

### 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: \_\_\_\_\_



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

## NOTICE OF PRIVACY PRACTICES-ACKNOWLEDGMENT

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. Supplying medical records to outside agencies may result in a processing fee.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed and how you may access your information.

By signing below I acknowledge receipt of the **Notice of Privacy Practices**, and have been informed of our office **Financial Policy** and **Refraction Fee** on the previous page.

\_\_\_\_\_  
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. If you have medical insurance, we will bill your insurance carrier as a service to you. Swedberg Eye Care's payment policy is as follows:

**Payment for services are due at that time the services are rendered** unless payment arrangements have been arranged in advance. Understanding your health care insurance plan may be difficult but we are here to help.

1. Your insurance is a contract between you, your employer and the insurance company. **You need to make every effort to understand what your insurance will pay for and what they will expect you to pay for.**
2. **Referrals from your Primary Care Physician and Authorization from your Insurance Plan, are often required under your policy.** It is your responsibility to check with your insurance to see if any of these are required and to ask your Primary Care Physician for a referral to see another physician.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select services they will not cover. For example, **some insurance policies will not cover routine eye exams and refractions, thereby making you completely responsible for the charges.** A **Refraction** is the process of determining the eye's refractive error for an eyeglass prescription. This exam is not a covered service by **Medicare, Secure Horizons** or most other insurances. The **refraction fee is \$70.00.**
4. As the patient, you are responsible for payment for services received. We will do our best to bill your insurance first. All balances are your responsibility. We accept cash, Visa, Master Card, Care Credit and checks payable to Dr. Steven H Swedberg, MD, PS. Convenient payment plans may be arranged.

**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.

There will be a fee of \$30 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 76<sup>th</sup> Avenue West, Suite 102, Edmonds, WA 98026 (425) 778-2500 fax (425) 778-5600

**AUTHORIZATION TO BILL MEDICARE / MEDIGAP**

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

You will NOT receive a Glasses Prescription (Refraction) unless the physician determines that it is necessary or you ask for a prescription.

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

- **You may refuse the refraction.**
- Refractions are not generally paid by insurance.
- Without a refraction, a prescription for glasses will not be available from your visit.
- Our office fee for a refraction is \$70.00 we will mail you a bill once your insurance has processed the visit.
- This fee in addition to any insurance copayment at the time of service.

A refraction is the process of determining the eye's refractive error for an eyeglass prescription and as a diagnostic test to determine the medical necessity for surgery. It is an essential part of an eye examination, but is **NOT** always a covered service by the majority of insurance companies including Medicare and AARP.

### ACKNOWLEDGMENT

I have read the above information and understand that the **refraction** is a **non-covered service** by **Medicare** and/or my insurance. I except full financial responsibility for the cost of this service should I receive one. I understand that the insurance copayment is separate from and not included in the refraction fee.

\_\_\_\_\_  
Patient signature (Parent for minor)      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: _____ _____ _____ _____
--	---

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