ADVANCED EYE INSTITUTE

Richard Arceneaux, MD Jonathan Carrere, MD Tyler Goff, MD Darby Chiasson, OD

DATE: _____

PATIENT INFORMATION

Name of Patient: _____
Last *First* *M.I.*

Date of Birth: _____ Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile phone: _____

SS#: _____-_____-_____ E-mail: _____

Preferred Method of Contact: (circle one) Home or Mobile

RESPONSIBLE PARTY

□ Self □ Spouse □ Parent □ Guardian

If other than patient please complete the following:

Name of Guarantor: _____
Last *First* *Date of Birth*

Mailing address: _____ Contact #: _____

INSURANCE

Primary Insurance Company: _____

Policy Holder Name: _____ Relation to patient: _____

Policy Holder SS#: _____-_____-_____ Policy Holder Date of Birth: _____

Policy Holder Employer: _____

Secondary Insurance Company: _____

Policy Holder Name: _____ Relationship to Patient: _____

Policy Holder SS#: _____-_____-_____ Policy Holder Date of Birth: _____

Policy Holder Employer: _____

ADDITIONAL INFORMATION

Emergency contact (HIPAA Contact): _____ Relation: _____ Ph#: _____

Primary Care Physician: _____ Referred by PCP? Yes / no

Preferred Pharmacy: _____ Location: _____

HIPAA Contacts: (Name of Relative or friend we can discuss your medical needs with if necessary):

Name: _____ Relationship: _____ Ph# _____

Name: _____ Relationship: _____ Ph# _____

Please list all past surgeries in your lifetime: _____

_____

_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize Advanced Eye Institute, LLC, its physicians and its employees and others involved in my care to disclose and release medical record information consisting of diagnosis (including alcohol or drug abuse under Title 42 of the code of Federal Regulation), operative and special procedures and treatment, and the like relating to my hospital admission, to each other and to any person or organization which is or may be liable or responsible for payment of charges for or related to my care, including but limited to the Social Security Administration and its intermediaries, Medicare, Medicaid, the Peer Review Organizations, employers, welfare funds, insurance companies, and also to medical audit or review organizations retained by any such other healthcare agency or facility (including, without limitation, other hospital or nursing homes) or discharge planning agency which is or may be involved with my discharge planning and my care after my discharge. My medical information described above and appropriate records as permitted by law may be disclosed and released to any such person or organization upon their request both during and after my care and treatment by or at this Clinic. I discharge and release Advanced Eye Institute, LLC and its employees from any responsibility and liability arising out of the disclosure to or the use of such information by such persons or organizations.

PAYMENT AUTHORIZATION

I understand that I am financially responsible to Advanced Eye Institute., LLC for all private charges for medical or surgical services rendered to my family or me. I hereby assign payment of any insurance benefits that are filed by Advanced Eye Institute, LLC for services for my family or myself. If I fail to pay any charges for services rendered for me, I understand the debt is turned over to an attorney for collection, I will pay reasonable attorney fees and any court cost.

GENERAL CONSENT FOR TREATMENT AND TESTS

I DESIRE TO BE SEEN AND TREATED LLC, I hereby agree and consent to be seen and treated at Advanced Eye Institute, LLC, by its physicians, employees and others involved in my care to treat me in ways they judge to be beneficial to me. I understand that I have the right to ask questions and to receive information about my care and treatment, and the right to withdraw my consent to treatment or tests. I consent to examination, x-rays, blood tests, including blood test for communicable disease such as hepatitis, and AIDS (including testing where health care personnel have been exposed to my blood and/or body fluids), laboratory procedures, medications, infusions, transfusions of blood or blood products, anesthesia, radiation therapy and other services or treatments rendered at the Clinic, ordered or performed by its physicians or performed or provided by its employees or contractors. I understand that State law requires the Clinic and/or such person to report certain positive test results, such as hepatitis and the antibody for the AIDS virus, to the Health Department.

HIPAA PRIVACY PRACTICES

I have had the opportunity to read and understand the HIPAA Privacy Policy of this clinic.

I have had the opportunity to read and understand the consent for treatment, payment authorization, and release of medical information.

XX_____ _____

Signature of Patient DATE

XX_____

Signature of Guardian/Parent Please print name DATE

MEDICARE OR MEDICAID LIFETIME SIGNATURE

I request that payment of authorized Medicare or Medicaid benefits be made to Advanced Eye Institute, LLC for any services furnished to me.

XX_____ _____

Signature of Patient/Guardian DATE

ADVANCED EYE INSTITUTE

Patient Satisfaction Survey

Patient Name (optional): _____

Date of Service: _____ Appointment Time: _____

At Advanced Eye Institute, we are always striving to better ourselves and your overall experience. Please take a moment to let us know how we are doing!!
Please circle a number, 5 being an excellent experience and 1 being the worst.

1. Ease of booking an appointment	1	2	3	4	5
2. Friendliness of check-in staff	1	2	3	4	5
3. Rate your wait time	1	2	3	4	5
4. Technician friendliness & knowledge	1	2	3	4	5
5. Overall physician interaction & knowledge	1	2	3	4	5
6. Friendliness of optical staff (if N/A please leave blank)	1	2	3	4	5
7. Friendliness of check-out staff	1	2	3	4	5

8. What was the total time spent in the office today?

_____

9. Did anyone go out of their way to make your experience wonderful?

_____

10. Please rate your overall experience.	1	2	3	4	5

COMMENTS:

_____
_____
_____
_____
_____
_____

Please place in patient mailbox, outside of checkout window! Thank you for your help!