennings, Administrator
Southern Eye Associates
5350 Poplar Avenue Ste. 950
Memphis, TN 38119
(901)683-4600

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Patient Responsibility and Assignment

SOUTHERN EYE *of Southaven*

Patient's Name: _____ Chart # _____

Our office participates with **Medicare** and **Medicaid** for those services in which these two agencies cover. Just like any private insurance plan you've had in the past, **Medicare** requires you to pay a portion of your medical bills.

- **Medicare** requires that you pay 20% of your bills after you have paid your deductible. This is called your **Medicare Co-Insurance**. In order to maintain our reasonable fees, we request that you pay this 20% at the time of service unless you have a secondary insurance.
- **Medicaid** has no yearly deductible.
- **TennCare** requires a referral from your Primary Physician, depending on which type you have.
- **Private Insurance**, when it is Primary, will usually have a percentage or set dollar amount that you pay at the time of service. This is called your **Insurance Co-Pay**.

Note: You will continue to receive a statement of your account each month as long as you have an outstanding balance.

Our office will file your Primary and Secondary Private Insurance for you. If we have not received payment within 60 days after filing your Secondary Insurance, you are responsible for the balance.

Authorization to Pay Benefits to Provider:

I hereby authorize payment directly to all providers of the surgical and/or medical benefits, if any; otherwise payable to me for services rendered by **Southern Eye Associates, PLLC**.

I understand that I am responsible for any charges incurred by me or any party for whom I am legally responsible. I also agree that in the case of default of payment, I will be responsible for any costs incurred in the collection of such account, including reasonable attorney fees and court costs. I hereby waive notice of dishonor, demand, and protest. All exemptions are waived.

I, the undersigned, hereby acknowledge that it is the policy of this office that full payment be made at each visit, and I am responsible for payment to **Southern Eye Associates, PLLC** for all services rendered the above patient that are not covered by Medicare assignment, Medicaid, Workman's Compensation, or other benefits agreed by the provider of such services. I certify that the information contained herein is complete and correct. I hereby authorize photocopies of this form to be valid as the original.

Payment is due at the time of service for all deductibles, co-pays, co-insurances, and services not covered by your insurance plan.

Do you wish to pay for this visit by: ☐ Cash ☐ Check ☐ Credit Card

_____ _____ _____

Signature of Patient/Responsible Party **Signature of Witness** **Date**

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Financial Assignment and Agreement

SOUTHERN EYE *of Memphis*

1. I request that payment of authorized Medicare and/or Insurance benefits be made on my behalf to Southern Eye Associates for any services furnished me by them. I authorize any holder of medical information about me to release to the Health Care Financing Administration/Center for Medicare and Medicaid Services, its agents, or any other insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.

2. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release information necessary to secure the payment.

3. Southern Eye Associates may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which s or may be liable or under contract to for reimbursement for services rendered, and (2) any health care provider for continued patient care. Southern Eye Associates may also disclose, on an anonymous basis, any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, status, or regulation.

4. I agree that in return for the services provided to the patient by Southern Eye Associates, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Southern Eye Associates for payment. If my account is sent to a collection agency for collection, I agree to pay collection expenses if applicable. I understand and agree that if my account is delinquent, I may be charged a service fee. Any benefits of any type under any policy of insurance insuring the patient or any other party liable to the patient is hereby assigned to Southern Eye Associates. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Southern Eye Associates. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

5. I understand that any requirement for completion of insurance precertification or referral is the responsibility of the policyholder. Southern Eye Associates will assist with obtaining precertification or referral but will not assume the responsibility for obtaining precertification or referral, and therefore will not be responsible for any impact which it may have on insurance payment.

6. I agree that I have been given the opportunity to read and receive a copy of the Southern Eye Associates Notice of Privacy Practices.

_____	_____	_____
Signature of Patient	**Printed Name of Patient**	**Date**
_____	_____	_____
Signature of Guardian/Representative	**Relationship/Authority** (i.e., state law, court order, etc.)	**Date**

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ADL Questionnaire

SOUTHERN EYE *of Memphis*

Name: _____ Chart#: _____ Date: _____

Reason for exam today (in patient's words):_____

_____

What specific improvements in your daily life do you hope to gain with surgery? _____

_____

Visual Function Status

1. Do you have **difficulty** seeing street signs or to drive? ☐ Yes ☐ No
   (such as curbs, freeway exits, traffic lights, or halos and glare around lights)
2. Do you have **difficulty** seeing movies or the television? ☐ Yes ☐ No
   (such as the faces, numbers, or printing on the screen)
3. Do you have **difficulty** reading small print with good light and proper glasses? ☐ Yes ☐ No
   (such as a telephone book, newspaper, book, medicine labels, instructions)
4. Do you have **difficulty** performing handiwork? ☐ Yes ☐ No
   (such as sewing, knitting, corcheting embroidery, or other fine tasks)
5. Do you have **difficulty** with personal correspondence? ☐ Yes ☐ No
   (such as writing checks, reading bills, filling out forms)
6. Do you have **difficulty** with leisure activities? ☐ Yes ☐ No
   (such as playing card games, bingo, dominoes, or sport activities like golfing, hunting, tennis, or bowling)
7. Do you have visual **difficulty** with navigation around the house? ☐ Yes ☐ No
   (such as cooking, climbing steps or curbs, dialing the phone, or reading a watch)
8. Are you **able** to see and recognize the faces of people from a distance? ☐ Yes ☐ No
   (such as people at church, the grocery store, and clubs)
9. Are you **able** to care for yourself with your present vision? Do you live alone and wish to remain independent? ☐ Yes ☐ No

Do you have any of the following visual symptoms?

Double or distorted vision? ☐ Yes ☐ No
Glare, halos, rings around lights? ☐ Yes ☐ No
Difficulty with color perception? ☐ Yes ☐ No
Difficulty with depth perception? ☐ Yes ☐ No
Worsening/blurred vision? ☐ Yes ☐ No

_____ _____

Signature of Patient **Date**

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Record of Medical Care and Patient Questionnaire

SOUTHERN EYE *of Memphis*

Last Medical Exam: _____/_____/_____ Last Eye Exam: _____/_____/_____ Your weight: _____ lbs.

Primary Care Physician: _____ Address: _____ Phone #: (____)_____

Do have any allergies to medications? ☐ Yes ☐ No _____

If yes, please explain:_____

List **any** medications you take (including prescriptions, over the counter medications, and home remedies): ☐ None

_____

_____

List **all** major injuries, surgeries, and hospitalizations you have had in the past: ☐ None

_____

_____

List **any** of the following that you have had in the past: crossed eyes, lazy eye, drooping eye lid, prominent eyes, glaucoma, retinal disease or detachment, cataracts, eye infection, or eye injury: ☐ None

_____

_____

Review of Symptoms

Do you currently or have you **ever** had any problems in the following areas? If Yes, please explain.

Neurological:

Headaches	☐ Yes ☐ No_____	Seizures	☐ Yes ☐ No _____
Migraines	☐ Yes ☐ No_____		

Eyes:

Loss of Vision	☐ Yes ☐ No_____	Dryness	☐ Yes ☐ No _____
Loss of Side Vision	☐ Yes ☐ No_____	Redness	☐ Yes ☐ No _____
Loss of Central Vision	☐ Yes ☐ No_____	Itching	☐ Yes ☐ No _____
Distorted Vision	☐ Yes ☐ No_____	Burning	☐ Yes ☐ No _____
Blurred Vision	☐ Yes ☐ No_____	Sandy or Gritty Feeling	☐ Yes ☐ No _____
Double Vision	☐ Yes ☐ No_____	Foreign Body Sensation	☐ Yes ☐ No _____
Glare/Light Sensitivity	☐ Yes ☐ No_____	Excess Tearing/Watering	☐ Yes ☐ No _____
Halos Around Lights	☐ Yes ☐ No_____	Mucous Discharge	☐ Yes ☐ No _____
Flashes of Light/Floaters	☐ Yes ☐ No_____	Chronic Infections	☐ Yes ☐ No _____
Eye Pain or Soreness	☐ Yes ☐ No_____	Stye or Chalazion	☐ Yes ☐ No _____
Tired Eyes	☐ Yes ☐ No_____		

Patient's Name: _____ **Chart:**_____

Referring Doctor: _____ **Date:** _____

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Record of Medical Care and Patient Questionnaire (Continued)

Do you currently or have you **ever** had any problems in the following areas? If Yes, please explain.

Ear, Nose, Throat, and Mouth

Allergies	☐ Yes ☐ No_____	Hay Fever	☐ Yes ☐ No_____
Sinus Congestion	☐ Yes ☐ No_____	Runny Nose	☐ Yes ☐ No_____
Post-Nasal Drip	☐ Yes ☐ No_____	Chronic Cough	☐ Yes ☐ No_____
Dry Mouth/Throat	☐ Yes ☐ No_____		

Respiratory

Asthma	☐ Yes ☐ No_____	Chronic Bronchitis	☐ Yes ☐ No_____
Emphysema	☐ Yes ☐ No_____	Sleep Apnea/CPAP	☐ Yes ☐ No_____

Vascular

Diabetes	☐ Yes ☐ No_____	Heart Pain	☐ Yes ☐ No_____
High Blood Pressure	☐ Yes ☐ No_____	Vascular Disease	☐ Yes ☐ No_____

Gastrointestinal

Diarrhea	☐ Yes ☐ No_____	Constipation	☐ Yes ☐ No_____

Genitourinary

Genitals/Kidney/Bladder ☐ Yes ☐ No_____

Bones, Joints, and Muscles

Rheumatoid Arthritis	☐ Yes ☐ No_____	Muscle Pain	☐ Yes ☐ No_____
Joint Pain	☐ Yes ☐ No_____		

Lymphatic / Hematological

Anemia	☐ Yes ☐ No_____	Bleeding	☐ Yes ☐ No_____

Endocrine

Thyroid or Other Glands ☐ Yes ☐ No_____

Psychiatric ☐ Yes ☐ No_____

Social History

Do you use tobacco products? ☐ Yes ☐ No_____ Do you drink alcohol? ☐ Yes ☐ No_____

Do you use illegal drugs? ☐ Yes ☐ No_____

Have you ever been exposed or infected with: ☐ Gonorrhea ☐ Syphilis ☐ HIV ☐ Hepatitis ☐ None of the Above

Family History

Please note any **family members** (blood relatives, living **or** deceased) who've had the following medical conditions:

Blindness	☐ Yes ☐ No_____	Arthritis	☐ Yes ☐ No_____
Crossed Eyes	☐ Yes ☐ No_____	Lupus	☐ Yes ☐ No_____
Macular Degeneration	☐ Yes ☐ No_____	Cancer	☐ Yes ☐ No_____
Retinal Detachment	☐ Yes ☐ No_____	Heart Disease	☐ Yes ☐ No_____
Glaucoma	☐ Yes ☐ No_____	Kidney Disease	☐ Yes ☐ No_____
Cataract	☐ Yes ☐ No_____	Thyroid Disease	☐ Yes ☐ No_____
High Blood Pressure	☐ Yes ☐ No_____	Other	☐ Yes ☐ No_____
Diabetes	☐ Yes ☐ No_____		

Patient's Name: _____

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No Show Policy

SOUTHERN EYE

To our Patients:

We appreciate your choosing Southern Eye Associates for your eye care needs. As part of our commitment to you, we strive to fulfill your appointment needs.

In order to continue to meet your needs, we find that it has become necessary to implement a charge when patients fail to keep their scheduled appointment.

Effective January 1, 2012, will begin charging $25.00 for each "no show" visit.

In order for you to avoid this charge, we ask that you give us 24 hours notice if you find you cannot keep an appointment. Our appointment schedulers will be happy to work with you to reschedule you for a time that better meets your needs.

We thank you in advance for taking the time to cancel or reschedule those appointments you know you will not be able to keep. We will make every effort to accommodate your scheduling requests.

Sincerely,

The Doctors and Staff of Southern Eye Associates.

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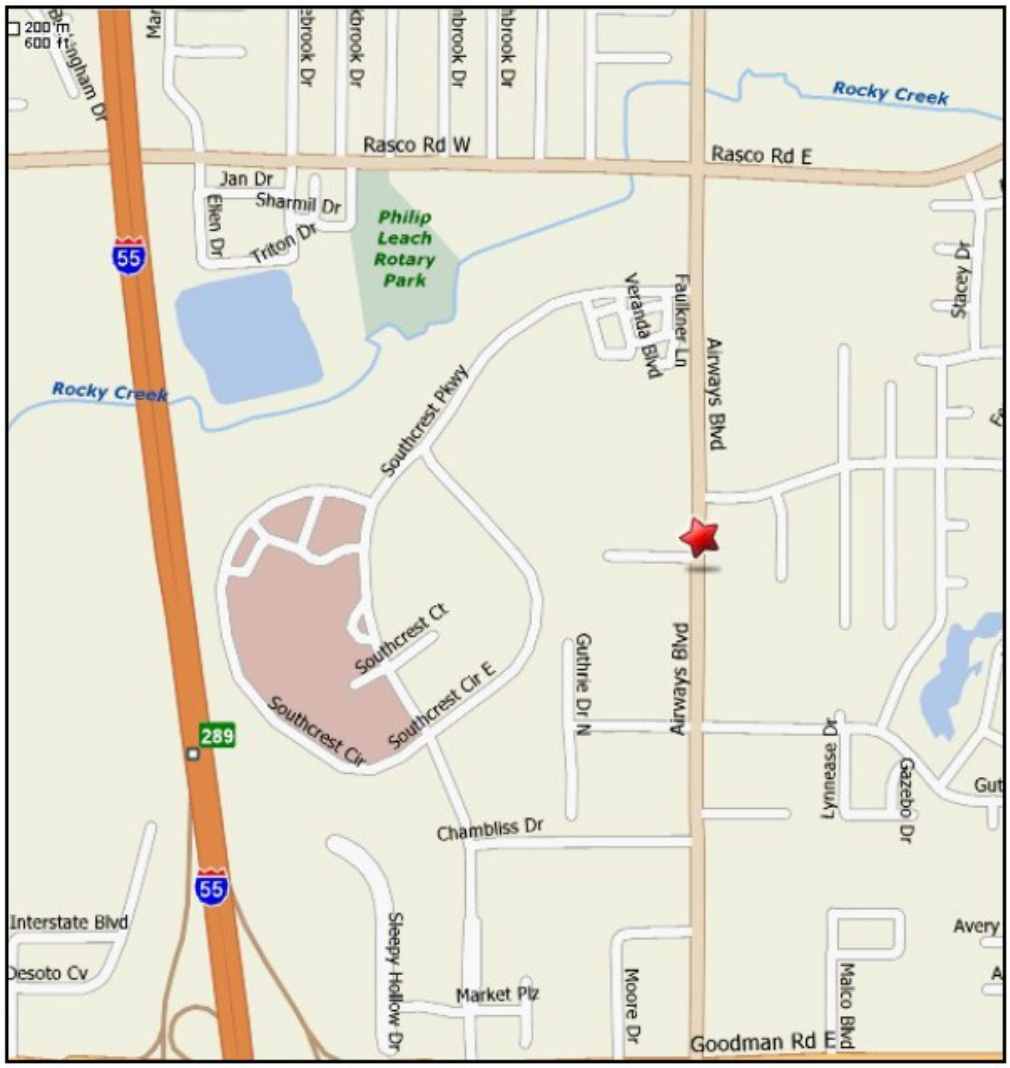
Directions to our Southaven Office



Directions from Southern Eye Associates:

1. Start at 5350 Poplar Avenue, Memphis, going East - go 0.6 mi
2. Take 1-240 West - go 7.9 mi
3. Take the South Airways Boulevard exit (Exit #23B) towards the airport- go 0.2 mi
4. Continue on Airways Boulevard exit - go 7.4 mi
5. End at 7600 Airways, Suite C, Blvd Southaven, MS 38671-5138

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