Glaucoma and Cataract
Associates of North Carolina

PATIENT INFORMATION

Please present insurance cards to the receptionist so copies may be made.

Patient Name: _____ Home Phone: (____) _____

Address: _____ Daytime Phone: (____) _____

City: _____ St: _____ Zip: _____ Date of Birth: _____/ _____/ _____

Sex (M/F): ___ Employed (Y/N): ___ Student (FT/PT): _____ PT's Social Sec. #: _____

Email: _____

Occupation: _____ Marital Status: ____ Race: _____

Employer/School Name: _____ Phone #: (____) _____

Employer's Address: _____

_____

City State Zip Code

Person to notify in case of Emergency: _____

Relationship to Pt: _____ Phone #: (____) _____

Referred By: _____ Phone #: (____) _____

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PATIENT ACKNOWLEDGEMENT /CONSENT FORM

Use and Disclose of Protected Health Information

I have read the Glaucoma and Cataract Associates of NC, PC. **Notice of Privacy Practices.** Our Notice of Privacy Practices states that we reserve the right to change the terms described. Should this happen, you may receive a revised copy by mail.

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 request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions, but if we do, we are bound by our agreement with you. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

I consent to the physician(s) of Glaucoma and Cataract Associates of NC, PC. To consult as needed in their sole direction with other medical providers regarding my medical care.

I request that payment of authorized Medicare/Insurance carrier benefits be made on my behalf of *Glaucoma and Cataract Associates of NC, PC.* For any services furnished to me by any physician or supplier in this practice. I authorize any holder of medical information and about me to release to the Centers for Medicare/Medicaid Services and its agent and/or any other Insurance Carriers for which I have coverage, any information needed to determine these benefits or the benefits payable for related services. I agree to provide all referral and treatment plan(s) as required by my insurance carrier(s).

All co-pays must be paid at the time of service in accordance with the contracted Insurance Carrier agreements. I understand that my copay and/or any coinsurance payments are due at the time of service. I understand if I have insurance, and have provided accurate and complete information regarding my insurance, my charges will be filed with my insurance carrier; however, the financial responsibility for services rendered to the patient ultimately rests with the patient or responsible party.

Glaucoma and Cataract Associates of NC, PC accepts personal checks as a method of payment; however, if a check is returned for insufficient funds, there will be a $25.00 returned check fee.

A refraction (the measurement of your eyes for a glasses prescription by either the doctor, or one of the ophthalmology technicians) is typically not a covered benefit of your insurance plan. In the course of your examination, when it is necessary to perform a refraction, it is with the understanding that you will be held financially responsible for this charge ($50). **We do not file vision plans of any kind; however, when you pay for your refraction you may take your receipt and file for reimbursement through your vision plan provider.**

If I do not have insurance or my charges are not to be filed with insurance, payment in full is due at the time of service. In the even legal action should become necessary to collect an unpaid balance for medical services rendered to me, I agree to pay all reasonable attorney's fees and any other court costs or costs of collection. **We understand unexpected situations can arise, but we ask that you give us a 24 hour notice for any cancellations, or you will be charged a fee of $25.**

Signature _____ Date_____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION (Please Print)

Name: _____ Date of Birth:_____

Social Security (Last 4 digits) #:_____

Address: _____

City: _____ State: _____Zip: _____

Phone: _____

RELEASE MY MEDICAL RECORDS FROM:

NAME: _____

TEL: _____

FAX: _____

TO:

NOUMAN SIDDIQUI, M.D.

Glaucoma and Cataract Associates of NC.

Phone: (919)-659-8436 Fax: (919) 301-0786

Please send medical records no later than: _____

Please release a copy of all my medical records, including but not limited to, **clinic notes, operative notes, visual fields,** and **diagnostic tests**.

BY MY SIGNATURE I AUTHORIZE RELEASE OF MEDICAL RECORDS:

Patient: **X** _____ Date: _____

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I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to my physicians.

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies our staff is trained to inform you of the financial policies of this office**. PAYMENT IS EXPECTED FROM YOU, AT THE TIME OF SERVICE**, FOR "YOUR PART" OF THE CHARGES. WE ACCEPT CASH, CHECK, VISA, MASTERCARD AND DISCOVER FOR YOUR CONVENIENCE. Any balances due that are not paid at the time of service will be billed to you and payment is expected within 30 days of invoicing.

Your signature below indicates that you understand and accept this policy. Further, your signature authorizes the Doctor to release such medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to the Doctor when an assigned claim is filed.

X_____ _____
Signature of patient or legal guardian Date

Name of policy owner if other than patient_____

Patient relationship to policy owner: ___ Self ___Child ___Other

Glaucoma and Cataract Associates of NC can discuss my medical condition/information with the following:

(please circle)

Spouse **Yes** **No**

Parents **Yes** **No**

Children **Yes** **No**

Please specifically list the names of friends that we may talk with:_____

Do we have your permission to:

(Please circle)

Leave a message on your answering machine at home? Yes No

Leave a message at your place of employment? Yes No

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NEW PATIENT QUESTIONNAIRE

YOUR NAME:_____ DATE:_____

Please take a few minutes to answer the questions on these pages. If you are uncomfortable about answering any of the questions, please leave them blank and inform the Doctor.

Please print and write legibly.

How did you hear about our practice? (If physician referral, state name below)

Have you ever had any injury to your eyes? (please circle) YES NO

Do you have a history of migraines?) YES NO

Do you have a history of blood loss or transfusions?) YES NO

Have you had any LASER surgery FOR GLAUCOMA? YES NO if Yes, which eye_____

List any operating room or other laser surgery you have had done on your eyes:

Which Eye Date Name of Operation

_____

_____

_____

DO YOU HAVE ANY BLOOD RELATIVES WITH:

GLAUCOMA? YES NO If yes, who is it? _____

HAVE THEY LOST VISION FROM GLAUCOMA?_____

Diabetes? YES NO If yes, who is it? _____

Macular Degeneration? YES NO If yes, who is it? _____

Blindness? YES NO If yes, who is it? _____

Other Eye Disease? YES NO If yes, who is it? _____

PREFERRED PHARMACY
Name _____ Phone #: (___)_____
Address _____

NAME OF PRIMARY CARE PHYSICIAN: _____
Phone #: (___)_____

DO YOU TAKE ANY EYE DROPS (Both Prescription and non-prescription?) YES NO

If yes, please list the following information for each drop you take:

NAME OF DROP /WHICH EYE/HOW OFTEN/WHEN STARTED (Approximate date)

_____

_____

PLEASE LIST ALL MEDICINES YOU TAKE FOR YOUR GENERAL HEALTH:

_____

_____

_____

ARE YOU TAKING ANY MEDICATIONS THAT ARE CONSIDERED BLOOD THINNERS?

(Coumadin, Lovenox, Aspirin, Advil, Motrin, Aleve, Nonsteroidals, etc.)

_____

Do you smoke? Yes _____ No _____

Have you ever smoked? Yes _____ No _____

PLEASE LIST ALL MEDICATIONS TO WHICH YOU ARE ALLERGIC:

_____

_____

HAVE YOU HAD ANY SURGERY IN THE PAST? IF SO, WHAT KIND?

_____

_____

HAVE YOU HAD HEART SURGERY IN THE PAST? Yes _____ No _____

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DO YOU HAVE ANY OF THE FOLLOWING PROBLEMS?

Diabetes?	**Yes** _____	**No** _____	
High blood pressure?	**Yes** _____	**No** _____	
Heart disease?	**Yes** _____	**No** _____	**Type?**_____
Lung disease or breathing problems?	**Yes** _____	**No** _____	**Type?**_____
Unexplained weight loss or fever?	**Yes** _____	**No** _____	
Ear, nose, mouth, or throat problems	**Yes** _____	**No** _____	**Type?**_____
Gastrointestinal problems?	**Yes** _____	**No** _____	**Type?**_____
Kidney problems or kidney stones?	**Yes** _____	**No** _____	**Type?**_____
Musculoskeletal problems?	**Yes** _____	**No** _____	**Type?**_____
Skin or breast problems?	**Yes** _____	**No** _____	**Type?**_____
Neurological problems?	**Yes** _____	**No** _____	**Type?**_____
Thyroid problems?	**Yes** _____	**No** _____	**Type?**_____
Blood problems?	**Yes** _____	**No** _____	**Type?**_____
Cancer?	**Yes** _____	**No** _____	**Type?**_____

Thank you!

_____

Physician's Signature

CONSENT FOR TREATMENT

I HEREBY AUTHORIZE . Glaucoma and Cataract Associates, PC to examine and treat me, or the individual for whom I am responsible.

During the course of diagnosis or treatment, eye drops may be used to dilate the pupils. These drops may cause temporary blurred vision and glare. Driving an automobile, or operating machinery, is not advised until the effects of the drops have worn off.

I authorize Glaucoma and Cataract Associates, PC to release information acquired in the course of my examination and treatment to my insurance carriers.

I further understand that I have primary responsibility for payment of my charges.

X _____
Signature of Patient (or guardian)

FOR OUR MEDICARE PATIENTS

After you are seen by the doctor, Glaucoma and Cataract Associates, PC. will submit a completed insurance form to Medicare. Their guidelines permit us to obtain a one-time signature that is valid for this and future visits to our office. By signing below, the notation "SIGNATURE ON FILE" will appear in lieu of your signature on all Medicare forms submitted for you by our office.

X _____
Signature of Medicare Beneficiary