Randolph County Eye Care Center

Dr. Jenna Gongola and Dr. Kevin Lambert

Patient Name: ____

Sex at Birth M/F: ___________________ Preferred Pronouns: ________________________________

SSN:______________________________ DOB: ______________________ Race: _________________________

Marital Status: ______________________ Email: ____

Home Phone: ________________________ Work: ________________________ Cell: _______________________

Address: ____

City: ____ State: __________ Zip: ______________________

Spouse's Name/If child, Parent's Name: ____

Patient's Employer or School: _____________________________ Occupation/Grade: __________________________

Name of Person Responsible for Account: _______________________ Employed By: _________________________

Date of Last Eye Exam: _________________ Eye Doctor/Facility: ______________________________________

Primary Care Medical Doctor/Facility: ____

Year of Last Physical Exam: _____________ Phone Number of Primary Care: ________________________________

Please Indicate any of the following ocular problems you have had:

___Cataracts

___Glaucoma

___Lazy Eye

___Macular Degeneration

___Retinal Detachments

___Other Eye Diseases

___Cataract Surgery:

Date: ___________

Other Eye Surgeries?

(if so, please include the dates)

Any Injuries to the Eye?

(if so, please include the dates)

If Female: Are you Pregnant: __________ Are you nursing: __________

Please check conditions which you have:

___ High Blood Pressure

___ Dizziness

___ Lupus

___ Allergies

___ Multiple Sclerosis

___ Anemia

___ Easy Bruising/Bleeding

___ Anxiety

___ Arthritis

___ Headaches

___ Skin Problems

___ Asthma

___ Hearing Loss

___ Sleep Apnea

___ Autoimmune Disease

___ Heart Problems

___ Blood Clots

___ Carotid Artery Disease

___ Stroke *(If so, what year)*: _______

___ Liver Failure

___ Thyroid

___ High Cholesterol

___ Cold/Heat Intolerance

___ Joint Pain

___ Weight Loss

___ Alzheimer's/Dementia

___ COPD

___ Depression

___ Kidney Failure

___ Seizures

___ Diabetes

(*If so, what type):*__________________

A1C: ________ *Year Diagnosed:* ______

___Cancer *(If so, what type):*

____

___Hepatitis *(If so, what type):*

____

Other:

____

Please indicate when you last had any of the following preventative test or services:
(If selected, please put the date or year it was completed)

___ Blood Sugar ___________

___ Blood Pressure ___________

___ Cholesterol ___________

___ Carotid Artery ___________

Please list any surgeries you have had, as well as where and when you've had them:

Surgery	**Hospital/Facility**	**Date**

Please select the information which applies best to you *(If indicated, please fill out the rest)*:

Tobacco:

Habits: _____ Never _____ Past _____ Current
If you selected never, move to the next substance:
Year started _____ if stopped, year stopped _____
Type: _____ Smoke _____Chew
Occurrences: _____ Packs/Day _____ Cans/Week

Alcohol:

Habits: _____ Never _____ Past _____ Current
If you selected never, move to the next substance:
Occurrences: _____ Drinks/Day or _____ Drinks/Week or _____ Drinks/Month

Caffeine:

Habits: _____ Never _____ Past _____ Current
If you selected never, move to the next substance:
Type: _____ Coffee _____ Tea _____Soda
Occurrences: _____ Cans/Day or _____ Cups/Day

Recreational Drugs:

Habits: _____ Never _____ Past _____ Current
Type: ___________________________________

Please select if you are on any of the following medications:

___Topamax:

Dose: ________

___Elmiron:

Dose: ________

___Flomax:

Dose: ________

___Prednisone:

Dose: ________

___Flonase:

Dose: ________

___Tamoxifem:

Dose: ________

___Hydroxychloroquine (Plaquenil) or Chloroquine:
If taken, fill out the HCQ Questionnaire on last page

Dose: ________

___Accutane:

Dose: ________

Please list all other medications you're on:

(include vitamins & over the counter medicine)
If more room is needed, bring/attach a copy of the medications.

Please select or list any major illness that you know of in your family members:
(Family members include Mother, Father, Brother, Sister, or Children)

_____ Glaucoma
_____ Macular Degeneration
_____ Retinal Detachments/Problems
_____ Cataracts
_____ Lazy Eye
_____ Cancer
_____ Diabetes
_____ Heart Disease
_____ High Blood Pressure
_____ Kidney Disease
_____ Liver Disease
_____ Thyroid Disease

Other: ____

Are you allergic to Latex. Yes: _____ or No: _____

List any other allergies or intolerances to drugs or other substances you might have:

Patient Signature (or Parent/Guardian): ____ Date:________________

Voluntary Consent Form

Randolph County Eye Care Center P.C.
P.O. Box 1489 Elkins, WV 26241
(304) 636-3887
Fax: (304) 636-0538

Consent to use or disclose health information for treatment, payment and health care operations.

Patient Name: ______________________________
Patient Date of Birth: ______________________ Patient Phone Number: ______________________
Patient Address: ______________________________

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct healthcare operations involving our office.

We have a comprehensive *Notice of Privacy Practices* that describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this *Consent Form*. As described in our *Notice of Privacy Practices*, the use and disclosure of your health information for treatment purposes not only includes care answers provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our *Notice of Privacy Practices*. Our *Notice of Privacy Practices* will be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform health care operations. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent.

You have the right to ask us to restrict the uses or discloses made for the purposes of treatment, payment, or health care operations, but as described in the *Notice of Privacy Practices*, we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our *Notice of Privacy Practices* describes how to ask for a restriction.

I have read this consent and understand it. I consent to the use and disclosure of my health information for purpose of treatment, payment, and health care operation.

______________________________ ______________________
Signature Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

______________________________ ______________________________
Relationship to Patient Print Name

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

______________________________ ______________________________

Patient or Beneficiary Name (Print) Ins. Policy Number/Medicare

1. INSURANCE/MEDICARE: I request that payment of authorized Medicare or other Insurance benefits be made on my behalf to Randolph County Eye Care, P.C. (RCECC), tor services furnished me be RCECC, I authorize any holder of medical information about me to release to my insurance company or the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.
2. RELEASE OF INFORMATION: RCECC may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, of HIV to any person or corporation (l) which is or may be liable or under contract to RCECC for reimbursement for services rendered, and (2) any health care provider for continued patient care RCECC may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of the authorization may be used in place of the original.
3. NON-COVERED SERVICES: understand that RCECC's contracts with health care service plans relate only to items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered.
4. FINANCIAL AGREEMENT: agree that in return for the services provided to the patient by RCECC, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to RCECC for payment. If an account IS sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance Insuring the patient, or any other party liable to the patient, is hereby assigned to RCECC, [f co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to RCECC. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

☐ I consent to receive updates such as appointment and pickup reminders via SMS. Msg and data rates may apply. Reply STOP to opt-out. Up to 4 msgs per month.

______________________________ ______________________________

Patient or Beneficiary (Signature) Date

HCQ Questionnaire

Only complete if you are taking Hydroxychloroquine or Chloroquine

Age: _____ **Weight** (important for medication dosage)**:** _________ **Date of Birth:** _______________
Referring /Specialty Dr. __________________________ **Last seen:** ______

Are you currently under the care of an ophthalmologist or optometrist?
____Yes ____No If yes, please include name and date last seen _______________________

Have you ever had ocular baseline testing done?
____Yes ____No ____Unsure

Which medication are you taking that you are being monitored for ocular toxicity?
____Chloroquine ____Hydroxychloroquine ____Other: __________________
Dosage: _______________________ **Duration:** ________________________

Why are you taking this medication?
____Lupus ____Rheumatoid Arthritis ____Other: _________________

Are you currently being treated or monitored for kidney disease?
____Yes ____No

Any recent major weight loss?
____Yes ____No

Are you also using the medication Tamoxifen (commonly used to prevent breast cancer)?
____Yes ____No

Any changes in your vision or color vision?
____Yes ____No If yes, please explain: __________________________________

Any changes seen with your at home Amsler grid testing?
____Yes ____No ____Unsure If yes, please attach Amsler with explanation ______________________