NAME	DATE
STREET ADDRESS APT. #	SOCIAL SECURITY #

CITY, STATE, ZIP

RACE ☐ ASIAN ☐ AMERICAN INDIAN ☐ ALASKA NATIVE ☐ BLACK OR AFRICAN AMERICAN ☐ WHITE ☐ DECLINE ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	**SPECIAL NEEDS** ☐ HEARING IMPAIRED ☐ WHEELCHAIR ☐ TRANSLATOR ☐ WALKER ☐ OTHER

BIRTH DATE	AGE	PREFERRED LANGUAGE	ETHNIC ORIGIN ☐ HISPANIC OR LATINO ☐ NON-HISPANIC OR LATINO ☐ DECLINE	SEX ☐ MALE ☐ FEMALE

HOME PHONE	CELL PHONE	MARITAL STATUS ☐ S ☐ M ☐ D ☐ W

EMPLOYER NAME/ADDRESS	POSITION/DEPARTMENT
SPOUSE'S NAME	SPOUSE'S PHONE NUMBER
EMERGENCY CONTACT NAME AND PHONE NUMBER	YOUR E-MAIL ADDRESS

BILLING

GUARANTOR (FINANCIALLY RESPONSIBLE PERSON) NAME________________________ SOCIAL SECURITY #	RELATIONSHIP TO PATIENT ☐ SELF ☐ PARENT ☐ SPOUSE ☐ OTHER
STREET ADDRESS	BIRTH DATE / / PHONE NUMBER ( ) -
CITY	STATE ZIP
SEND WORKERS COMP BILL TO	AUTHORIZED BY NAME PHONE NUMBER

REFERRAL

WHOM MAY WE THANK FOR TELLING YOU ABOUT OUR PRACTICE? PHONE NUMBER ( ) -	☐ FRIEND/FAMILY ☐ NEWSPAPER ☐ M.D. ☐ RADIO ☐ OPTOMETRIST ☐ TELEVISION ☐ YELLOW PAGES ☐ OTHER

PRIMARY CARE DOCTOR	PHONE

STREET ADDRESS	CITY	STATE	ZIP

Agreement of Responsibility

I understand that professional services are rendered to the patient and the patient is responsible for charges incurred for these services. Payment for annual deductibles and co-insurance may be collected at the time of service. I understand that I am financially responsible for charges not covered by my insurance company.

Consent to Treat

I voluntarily consent to such care and treatment as prescribed by the physician as is necessary in his/her medical judgment.

Release of Information/Assignment of Benefits

I authorize use of this form on all my insurance submissions and authorize release of information needed to process a claim to all my insurance companies. I permit a copy of this authorization to be used in place of the original. I authorize the provider to act as my agent in helping me obtain payment from my insurance companies. I understand the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement on disputed claims. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand I will receive a monthly statement for any balance due by me.

This Agreement is in effect until revoked in writing by the patient.

Signature: ___________________________________ Date: _______/________/________

Medicare Authorization Medicare No. ______________________________

I request payment of authorized Medicare benefits be made on my behalf to SureVision Eye Centers – Midwest, LLC for any services furnished me by that physician/supplier. I authorize the holder of medical information about me to release to Medicare and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and the uncovered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Medigap Authorization Insurance Co.______________________________

Policy No.________________________________

Fill out if you have a Medigap insurance policy for which you wish to assign benefits. A Medigap or Medicare Supplemental policy is a health insurance policy or other health benefit plan, offered by a private company, to those entitled to Medicare benefits. It is designed to pay certain costs that Medicare does not pay. By law, this excludes a policy or plan offered by an employer to employees or former employees, as well as a policy or plan offered by a labor organization to members or former members.

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

This Consent was signed by: ____

Signature   Printed Name – Patient or Representative

Relationship to Patient (if other than patient): ______________________________

Date: ______/______/______

Witnessed by: ____

Printed Name – Practice Representative

I agree to have my health information disclosed to the following person(s):

______________________________   ______________________

Name   Relationship to Patient

______________________________   ______________________

Name   Relationship to Patient

Name: **Date:**
Birth Date:

FAMILY DOCTOR:
Address:
City: State: Zip:
Telephone:

REFERRING DOCTOR:
Address:
City: State: Zip:
Telephone:

HEALTH HISTORY (Please check all that apply):

__ Diabetes
__ Hypertension
__ Heart Disease
__ Rheumatoid Arthritis
__ Lung Disease
__ Kidney Disease
__ Stomach/Colon Disease
__ Liver Disease
__ Seizure Disorder
__ Cancer/Lymphoma
__ Autoimmune Disease
__ Thyroid/Gland Disease
__ Skin Disease
__ HIV Positive
__ Claustrophobia
__ Other (please list)______________________________

FAMILY HISTORY (Please list family member next to all that apply):

__________ Diabetes __________ Crossed Eyes __________ Retinal Disease
__________ Glaucoma __________ Corneal Disease __________ Heart Disease

SOCIAL HISTORY (Please check all that apply):

__ Smoking/Tobacco *Currently using?* ***Yes*** ***No*** *Packs/day*_____ *Start*______ *Quit*______
__ Alcohol Use *How much?* ________________ *How often?* ________________
__ Drug Abuse

ALLERGIES:

CURRENT MEDICATIONS (Write out or attach a list):

EYE HISTORY / SURGERY OF THE EYE:

Date	Diagnosis/Surgery	Doctor

EYE MEDICATIONS/VITAMINS:

Optomap®

Retinal Exam

We all want to protect our gift of sight. That is why it is important to have annual eye health examinations. Annual check-ups not only allow Dr. Mulqueeny to improve the quality of your vision by changing the prescription of your glasses and contact lens, but it also provides the opportunity to determine the overall health of your eye – from the clear window of the eye (cornea) to the very back of the eye (the retina).

Dr. Mulqueeny highly recommends that you have an Optomap® Retinal Exam, a comprehensive method of evaluating, monitoring and helping treat various eye conditions. This previously unavailable medical technology assists Dr. Mulqueeny in viewing the retina to detect early signs of eye disease as well as diabetes, heart disease, hypertension and cancer. In these instances, individuals typically do not experience any pain or outward symptoms.

Another benefit to consider – Optomap® allows you to have your annual eye health exam without having your eyes dilated. If you have ever experienced a long delay in having your eyes return to "normal", have headaches associated with dilation or are light sensitive, this is the option that you have been searching for.

The Optomap® takes just minutes to perform. It is fast, painless and comfortable. It is particularly helpful when you return for your annual exam as it provides a permanent record of the condition of your retina, which will allow Dr. Mulqueeny to compare each year's Optomap® side by side to detect subtle changes. Early detection of retinal disorders is critical to preventing serious progression and loss of vision.

Dr. Mulqueeny strongly believes the Optomap Retinal Exam is an essential part of your comprehensive eye exam and highly recommends it for all patients once a year. If you choose the advanced technology of Optomap instead of dilation, the cost to you is $40.00. Depending on your eye health history, the doctor may be able to submit to your insurance company; however, you will be responsible for any deductible and / or co-pay. Please feel free to discuss the Optomap Retinal Scan with a technician or Dr. Mulqueeny.

I understand the above and choose to:

___ **Accept test**

___ **Decline test**

_______________________________ Patient Signature

_______________ Date

Age Related Macular Degeneration Risk Factors & Visual Performance Assessment

Name ____

DOB ____________________ Age __________ Exam Date ________________

AMD Risk Factors

(Please check all that apply)

- ☐ Age (over 50)
- ☐ Family history of macular degeneration
- ☐ Low macular pigment
- ☐ Smoker (current or prior)
- ☐ Cardiovascular disease
- ☐ Light colored eyes
- ☐ Caucasian
- ☐ Female
- ☐ Overweight

Visual Performance Challenges

(Please check all that apply)

- ☐ Night driving difficulty
- ☐ Discomfort due to glare, night or day
- ☐ Sensitivity to bright light
- ☐ Difficulty seeing objects against their background (contrast sensitivity)

FOR OFFICE USE

PATIENT RISK DETERMINATION

# of AMD Risk Factors ________

# of Visual Performance Factors ________

MPOD Score ________ L / R

☐ <.50 *Lower Range* ☐ >.50 *Higher Range*

Age-Related Macular Degeneration (AMD) is the leading cause of vision loss in adults, currently affecting more than 15 million Americans. Its effects may be permanent and irreversible however you can reduce your risk. Consuming adequate quantities of dietary nutrients that support eye health on a regular basis has been demonstrated to reduce risk. Patients not routinely consuming these nutrients may supplement their diet with vitamins formulated specifically for eye health. Our doctors strongly recommend the QuantifEye® macular pigment optical density (MPOD) measurement to determine the density of the pigment in your macula. These pigments protect your visual cells and their density can be increased in most people. The measurement is not covered by insurance however it is available for a nominal fee and our doctor feels it is very important.

Visual Performance Challenges may be related to low MPOD. Routinely consuming adequate quantities of ***zeaxanthin*** and ***lutein*** has been scientifically demonstrated to increase MPOD, thereby improving visual performance factors such as glare recovery time, decreased bright light sensitivity, improved contrast sensitivity, and improved visual acuity (ability to read more letters and lines on an eye chart). Many also report an improved ability and confidence to drive at night after increasing their MPOD. Scientific evidence suggests macular pigment density may also be important for optimal visual performance in athletes, shooters, military personnel, commercial pilots, truck drivers, etc.

QuantifEye MPOD Test: Accept ____ Decline ____