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(256) 880-8058

Patient Information

PERSONAL INFORMATION

LAST NAME _____ FIRST NAME _____ MI _____
TITLE _____ MISS _____ MRS. _____ MR. _____ MS. _____ OTHER NAME OF SPOUSE _____
HEAD OF HOUSEHOLD (MAILINGS, ETC.)? _____ YES _____ NO IF NO, NAME _____
STREET ADDRESS _____
CITY _____ STATE _____ ZIP _____
HOME TEL # ( ) _____ (SELF) SOCIAL SEC. # _____
BIRTHDATE (MONTH/DAY/YEAR) ____ / ____ / ____ (SPOUSE) SOCIAL SEC. # _____
EMPLOYER _____ OCCUPATION _____
DAYTIME # ( ) _____ CELL # _____ MAY WE TEXT APPOINTMENT REMINDERS __ YES __ NO
EMAIL _____ CONTACT PREFERENCE: ☐ POSTAL ☐ EMAIL ☐ TELEPHONE

PERSON RESPONSIBLE FOR BILLING

LAST NAME _____ FIRST NAME _____
TITLE _____ MISS _____ MRS. _____ MR. _____ MS. _____ OTHER DOB _____
STREET ADDRESS _____
CITY _____ STATE _____ ZIP _____
HOME TEL # ( ) _____ SOCIAL SECURITY # _____
EMPLOYER _____ OCCUPATION _____
DAYTIME # ( ) _____ TEXT ____ YES ____ NO
CELL # _____ EMAIL _____

If my account at any time becomes past due and is forwarded to your attorney's for collection, I agree to pay all costs of collection including a reasonable attorney's fee. A fee will be assessed for missed appointments.

Date _____ _____
Responsible Party Signature

INSURANCE INFORMATION

PRIMARYHEALTH INSURANCE: _____ MEDICARE _____ BC/BS OTHER _____
NAME OF INSURED: _____ INSURED'S DATE OF BIRTH _____
INSURED'S ID # _____ RELATIONSHIP _____ SELF _____ SPOUSE _____ CHILD _____ OTHER
SECONDARYHEALTH INSURANCE: _____ BC/BS OTHER _____
NAME OF INSURED: _____ INSURED'S DATE OF BIRTH _____
INSURED'S ID # _____ RELATIONSHIP _____ SELF _____ SPOUSE _____ CHILD _____ OTHER
VISION INSURANCE _____
NAME OF INSURED: _____ INSURED'S DATE OF BIRTH _____
INSURED'S ID # _____ RELATIONSHIP _____ SELF _____ SPOUSE _____ CHILD _____ OTHER

REFERRAL INFORMATION

WERE YOU REFERRED TO OUR OFFICE? _____ YES _____ NO IF YES, BY:
_____ YELLOW PAGES _____ OTHER (NAME) _____

THANK YOU!

HEALTH HISTORY

Please take a moment to complete this medical information. It will enable us to better help you. If you have any questions, please ask -

Name _____ DOB _____

Have you ever been diagnosed or treated for any of the following conditions:

Y	N	Cataracts
Y	N	Glaucoma
Y	N	Macular Degeneration
Y	N	Lazy Eye (Amblyopia)
Y	N	Eye Turn (Strabismus)
Y	N	Iritis
Y	N	Histoplasmosis or Toxoplasmosis
Y	N	Eye or Head Injury
Y	N	Corneal Dystrophy
Y	N	Retinal Detachment
Y	N	Other Eye Condition _____
Y	N	Eye Surgery
Y	N	Dry Eye

Have you ever been diagnosed or treated for any of the following:

Y	N	Diabetes/Hypoglycemia
Y	N	High Blood Pressure
Y	N	Heart Disease/Other Heart Condition
Y	N	Developmental Delays _____
Y	N	Stroke
Y	N	Thyroid
Y	N	Blood Disorders
Y	N	Hepatitis
Y	N	Cancer/Chemo or Radiation
Y	N	HIV/Venereal Disease
Y	N	Arthritis
Y	N	Epilepsy
Y	N	Multiple Sclerosis/Neurologic Condition
Y	N	Emphysema/Asthma
Y	N	High Cholesterol
Y	N	ADD/ADHD
Y	N	Current Pregnancy
Y	N	TB/Sarcoidosis
Y	N	Migraine
Y	N	Autism
Y	N	Sleep Apnea

Have any immediate family members ever been diagnosed with any of the above conditions?
Y N Please specify: _____

_____

_____

Medication can affect your vision. Please list **ALL** medications including hormones, birth control, eye drops, over the counter medications or vitamins:

_____

_____

Are you allergic to any:

Medicines? Y N If so, please list

_____

Food? Y N If so, please list

_____

Seasonal or Environmental
Y N If so, please list

_____

Tobacco Use?

☐ Never ☐ Former Smoker ☐ Smokeless

☐ Current Smoker Packs per Day _____

Alcohol Use?

☐ None ☐ Social use only ☐ 1-2 drinks daily

☐ Above average use ☐ Alcohol dependence

General Physician:

_____

Last Physical Exam:

_____

Are you wearing contacts? Y N

Preferred Language: ☐ English ☐ Spanish

Race:
☐ American Indian/Alaska Native
☐ Asian ☐ Black/African American
☐ Hispanic ☐ Indian ☐ White
☐ Native Hawaiian/Other Pacific Islander

Ethnicity:
☐ Hispanic/Latino
☐ Native Hawaiian/Other Pacific Islander
☐ Not Hispanic or Latino

The information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the Doctor/ Staff to perform any necessary services, such as dilation, that I may need during diagnosis and treatment with my informed consent.

_____

Signature Date

Insurance Information

We will need to make a copy of all Insurance Cards. Our office accepts assignment on the following insurances:

Blue Cross & Blue Shield of Alabama
Medicare
Southland National Insurance
Medicaid (For Existing Patients or Immediate Family Members of Existing Patients)
Vision Service Plan
Vision Care Plan
Principal Mutual
United Health Care

We can usually give you an estimate of what we expect your insurance will pay, the balance will be due at the time services are rendered.

You will receive a statement each month if your account has a balance. You are responsible for payment if your insurance company denies payment for any reason.

I have read and understand the above information. My signature on this form will serve as a "Signature on File" for processing claim forms and as a release of information to insurance carrier.

_____ _____

Signature Date

INDIVIDUAL PATIENT'S AUTHORIZATION

DRS. COULTER, MCROY AND ASSOCIATES

8200 Whitesburg Drive
Huntsville, AL 35802
Telephone: (256) 880-8058

Name _____ DOB _____ Social Security # _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that, if the persons or organizations I authorize to receive and/or use the protected health information described below are not health plans, health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To inspect or copy the protected health information to be used or disclosed.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations - and that the organization is not required to agree to the restrictions requested, except for requests to restrict disclosures to a health plan if the disclosure is for payment or health care operations and pertains to a health care item or service for which you have paid your health care provider out of pocket in full prior to the service.
- To refuse to sign the authorization.
- To a statement that covered entity may receive remuneration from use or disclosure of requested information.
- To a copy of this form.
- To receive notifcation in the event of a breach.

I understand that I may revoke this authorization at any time by giving written notice. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization or if the covered entity had taken action in reliance thereon. In addition, I understand that if I am giving this authorization as a condition of obtaining insurance coverage, and I revoke this authorization, the insurance company has a right to contest my claims under the insurance policy.

Specifically describe the information to be used or disclosed, such as date(s) of service, level of detail to be released, origin of information,etc.)

_____

The information will be used or disclosed for the following purpose ("at the request of the individual" is a sufficient description of the purpose when an individual initiates the authorization and does not, or elects not to, provide a statement of the purpose):

_____

I request the following restrictions to the use or disclosure of my health information:

_____

Name/Identification of person(s) to whom the covered entity may make the requested use or disclosure:

_____

Expiration date or event that relates to the individual or the purpose of the use or disclosure:

_____

Signing this authorization is not a condition of treatment. My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Individual Patient's Signature

I have had the chance to read and think about the consent of this authorization form and I agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form.

X _____ _____
Signature of Patient or Legal Representative Date

_____ I acknowledge receipt of the Notice of Privacy Practices form which details how Protected Health Information may be used and disclosed, and how I may access that information.

X _____ _____
Signature of Patient or Legal Representative Date

optos®

Retinal Exam

At **Drs. Coulter, McRoy & Associates, PC**, we pride ourselves on providing you with the best possible standard of care. Because of this we offer the Optomap® retinal exam. This non-invasive imaging test allows the doctor to see a much more detailed view of the retina than with traditional methods. The image becomes a permanent part of your medical file allowing the doctor to make important comparisons year over year. In many cases there will not be a need to dilate after this process. If the doctor determines that there is a need for dilation and/or more detailed retinal view, this will be discussed during your exam.

These images will help see early signs of many ocular conditions and systemic diseases such as:

- Glaucoma
- Age related macular degeneration
- High blood pressure
- Diabetes
- Retinal holes or detachments

The $29.00 fee for this procedure is a service that is not covered by insurance. Any questions you have about the Optomap® Retinal Exam can be directed to your doctor during your examination. The doctor strongly believes that either traditional dilation OR the Optomap® Retinal Exam is an essential part of your comprehensive eye health exam and recommends it for all patients once per year.

( ) **YES:** I understand the importance of having the OPTOMAP Retinal Exam and would like to have it performed ($29 fee).

( ) **NO:** I elect to have my eyes dilated (no additional charge). I understand that it will cause light sensitivity and may blur my vision for about 2-4 hours. Also, I should not operate heavy equipment or drive an automobile until I feel safe to accomplish these tasks. Any lasting affects such as redness and swelling or ocular pain should be reported as soon as possible.

Patient signature: _____ date: _____