

# Welcome to Bradley Eye Associates

## HIPPA COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

Your information is kept confidential and we comply with the Health Insurance Portability Act. Inactive records are professionally destroyed after 5 years.

Patient's Name: \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_-\_\_\_\_-\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State GA  \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

CELL PHONE \_\_\_\_\_ Is it ok to text you? Yes

Email \_\_\_\_\_@\_\_\_\_\_

Patient's Employer Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Patient's relationship to insured: Self  Spouse  Child  Other  \_\_\_\_\_

### If insured is different from the patient fill out below

Insured's Name \_\_\_\_\_ SS# \_\_\_\_-\_\_\_\_-\_\_\_\_

Insured's Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

### ASSIGNMENT OF BENEFITS AND/OR AUTHORIZATION FOR TREATMENT

I hereby authorize treatment of the person listed above and further authorize that any payment of benefits be made to the provider of these services on the patient's behalf. If for any reason my insurance refuses to pay the claim, I will be responsible for the full balance. In the event my account must be placed with a collection agency, I will be responsible for any collection and attorney's fees. I will notify Bradley Eye Associates in writing should I wish to revoke this authorization.

*\*The refraction is a test performed to establish how well a person can see. The results may be used to determine a prescription for glasses. Refractions are a necessary part of the eye exam. WE REGRET THAT MEDICARE WILL NOT PAY FOR THIS TEST.*

I attest that I have received and reviewed the Notice of Privacy Practices under HIPPA, and have attained a copy for my personal records.

I give my permission to Dr. Bradley and staff to release any medical information related to vision services, exam findings, insurance information, chart notes, and any information therein to other doctor(s) being referred to or requesting information and for purposes of filing insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_

RELATIONSHIP TO THE PATIENT: Self Parent Spouse Guardian (Circle one)

Patients Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Medical/Ocular/Social History				
	Self		Family	
Asthma	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
COPD	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Other breathing difficulties	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Heart condition	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Arthritis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
High Blood Pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
High Cholesterol	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Stroke	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cancer	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Leukemia	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Thyroid	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
HIV/Aids	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Glaucoma	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Macular Degeneration	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cataracts	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you smoke?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		

Any other eye conditions or eye history? \_\_\_\_\_

Any other medical conditions that we should be aware? \_\_\_\_\_

Allergies to any medications? No  Yes : Penicillin  Codeine  Sulfa Drugs  Other

\_\_\_\_\_

List any medications you are currently taking: \_\_\_\_\_

\_\_\_\_\_

List persons with whom we may discuss your medical information:

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_