Song Eye Center Dae Y. Song, M.D | Ashley R. Williams, O.D

Patient Information

In order to provide you the best possible care, please complete this form and bring it to your first appointment. All information is strictly **CONFIDENTIAL.**

Patient Information:

Name:____ Gender:_____ Age:_____

Date of Birth:_____/_______/________ Social Security Number:_______-________-____________

Home Phone: (______)_______-__________ Mobile Number: (________)________-___________

Address:_______________________________City:___________ State:___ Zip Code_______

Employer(Company):_________________________ Work Phone: (____)_______-____________

E-Mail Address:____

Emergency Contact:_____________________ Phone:(___)_____-______ Relationship:________

Spouse or Responsible Party Information:

Name:________________________________ Date of Birth:_____________________________

Social Security Number:_______-________-________ Relationship to Patient_________________

Home Phone: (____) ______-________ Mobile Phone: (____) _______-_______________________

Employer(Company):____________________________ Work Phone: (_____)_______-_________

E-Mail Address:____

Medical Insurance:

Insured's Name:_____________________________ Relationship to Patient:_________________

Social Security Number:_______-________-________ Date of Birth:______/_______/___________

Primary Insurance Name:____

Policy/Contract/I.D. No.:____

Secondary Insurance Name:____

Policy/Contract/I.D. No.:____

Do you have a specific vision insurance coverage plan? **YES/NO**

***If you are unsure please contact your insurance provider before you visit.**

Vision Insurance Name:______________ Insured's Name:_________________DOB:____/____/_____

Member ID No.:____________________________ Social Security Number:______-_______-_________

PLEASE READ AND SIGN THE BELOW AGREEMENT:

I understand that the charges made by Song Eye Center (SEC) for professional services may not be covered in full by any insurance covering such services to the patient. The patient and/or party responsible for payment of fees for services rendered to the patient agrees to pay in full in such cases. The undersigned accepts the fees charged as a lawful debt and promises to pay said fee including up to 33.33% of the debt for the cost of collection, in addition to attorney's fees, and court cost if necessary, waiving now and forever the right to claim exempt under the constitution and laws of the State of Alabama or any other state. I understand that I am required to pay any health insurance deductibles, co-insurance, co-payments or any other charges incurred which are not paid by insurance. I understand that my insurance may or may NOT cover refractions or other services that the doctor feels necessary for the treatment of my condition and/or maintenance of good health. If I receive a refraction or other non-covered service by my insurance today and future visits, I agree to pay for these services in full. I authorize the release of any medical information necessary to process an insurance claim. **ALL PAYMENTS ARE DUE AT THE TIME SERVICES ARE RENDERED.**

SIGNATURE:___________________________________ **DATE:**____________________________

PATIENT HIPAA ACKNOWLEDGEMENT AND DISIGNATION DISCLOSURE FORM

Request to Receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby authorize the Practice to communicate with me by the alternative means that I have listed below.

PLEASE CHECK ALL THAT APPLY

Home Phone Number:_____________________ **Cell Number:**________________________

__OK to leave message with detailed information __OK the leave message with detailed information

__Leave message with call back numbers only __Leave message with call back numbers only

__OK to Fax to the number listed above __OK to text to the number listed above

E-Mail me at:________________________________ **Other:**______________________________

__OK to send email corresponding appointments, reminders or other office related business

How did you hear about us? Circle one

Friend **Family** **Newspaper** **Work** **Internet Search**

Our Website **Event** **Facebook** **Insurance** **Other**________________________

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

Acknowledgement of Practice's Notice of Privacy Practices:

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

Name of Patient:______________________________ **Date of Birth:**___________________

Signature of Patient/Parent/Guardian_______________________ **Date:**_______________

Designation of Certain Relatives, Close Friends and Other Caregivers as my Personal Representative:

I agree that the practice may disclose certain health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my health care. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Print Name:_____________________________ **Relationship:**__________________________

Print Name:_____________________________ **Relationship:**__________________________

Print Name:_____________________________ **Relationship:**__________________________

(Please check any that apply)

Medical Conditions

CARDIOVASCULAR
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Murmur

ENDOCRINE
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Thyroid Disease

ENT
- ☐ Deafness
- ☐ Sinus Problems

GENERAL
- ☐ Fatigue
- ☐ Fever
- ☐ Loss of Appetite
- ☐ Weight Gain/Loss

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression

GASTROINTESTINAL
- ☐ HEPATITIS
- ☐ Cancer
- ☐ Ulcer
- ☐ Hernia
- ☐ Acid Reflux

GENITOURINARY
- ☐ Cancer
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Prostate Disease

HEMATOLOGY
- ☐ Anemia
- ☐ Bleeding Disorder
- ☐ HIV/AIDs

MUSCOSKELETAL
- ☐ Arthritis
- ☐ Lupus
- ☐ Muscle Aches
- ☐ Rheumatic Disease

RESPIRATORY
- ☐ Allergies
- ☐ Asthma
- ☐ Shortness of Breath

SKIN
- ☐ Itching
- ☐ Rash
- ☐ Redness
- ☐ Shingles

NEUROLOGICAL
- ☐ Headache
- ☐ Migraine
- ☐ Seizure
- ☐ Stroke
- ☐ Vertigo

EYES
- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Double Vision
- ☐ Dryness/Tearing
- ☐ Flashes of Light
- ☐ Floaters
- ☐ Glaucoma
- ☐ Injury
- ☐ Itching/Redness
- ☐ Infection
- ☐ Poor Night Vision
- ☐ Other____________

Medical History

Primary Care Physician:_________________________________ Phone #:_(___)_______-_________________

Pharmacy Name:______________________________________ Phone #:_(___)_______-_________________

Drug Allergies:____

Use of Alcohol: **Yes / No** Use of Tobacco: **Yes / No**

Prior Surgeries:____

Family History: (Mark **M** for mother, **F** for father, **GP** for grandparent, **B** for brother, **S** for sister, **C** for child)

_______Eye Disease _______Cancer _______Diabetes _______Heart Disease _______Stroke

_______High Blood Pressure _______Thyroid Disease _______High Cholesterol

Print Name:____

Signature:____ **Date:**____________________

SONG EYE CENTER
OFFICE POLICIES

OUR OFFICE HOURS ARE MONDAY THRU THURSDAY 8:00am-5:00pm AND FRIDAY 8:00am-12:00pm.

PLEASE GIVE US 24 HOURS NOTICE IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT, OTHERWISE YOU MAY BE SUBJECT TO A “NO SHOW” FEE OF $25.00.

PLEASE NOTIFY US OF ANY CHANGES IN YOUR PERSONAL INFORMATION SUCH AS INSURANCE, ADDRESS OR TELEPHONE NUMBERS.

PLEASE BE PREPARED TO PAY YOUR COPAY OR DEDUCTIBLE AT THE TIME OF YOUR VISIT. IF YOU ARE UNABLE TO PAY AT THE TIME OF YOUR VISIT, WE WILL NEED TO RESCHEDULE YOUR APPOINTMENT FOR A LATER DATE.

WE ACCEPT PAYMENTS BY CASH, CHECK, AND CREDIT/DEBIT CARDS.

IF YOU DO NOT HAVE ROUTINE VISION ON YOUR INSURACE POLICY, THERE MAY BE A $20 REFRACTION FEE THAT MUST BE PAID ON THE DAY OF YOUR EXAM. THIS FEE IS NOT COVERED BY ANY **MEDICAL INSURANCE**.

TO AVOID ANY MISUNDERSTANDING, PLEASE DO NOT HESITATE TO DISCUSS ANY ASPECT OF OUR OFFICE AND PAYMENT POLICIES WITH US.

I HAVE READ, UNDERSTAND, AND AGREE WITH THE ABOVE POLICIES.

SIGNATURE:_______________________________________ DATE:___________