Farragut Eye Clinic

Today's Date:_____

****Patient Information:**

Name:_____ DOB: _____ Age: _____
_____*Male* _____*Female* _____*Married*

Race: __*Caucasian* __*African-American* __*Asian* __*Hispanic* __*Other* __*Decline to Answer*

Street Address: _____ City: _____ Zip Code: _____
Mobile Phone: _____ Other Phone: _____
Email: _____
Spouse/Parent name if minor: _____

****Insurance Policy Holder Information:**

Name:_____ DOB: _____
SSN: _____ Relation to patient: _____

How did you hear about our office:

REASON FOR YOUR VISIT TODAY: _____

MEDICATIONS:
List all medications you are currently taking, prescription and over-the-counter
_____
_____
_____

ALLERGIES TO MEDICATIONS:
List all allergies to medications ___ *Check here if **NO** known drug allergies*
_____
_____

Check if you wear GLASSES for: ____*Distance* ____*Reading* ____*Multifocal*
If you wear Contact Lenses: *Brand:* _____

Do you have a family history of:
____*Diabetes* ____*Glaucoma* ____*Macular Degeneration* ____*Cataracts* ____*Other*

CONSENT FOR TREATMENT:
As a patient, you acknowledge that by presenting yourself or child, you grant full authority to Drs. Desai and assistants at Farragut Eye Clinic to administer and perform any and all medications, treatments, tests, retinal scans and imaging, and glasses and contact lens fittings as is necessary for your care.

Patient/Parent Signature: _____ *Date:*_____

Farragut Eye Clinic

Patient Name: _____ **Date:** _____

Please **CHECK** if you have any of the following:

OCULAR: (with perscription correction)

___Blurry Distance Vision
___Blurry Near Vision
___Itchy Eyes
___Cataracts
___Glaucoma
___Glasses
___Other
___Tearing
___Redness
___Light Sensitivity
___Strabismus
___Eye Injury
___Contact Lenses
___Eye Pain
___Dry Eyes
___Macular Degeneration
___Amblyopia
___Eye Surgery
___Retina Problems

OVERALL HEALTH

___Pregnant
___Cancer
___Other

EAR, NOSE, THROAT

___Sinus Problems
___Hearing Problems
___Other

CARDIOVASCULAR

___High Blood Pressure
___High Cholesterol
___Stroke
___Other
___Heart Disease

RESPIRATORY

___Asthma
___Cigarette Smoker
___Other

GASTROINTESTINAL

___Acid Reflux
___Colitis
___Other

MUSCULOSKELETAL

___Arthritis
___Multiple Sclerosis
___Other

PSYCHIATRIC

___Anxiety
___Attention Deficit Disorder
___Other

ENDOCRINE

___Type I Diabetes
___Thyroid Abnormalities
___Other

___Seizure

NEUROLOGICAL

___Headaches / Migraines
___Other

SKIN

___Eczema
___Rosacea
___Other

ALLERGIC / IMMUNOLOGICAL

___Drug Allergies
___Lupus
___Environmental Allergies
___Sjogren's Syndrome
___Rheumatoid Arthritis
___Other

Farragut Eye Clinic

About Your Insurance

There are two types of health insurance that will help pay for your eye care services and products. You may have both and our practice accepts both:

1. **Vision Care Plans** (such as VSP and EyeMed)
2. **Medical Insurance** (such as BCBS and Medicare)

* Vision care plans ONLY cover routine exams and may cover some materials (such as glasses or contacts). Vision plans only cover a basic screening for eye disease. They do not cover diagnosis, management or treatment of eye diseases.
* Medical insurance must be used if you have any eye health problem or systemic health problem that has ocular complications. Your doctor will determine if these conditions apply to you, but some are determined by your case history.
* If you have both types of insurance plans it may be necessary for us to bill some services to one plan and other services to the other. We will use coordination of benefits to do this properly and to minimize your out-of-pocket expense.
* We will bill your insurance plan for services if we are a participating provider for that plan. We will try to obtain advanced authorization of your insurance benefits so we can tell you what is covered. If some fees are not paid by your own plan, we may bill you for any unpaid deductibles, co-pays or non-covered services as allowed by the insurance contract.
* While Farragut Eye Clinic is happy to file my insurance for me, I understand I am responsible for all co-payments and balances.

Insurance Signature on File

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits and I authorize payment of these benefits directly to Farragut Eye Clinic on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in item 9 of the CMS-1500 Claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

By signing below, I certify that I have read and understand all of the above.

_____ _____

Patient Signature (guardian if under 18) **Date**

Farragut Eye Clinic

11232 West Point Drive, Ste A., Knoxville, TN 37934

(865) 777-2020

HIPPA CONSENT FORM

Dr. Milind Desai, Dr. Lina Desai, and Farragut Eye Clinic provides this Consent to Comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your protected health information is kept private.

This is a summary of and consent for the privacy practices and patient care at Farragut Eye Clinic and serves as a condensed version of our Notice of Privacy Practices. You have the right to review our Notice before signing this Consent upon request. The terms of our Notice may change and you may obtain a revised copy by contacting our office.

If you believe your privacy right has been violated, you may file a complaint with Farragut Eye Clinic or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing complaints.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

How will we disclose your information? Here are a few examples:

- For vision, medical eye treatment, and referral
- To obtain payment and file insurance
- In emergency situations
- For appointment and patient recall reminders
- To run our practice more efficiently and ensure all our patients receive quality care
- For research and education
- Prevent serious threats to health safety
- For organ and tissue donation
- For workers' compensation programs
- In response to certain requests arising out of lawsuits or other disputes.

You have certain rights regarding the information we maintain about you. The rights include:

- The right to inspect and copy
- The right to amend
- The right to an accounting of disclosures
- The right to request restrictions
- The right to a paper copy of this notice
- The right to request confidential communications

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. Drs. Desai and Farragut Eye Clinic may condition treatment upon the execution of this Consent. Additionally, by signing this form, you acknowledge by presenting yourself as a patient or child you consent for medical and eye care by the doctors and staff of Drs. Desai and Farragut Eye Clinic. You hereby grant full authority to the optometrists and their respective assistants to administer and perform any and all drugs, treatments, tests, or diagnostic procedures to you, which may be advised or necessary.

By signing below, I agree that I have read and understand the privacy policy which protects my medical information from being given out without my consent.

Patient Name: _____

Signature: _____ Date: _____

Relationship (if other than patient): _____