

PATIENT INFORMATION FORM

Please fill out the information to the best of your ability. Complete and accurate information allows us to give you the best service possible.

PERSONAL INFORMATION

Name: First: _____ MI: _____ Last: _____
Date of Birth: _____ Social Security # _____ (Must include for Tricare) Gender: _____
Ethnicity / Language: _____
Do you need an interpreter (circle)? YES NO

CONTACT INFORMATION

Mailing address: _____
City: _____ State: _____ Zip: _____
Primary Phone #: _____ Cell Phone #: _____
May we leave a message that contains medical information on your cell phone (circle)? YES NO
Email address: _____
Employer: _____ Phone: _____
Marital Status: _____ Spouse's Name: _____
Emergency Contact: _____ Phone: _____
Primary Care Physician: _____ Facility: _____
Referring Physician: _____ City: _____
Pharmacy _____ City: _____ Phone: _____
Person Responsible for Payment: _____
DOB: _____ Social Security #: _____ Relationship: _____
Phone: _____ Address: _____
City: _____ State: _____ Zip: _____

INSURANCE INFORMATION

Primary Insurance: _____ ID / Member Number: _____
Group #: _____ Policy Holder: _____ DOB: _____
Secondary Insurance: : _____ ID / Member Number: _____
Group #: _____ Policy Holder: _____ DOB: _____

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to Dr. Steven H. Swedberg, MD PS as well as release of any information by provider or insurance company required for this account.

PAYMENT: I agree that I am responsible for providing up to date health insurance information and am financially responsible for the balance remaining after insurance adjudication. I agree to make payment arrangements for any unpaid balances due after 30 days after the billing statement.

SIGNED: _____ DATE: _____

HEALTH HISTORY

Patient Name: _____ Date: _____

Medical History (check all that apply)

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Retinal Detachment |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Keratoconus | <input type="checkbox"/> Strabismus |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Cataract | <input type="checkbox"/> Eye Injury |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Eye Surgery |

Medications: _____ _____ _____ _____	Medication Allergies: _____ _____ _____
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Please list all Eye Surgeries and any Recent /Past Major Surgeries:

Review of Systems:	YES	NO	If YES, please explain
Do you have any of the following problems:	___	___	_____
Chronic fever, unexpected weight loss/gain, fatigue	___	___	_____
Ear/nose/throat problems (e.g. hearing loss, sinus problems)	___	___	_____
Heart Problems (e.g. chest pain, irregular heart beat)	___	___	_____
High Blood Pressure	___	___	_____
Respiratory problems (e.g. shortness of breath, wheezing)	___	___	_____
Hay Fever	___	___	_____
Gastrointestinal problems (e.g. abdominal pain, diarrhea)	___	___	_____
Urinary problems (e.g. pain or discomfort, blood in urine)	___	___	_____
Skin problems (e.g. rashes, excessive dryness)	___	___	_____
Musculoskeletal problems (e.g. muscle aches, joint pain)	___	___	_____
Neurologic problems (e.g. numbness, weakness, headaches)	___	___	_____
Endocrine problems (e.g. diabetes, thyroid)	___	___	_____
Psychiatric problems (e.g. depression, anxiety)	___	___	_____

Family History:

- | | | |
|---|---|---|
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Crossed/Lazy Eye | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Cataract | <input type="checkbox"/> Macular Degeneration |

Social History:

- Tobacco Use: Former Currently Never
- Alcohol History: Occasionally Daily Never

NOTICE OF PRIVACY PRACTICES

This **Notice of Privacy Practices** describes how your health information may be used and disclosed and how you may access your information.

- We keep a record of the health care services we provide you.
- You may ask for your records at any time.
- You may also ask to correct that record.
- We will not disclose your medical records to others unless you sign a release of medical records request form or if the law authorizes us to do so. Release forms are available on our website swedbergeye.com.
- Supplying medical records to outside agencies may result in processing and administrative fees.

By signing below I acknowledge receipt of the **Notice of Privacy Practices**:

Patient or Legal Guardian

Date

Printed Name

Relationship

Printed name of person we may disclose medical information to in the case of an emergency.

Relationship

FINANCIAL POLICY

We are committed to providing you with the best possible eye care. As a courtesy, we will bill your medical insurance on your behalf.

Payment for services are due at the time of service unless payment arrangements have been made in advance.

1. **You are responsible for understanding your insurance.** Your insurance is a contract between you, your employer and /or the insurance company but we can help clarify information for you.
2. **HMO Patients: You are responsible for obtaining any referrals from your Primary Care Physician and Authorization from your Insurance Plan, before coming to your appointment.** Failure to do so can result in denial of your claim and you being responsible for the full balance of your bill.
3. **Not all services are covered by medical insurance.** Medical and Vision insurance are NOT the same thing. A glasses prescription is not usually covered by medical insurance.
4. **As the patient, you are responsible for payment for services received and all balances are your responsibility.** We will do our best to bill your insurance first. We accept cash, Visa, Master Card, and checks payable to Dr. Steven H Swedberg, MD, PS. Convenient payment plans may be arranged.
5. **Please make a secure online payment on our website SWEDBERGEYE.COM. All phone payments are processed on our website.**
6. **Missed appointments* are subject to a \$100 service charge.**

We must emphasize that, as medical care providers, our relationship is with you, not your insurance company. Any disputes between you and them must be resolved by you.

We will gladly discuss your proposed treatment and answer any questions related to your insurance.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. We are happy to make your visits to us affordable for you, and will work with you to establish a plan that can work for everyone.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help.

*Appointments that are not cancelled or rescheduled 24 hours or more before the scheduled appointment time.

There will be a fee of \$40 for all NSF checks. Past due accounts over 60 days may be charged a minimum of \$5.00 per month. Past due accounts over 90 days may face collection proceedings.

Name: _____ Date: _____



21827 76th Avenue West, Suite 102, Edmonds, WA 98026 (425) 778-2500 fax (425) 778-5600

**AUTHORIZATION TO BILL
MEDICARE / MEDIGAP / MEDICARE ADVANTAGE/ COMPLETE**

Patient's Name _____ Date of Birth _____

Medicare Member ID # _____ Account # _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Steven H. Swedberg, MD for any service furnished to me by that physician. I authorize release to the Centers for Medicare and Medicaid Services and its agents any medical information about me needed to determine the payments for related services.

Signature of Beneficiary, Guardian or Personal Representative Date

Printed Name of Guardian or Personal Representative Date

GLASSES PRESCRIPTION (REFRACTION) ACKNOWLEDGMENT

By signing below you acknowledge that we have informed you of the following:

- Your glasses prescription (Refraction) is not covered by Medical insurance.
- We **DO NOT** bill Vision insurance (VSP, DavisVision etc...).
- The cost is \$70.00 plus your copay if you have one.
- Contact your insurance company if you have any further questions.

I have read the above information and understand that my glasses prescription is a **non-covered service** by my insurance. I accept full financial responsibility for the cost of this. I understand that the insurance copayment is separate from the refraction fee.

Patient signature (Parent for minor) _____
Date