SARAH ALVAREZ , O.D.Ph.D.

2198 COLUMBIANA ROAD, SUITE 200
VESTAVIA HILLS, AL 35216

OFFICE: (205)877-2837 **FAX: (205) 877-1777**

NAME:_____ DOB:_____ AGE:_____
Address_____ City_____ State ____ Zip_____
Home #:_____ Work #_____ Cell#_____
Email_____ Can we email or text a confirmation for appointments? Y/N
SSN _____ Referred by_____ Occupation_____
Your Physicians Name_____ Date of Last Exam _____

PHYSICAL PROBLEMS: MEDICATION TAKEN:

_____ _____
_____ _____
_____ _____
_____ _____

MEDICINE OR OTHER ALLERGIES: _____
GENERAL HEALTH:
CHECK IF YQU HAVE OR HAVE HAD:
__HIGH BLOOD PRESSURE __EYE DISEASE __DIABETES _SINUSITIS __DIZZINESS
__EYE INJURY __MIGRAINES __EYE SURGERY __EPILEPSY __GLAUCOMA
__HEART PROBLEMS __DOUBLE VISION __CROSSED EYESm__TUNNEL VISION
___ TEMPORARY LOSS OF VISION __ OTHER _____
DO YOU SMOKE? Y/N PACKS PER DAY _____
ALCOHOL CONSUMPTION __WINE __BEER __ ALCOHOL ___X DAYS

CHECK IF ANY OF YOUR BLOOD RELATIVES HAVE OR HAVE HAD
_HEART DISEASE __HIGH BLOOD PRESSURE _DIABETES __CANCER __LUNG DISEASE
__THYROID _CATARACTS __GLAUCOMA __LAZY EYE __CROSSED EYE __BLINDNESS

EYE DOCTOR'S NAME: _____ DATE OF LAST EXAM_____
YOUR MAIN VISUAL COMPLAINT/ PROBLEM
_____

EYE PROBLEMS: EYEDROPS TAKEN:

_____ _____
_____ _____
_____ _____

CHECK IF YOUR EYES ARE BOTHERING YOU IN THE FOLLOWING WAYS:
__DOUBLE VISION __FLOATERS __LIGHT SENSITIVITY __NIGHT VISION __BURN __DRY
__BLUR __GRITTINESS __FLASHING __ACHE __HALO __ITCH __REDNESS __TEARING
__HEADACHES
DO YOU WEAR CONTACT LENS? Y/N SOLUTION USED_____
FILLED BY WHOM?_____
ARE YOU INTERESTED IN CONTACTS? Y/N
ARE YOU INTERESTED IN REFRACTIVE SURGERY? Y/N

_____
PATIENT'S SIGNATURE OR PARENT/GUARDIAN DATE DOCTOR'S SIGNATURE

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NAME_____DATE_____
ADDRESS_____,CITY_____
STATE ____ ZIP_____ HOME PHONE (___)_____
CELL (___)_____
EMPLOYER_____ WORK PHONE (___)_____
DATE OF BIRTH_____ AGE_____ SEX_____ SS# _____
EMAIL_____

EMERGENCY CONTACT_____
RELATION_____ TEL#_____

NAME OF RESPONSIBLE PARTY_____
ADDRESS OF RESPONSIBLE PARTY:
_____
CITY _____STATE____ ZIP_____
RELATIONSHIP TO PATIENT _____ BIRTHDATE_____

WERE YOU INJURED ON THE JOB? NO YES
DATE INJURED_____

PRIMARY INSURANCECOMPANY
_____
CONTRACT #_____ GROUP #_____
SECONDARY INSURANCE COMPANY
NAME_____
CONTRACT#_____ GROUP# _____

PATIENT OR AUTHORIZED PERSON'S SIGNATURE: I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW: I FURTHER AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE UNDER SIGNED PHYSICIAN OR SUPPLIER FOR SERVICES DESCRIBED BELOW.

_____
DATE PATIENT SIGNATURE

NOTICE OF PRIVACY POLICY OF

Pfister Vision C orrection Center

This notice describes how medical information concerning you may be used and disclosed. It also explains how you can get access to this information. Please review it carefully.

We will not release your medical or financial information to anyone without your written permission with the following exceptions:

Information about you with your permission has to be released to:

1. To lawyers or courts in response to a subpoena. By law, we most comply.
2. To your insurance company or other payers of your medical expenses.
3. To other healthcare provides who are taking care of you or are performing tests on you.
4. To family members or friend who are involved in your care, unless you specifically request not to do so.
5. To healthcare analysts or for research for the purpose of improving the quality of care for all patients we serve. In this case, all information which identifies you as the person will be removed.

All electronic transmission will be done in a secure manner, always encrypted software.

You have the right to inspect and copy your medical and financial records at a reasonable time and at reasonable copy costs. If you feel that the medical information we have about you is incorrect or incomplete, you may ask us to amend it.

If you believe your privacy rights have been violated, you may file a complaint in writing to our privacy officer.

Federal regulation requires that we obtain your signature that you have read and agree with this policy.

_____ _____

Signature Date

I have read and wish to make the following changes in this policy.

_____ _____

Signature Date

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PAYMENTS

WE ACCEPT CASH, CHECK, VISA, DISCOVER AND MASTERCARD. ALL MEDICARE AND BLUE CROSS CHARGES ARE FILED FOR YOU. MEDICARE AND BLUE CROSS WILL PAY THE DOCTOR DIRECTLY. SOME COMMERCIAL CARRIER INSURANCE MAY PAY THE PATIENT DIRECTLY. THE PATIENT IS ULTIMATELY RESPONSIBLE FOR PAYMENT OF ANY MONEYS OR SERVICE DEEMED NOT COVERED BY THEIR INSURANCE CARRIER. ALL CO-PAYS, DEDUCTIBLES, PHARMACEUTICALS, AND CONTACT LENSES ARE PAYABLE ON THE DAY OF YOUR VISIT OR AT THE THE TIME THEY ARE DISPENSED. IN THE EVENT THE ACCOUNT IS NOT PAID IN FULL, THE UNDERSIGNED WILL BE LIABLE FOR COLLECTION COSTS, ATTORNEY'S FEES, COURT COSTS, AND HEREBY WAIVE ALL RIGHTS OF EXEMPTION UNDER THE CONSTITUTION AND LAWS OF THE STATE OF ALABAMA

NOT-COVERED ROUTINE SERVICE POLICY

AS YOUR PHYSICIAN, I WANT TO PROVIDE YOU THE BEST CARE POSSIBLE. THERE MAY BE CERTAIN SERVICES THAT I FEEL ARE NECESSARY FOR THE MAINTENANCE OF GOOD HEALTH THAT ARE NOT COVERED BY YOUR MEDICARE OR BLUE CROSS CONTRACT, OR OTHER COMMERCIAL CARRIER INSURANCE. WE WILL BE HAPPY TO FILE THESE CHARGES WITH YOUR INSURANCE, AT YOUR REQUEST, BUT YOU WILL BE EXPECTED TO PAY FOR THESE SERVICES IN FULL AT THE TIME THEY ARE RENDERED.
EXAMPLES ARE:
A. ROUTINE EYE EXAMS
B. NON-THERAPEUTIC CONTACT LENS
C COLOR VISION TESTS
D. CONTACT LENS FITTINGS
E. CONTRAST SENSITIVITY TESTING

LET ME ASSURE YOU THAT I WILL ONLY ORDER WHAT I FEEL IS NECESSARY FOR YOUR TREATMENT AND CARE.

I HAVE READ YOUR POLICY AND AGREE TO PAY FOR SERVICES NOT COVERED BY MY CONTRACT AS I INDICATED BY MY SIGNATURE BELOW.

_____ _____

DATE PATIENT SIGNATURE