SHOFNER VISION CENTER

Affordable Eye Care / Lasik & Cataract Surgery

PATIENT INFORMATION

Please complete all 4 pages and return to front desk upon arrival.

Email address: _____

Mr/Mrs/Ms: _____ Date: _____

Home Phone: _____ Work Phone: _____

Home Address: _____

City: _____ ST: _____ Zip: _____

Sex: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ D ☐ W

Social Security#: _____ - _____ - _____ Date of Birth: _____

Referred By: _____

Family Physician: _____

Patient's Employment: _____

Employer: _____ Phone: _____

Occupation: _____

Address: _____

City: _____ ST: _____ Zip: _____

Was this a work related injury? ☐ Yes ☐ No

Person responsible for this account: _____

Relationship to Patient: _____Date of Birth: _____

Social Security#: _____ - _____ - _____ Phone: _____

In case of emergency, who should be notified: _____

Phone: _____ Relationship: _____

I authorize the release of any medical information to process all claims. I further authorize the release of payment for medical benefits to Stewart Shofner, M.D., P.C.

Patient's Signature: _____

If you are here for laser refractive surgery, you are presently taking any of these three medications: Imitrex, Accutane, or Cordarone? ☐ Yes ☐ No

PATIENT INFORMATION PAGE TWO

What is your chief complaint for today's visit? _____

_____

Do you have or ever had any of the following?

	Self	Family History (which member)
Diabetes	_____	_____
Glaucoma	_____	_____
Cataracts	_____	_____
Asthma	_____	_____
High Blood Pressure	_____	_____
Arthritis	_____	_____
Sickle Cell	_____	_____
Other Eye Disorders	_____	_____

List any medications you are currently taking (including eye drops)

	Yes	No
Do you or have you ever used prescription eye drops?	_____	_____
Do you or have you ever worn contact lens?	_____	_____
If so, what brand?	_____	_____
Do you or have you ever worn glasses?	_____	_____
Are you or have you recently been pregnant?	_____	_____
Have you recently suffered any strokes?	_____	_____
Have you recently suffered any heart disease?	_____	_____
Do you have any allergies to any medications?	_____	_____
If so, what? _____	_____	_____

List significant past medical history (eg. Eye Surgery, Eye Injury, and dates)

_____

_____

_____

Comments: _____

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT FORM

By my signature below, I am acknowledging I have received a copy of Dr. Stewart Shofner's Notice of Privacy Practice concerning my protected healthcare information.

_____ _____

Patient Name Date

_____

Patient's Signature

I authorize the following individuals to receive information about my health status, which may include information about my protected healthcare information.

_____ _____

Print Name Relationship, Date of Birth

_____ _____

Print Name Relationship, Date of Birth

_____ _____

Print Name Relationship, Date of Birth

I understand Dr. Stewart Shofner's office will only release my protected healthcare information to the individuals that I have indicated on this form. All other requests for protected healthcare information must be made in accordance with Dr. Stewart Shofner's office HIPPA Policy and Procedure Manual concerning the privacy of my protected healthcare information.

_____ _____

Patient Name (printed) Date

_____

Patient's Signature

STEWART SHOFNER MD PC
FINANCIAL POLICY

We are doing everything possible to keep down the cost of medical care. The following is a summary of our payment policy. Please read this policy carefully, initial each paragraph, and sign at the bottom.

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

_____ Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and copayments for participating insurance companies. We accept cash, personal checks (in-state only), VISA, and MasterCard. There is a service charge for returned checks. We would be pleased to process your application for **Care Credit** (it is a very quick, simple process). We do not offer in house financing. Patients with an outstanding balance 60 days or more overdue must make arrangements for payment prior to scheduling appointments. We realize that financial difficulty is a reality and we will work with you to make sure you receive continued medically necessary treatment.

INSURANCE

_____ We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible and copayments at the time of service. If we have not received payment from your insurance company within 45 days of the date of service, you may be expected to pay the balance in full. You are responsible to be sure all charges are paid whether by you or by your insurance carrier. Over the past few years, we have noticed a significant increase in the amount of our patient's deductibles and co pays. In order to help make our services more affordable, we offer financing of copays and deductibles through **Care Credit.** We would be pleased to process your application for **Care Credit** (it is a very quick, simply process).

REFUNDS

_____ Patient/guarantor credits in amounts less than **$20.00** will be retained on account to be credited toward future balances unless a written request for refund is received. Amounts $20.00 and greater will automatically be refunded to the patient/guarantor.

REQUIRED REFERALS

_____ if you are enrolled in a managed care insurance plan (e.g. HMO), you must receive a referral from our office before seeing a specialist. Retroactive referrals are not guaranteed to provide insurance benefits.

MISSED APPOINTMENTS/LATE CANCELLATIONS

_____ Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed, late, or cancelled appointments.

I have read and understood the Stewart Shofner, MD PC Financial Policy. I agree to assign insurance benefits to the **Stewart Shofner MD PC** whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

Signature of insured or responsible party: _____

Date: _____