Callahan Eye PATIENT INFORMATION FORM

DATE_____ APPOINTMENT TYPE_____

NAME_____ E-MAIL_____

DATE OF BIRTH_____ OCCUPATION_____

ADDRESS_____ MARITAL STATUS:_____SEX:_____

_____ **EMERGENCY CONTACT:**

HOME PHONE_____ NAME _____

CELL PHONE_____ PHONE _____

WORK PHONE_____ RELATIONSHIP_____

RACE: __ASIAN __PACIFIC ISLANDER **ETHNICITY:** __HISPANIC
__BLACK __2 OR MORE __NOT HISPANIC
__WHITE __OTHER
__NATIVE AMERICAN

REFERRING DOCTOR/PERSON_____

SMOKING STATUS - REQUIRED (check one):

___ CURRENT EVERY DAY SMOKER ___ CURRENT SOME DAY SMOKER ___ FORMER SMOKER ___ NEVER SMOKED

CALLAHAN EYE MEDICAL HISTORY/UPDATE

Name_____Birth Date___/___/_____ Today's Date___/___/_____

WHO IS YOUR PRIMARY CARE PHYSICIAN?_____

List all **CURRENT MEDICATIONS** (prescription & over the counter):

_____

_____

List **ALLERGIES** to medications:

_____

Do you use any eye drops? **Yes** (please list) **No**

_____

Do you wear any of the following: Eyeglasses? **Yes No** Date of current prescription _____

Contact lenses? **Yes No** Date of current prescription_____; Type of lenses: Hard Soft

MEDICAL HISTORY:

Do you have a history of the following medical problems?

Circle Y or N	If yes, describe as necessary
Y N Glaucoma	
Y N Macular degeneration	
Y N Arthritis	
Y N Heart Disease	
Y N High Blood Pressure	
Y N High Cholesterol	
Y N Diabetes	
Y N Asthma/Emphysema	
Y N Stroke	
Y N Seasonal Allergies	
Y N Bleeding Problems	
Y N Kidney Disease	
Y N Autoimmune disease	
Y N Cancer	
Y N Other	

OCULAR HISTORY: Do you have any history of eye surgery or laser treatment on your eyes? **Yes No**

IF SO, PLEASE LIST:

_____

_____

_____

FAMILY HISTORY:

Has any family member had the following?

Circle Y or N	List relative(s)
Y N Glaucoma	
Y N Macular degeneration	
Y N Strabismus	
Y N Diabetes	
Y N Cataracts	
Y N Blindness	
Y N Other eye disease	

REVIEW OF SYSTEMS:

Do you currently have problems with any of the following?

Circle Y or N	If yes, please describe
Y N General – i.e. weight loss, fever	
Y N Ears/nose/throat – i.e. dry mouth, sinus problems	
Y N Lungs – i.e. cough, shortness of breath	
Y N Heart – i.e. arrhythmia, chest pain	
Y N Psychiatric – i.e. depression	
Y N Urinary – i.e. infection, frequent urination	
Y N Neurologic – i.e. migraines, memory problems	
Y N Digestive – i.e. reflux, ulcers	
Y N Musculoskeletal – i.e. joint swelling or pain	
Y N Blood/lymphatic – i.e. anemia, bleeding problems	

Signature of patient or parent/guardian_____

Callahan Eye

Claiborne, M. Callahan, M.D.
Diplomate, American Board of Ophthalmology

HIPAA PATIENT CONSENT FORM

In response to the misuse of Personal Health Information, the Department of Health and Human Services has established in a **Privacy Rule** to insure that your Personal Health Information is kept private. This rule was also established in order to provide a standard for health care providers to obtain their patient's consent for uses and disclosures of health information about the patient in order to carry out treatment, payment, or other health care operations.

We want you to know that we respect the privacy of your personal medical records and will take all reasonable measures to secure and protect your privacy. When necessary, we will provide the minimum necessary information to only those we feel are in need of your Personal Health Information, in order to provide health care that is in your best interest.

We support your full access to your medical records. You should be aware that we may have indirect treatment relationships with you that include, but are not limited to laboratories, pharmacies, and other medical offices. As such, we may need to disclose your Personal Health Information for purposes of treatment, payment and/or healthcare operations. These outside entities do not necessarily need to obtain your consent for this communication.

You have the right to refuse to consent to the use of disclosure of your Personal Health Information. This refusal must be made in writing. Under the HIPAA law, we have the right to refuse to treat you if you choose to refuse disclosure of your Personal Health Information. If you give consent to disclose your Personal Health Information, by signing this document, you can at some future time, request to refuse future disclosures of your Personal Health Information. This refusal must be made in writing. However, you may not revoke actions that have already been taken, which relied on this or a previously signed consent.

You may receive a copy of our Patient Privacy Policy upon request. You have the right to review our privacy notice, request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Please speak with our Administrative Staff if you have objections to this consent.

This will be signed electronically at Dr. Callahan's office.

Callahan Eye

Claiborne M. Callahan, M.D.
Diplomate, American
Board of Ophthalmology

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AUTHORIZATION TO DISCUSS MEDICAL CARE
WITH FAMILY MEMBERS AND/OR OTHER INDIVIDUALS

Patient's Name: _____ Date of Birth: _____

I hereby authorize Dr. Claiborne M. Callahan and staff to discuss the medical care of the patient named above with the following person(s):

NAME	RELATIONSHIP	TELEPHONE NUMBER
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

This permission may be revoked in writing or in person at any time. Line through revoked name, date, and initial. Authorization shall become effective immediately and remain in effect until one year from date of signature.

_____ _____
Signature of patient, parent, or legal guardian Today's date

Office Policies

Payment: I understand that payment is expected at the time of service. Payments may include my copay, deductible, coinsurance, prior balance, refraction fee or any non-covered service by my insurance company.

Insurance: Although Dr. Callahan participates with several different insurance plans, I understand that it is my responsibility to verify Dr. Callahan's participation with my insurance. I also understand that if Dr. Callahan is out of network with my insurance and I choose to proceed with my visit, I am assuming full responsibility for payment at the time of service. I acknowledge that the insurance cards I have presented are active and accurate. **Dr. Callahan does not participate with or file to any vision plans.** The office may provide me with a copy of my receipt to assist with my filing directly to my vison plan.

Referrals: I understand that I am responsible for obtaining a properly dated referral if required by my insurance company. If one is not obtained and present at the time of my visit, I understand that I will be responsible for full payment at the time of service or my appointment will be rescheduled.

Refraction Fee: Refraction is used to determine the best vision the eyes are capable of - also referred to as the best corrected visual acuity. It is an important part of evaluating the health of the eye. Refraction is also used to determine the lens power necessary to prescribe or change a glasses or contact lens prescription. I understand that most medical insurances do not cover refractions. The refraction fee will not be filed to my insurance, and I will be responsible for this fee at the time of my visit if Dr. Callahan decides that it is necessary. The current refraction fee is **$48.00**.

Returned Checks: I understand that a fee of **$25.00** will be added to my account for all returned checks.

Past Due Accounts: All accounts are considered past due if not paid within 90 days of service. Past due accounts may be subject to collection turnover and subject to penalties and interest and may affect my ability to schedule future appointments until my account is paid in full. The practice does not accept postdated checks.

Missed or Cancelled Appointments: I understand that a fee may be charged for missed or cancelled appointments unless notice is given at least 24 hours in advance of my scheduled appointment. Fee schedule is as follows: ***$100 New Patients***; ***$25 Established Patients; $50 In office Procedure or Test***

Surgery Charges: – I understand that I may incur surgery charges in addition to Dr. Callahan's fees from the surgery center, anesthesiologist, laboratory and/or radiologist. I also understand that I may be charged a **$350** fee if I cancel or miss my surgery unless notice is given at least one week in advance.

Patient Records: – I understand that this office will keep a copy of my medical records for a minimum of seven (7) years following the date of my last visit. Should I need to request a copy of my medical records, I understand that the request must be made in writing and that I should allow at least 48 hours for the request to be processed. I also understand that there may be a fee involved for the processing of my records.

Medical Release Authorization and Insurance Assignment: I request that payment of authorized insurance benefits be made on my behalf to Flinton Callahan II M.D. and Assoc., Inc. for any services furnished to me by Dr. Callahan. I hereby authorize this office to apply for benefits on my behalf for covered services rendered. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information, to my insurance company in order to determine insurance benefits to which I may be entitled. I may revoke this at any time in writing. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I authorize Flinton Callahan II, M.D. and Assoc., Inc. to release and/or send medical information regarding my case to other consulting and/or referring physicians.

This will be signed electronically at Dr. Callahan's office.