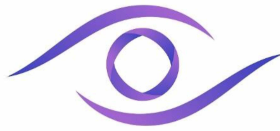

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Demographics

Name ____ Preferred Name _____________
(last name) (first name) (middle name)

Date of Birth ___________________________ Gender ________Social Security # ____________

Driver's License Number _________________________________ State Issued ______________

Address ______________________________ City ____________ State _____ Zip__________

Cell Phone _______________ Alt Phone _ ________________ Email ___________________

Preferred Appt Reminders ☐ Phone ☐ Text ☐ Email How did you hear about us? _______________

Marital Status ________________ Partner Name _____________________________________

Employer ___________________ Occupation _______________Primary Language __________

Ethnicity ☐ Hispanic/Latino ☐ non-Hispanic/Latino ☐ Decline to Answer

Race ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ White

☐ Native Hawaiian/Pacific Islander ☐ Decline to Answer ☐ Other

Emergency Contact Name and Number ____

Insurance

Primary Insurance ____

Policy/ID Number____________________________________ Group Number ______________

Name of Subscriber __________________________________ Relation ☐ Self ☐ Spouse ☐ Parent

Subscriber's Employer ________________________________ Subscriber's Date of Birth________

Secondary Insurance ____

Policy/ID Number____________________________________ Group Number _______________

Name of Subscriber __________________________________ Relation ☐ Self ☐ Spouse ☐ Parent

Subscriber's Employer ________________________________ Subscriber's Date of Birth________

Signature on File, Assignment of Benefits, Financial Agreement

Patient Name ____ Date of Birth __________________

Medicare: I request that payment of authorized Medicare benefits be made on my behalf to Genetic Eye Therapies for services rendered to me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine benefits payable for services rendered. I understand my signature requests that payment be made and authorizes release of medical information necessary for processing and reimbursement of claims. If another health insurance provider is listed as a Secondary Insurance, my signature likewise authorizes release of the information to the insurer shown.

Other Insurance: I request that payment of authorized benefits be made on my behalf to Genetic Eye Therapies for services rendered to me. I authorize any holder of medical information about me to release to my insurance provider any information needed to determine benefits payable for services rendered. I understand my signature requests that payment be made and authorizes release of medical information necessary for the processing and reimbursement of claims.

Patient is responsible for deductible balances, co-insurance, and non-covered amounts. Initial _______

Payment(s)/Co-payment(s) are due at the time service is rendered. Late fee of $50.00 will be charged if not paid in full within one month of receipt of bill. If sent to collections, an additional 5% fee will be added. Initial _______

Genetic Eye Therapies does not have the power to waive co-payments and deductibles. Initial _______

You are responsible for knowing your insurance benefits. Initial _______

Genetic Eye Therapies does not prescribe contact lenses, no prescription will be given. Initial _______

Medical forms to be filled by a physician are $30.00. FMLA packets are $50.00. Initial _______

No show policy: $50.00 no show fee. At least 24-hour notice is required to reschedule. Initial _______

____ ____________

Signature of patient or authorized representative Date

HIPAA Privacy Authorization Form

I authorize Genetic Eye Therapies (Genetic Eye Therapies, PC) to use and disclose my protected health information (PHI). Uses and disclosure for Treatment Records, Payment Information, and Healthcare Operations may be permitted without prior consent in an emergency.

This authorization for release of information covers the period of healthcare from all past, present, and future periods. This PHI may be used for medical treatment or consultation, billing or claims payment, or other purposes deemed necessary by Genetic Eye Therapies.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

If desired, please list the name(s) of the person(s) who has permission to access to your protected health information. Please also list the type of information they have access to, such as entire medical records or specific dates of service.

Name ____ Phone ____________________________________

Relationship ____ Information _______________________________

Name ____ Phone ____________________________________

Relationship ____ Information ______________________________

My signature below acknowledges the receipt of Genetic Eye Therapies privacy policies. I understand that my permission for the release of my protected health information to parties listed above will remain in effect indefinitely unless revoked in writing.

Printed name____ Date of Birth ______________________

Signature ____ Date ____________________________

Relationship to patient (i.e. patient is a minor) ____

Medical History

Patient Name: **Date of Birth:**

Reason for Visit ____

Primary Care Provider ______________________ **Phone** ____________________

Referring Provider _________________________ **Phone** ____________________

Pharmacy ______________________________ **Cross Streets** _______________

Do you have, or have you had in the past, any of the conditions listed below?

	Yes	No		Yes	No
Autoimmune Conditions	☐	☐	Heart Disease	☐	☐
Arthritis	☐	☐	High Blood Pressure	☐	☐
Asthma	☐	☐	Neuro Conditions	☐	☐
Diabetes	☐	☐	Thyroid Issues	☐	☐
GI Issues	☐	☐	Tuberculosis	☐	☐
Genetic Eye Disease					

Please specify or include any other conditions not listed above:

Please list all of the medications you are taking:

Please list all of your medication-related allergies:

Please list any surgeries you have had:

Please list any history of eye issues that you or your family have:

Smoking Status:

- Are you a current tobacco smoker? ☐ Yes ☐ No
- Are you a former smoker? ☐ Yes ☐ No

  If yes, start date: ___________ end date: ___________

Signature ____ Date ____________________

Relationship to patient (i.e. patient is a minor) ______________________________________