Dr. Mo Fouladvand M.D.
Neuro-Ophthalmology & Neurology

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Patient: Mr.___ Ms.___Mrs.___Dr. _____ _____

First Name Last Name

Date of Birth:___/___/___ Age:_____Gender: ___M ___F

Marital Status: Married __ Divorced __ Widowed__ Domestic Partner __ Single __

Preferred Language/ Ethnicity /Race: _____

Permanent Address: _____Apt:_____

City: _____State:_____Zip:_____

Home Phone:( )_____Cellular:( )_____

Email:_____

Preferred method of contact: Home ___ Cell( )_____Email _____

Work Phone:( )_____

Emergency Contact:_____

Relationship:_____ Phone: ( )_____

Primary Insurance Plan: _____ID#: _____

Policy Holder: Self___ Spouse___ Parent___

Secondary Insurance Plan:_____ID#:_____

Self Pay: ___

Primary Care or Referring Physician: _____

Phone:( )_____

Address: _____

Pharmacy Name: _____

Phone:( )_____

Address:_____

Confidential Patient Questionnaire

REVIEW OF SYSTEMS

Do you currently, or have you ever had problems in the following areas?

CONSTITUTIONAL

Fever, weight loss/gain	YES	NO
Other_____	YES	NO

VASCULAR/CARDIOVASCULAR

Heart problems Chest pain	YES	NO
Chest pain	YES	NO
Irregular heartbeat	YES	NO
Other_____	YES	NO

GASTROINTESTINAL.

Heartburn	YES	NO
Abdominal Pain	YES	NO
Diarrhea	YES	NO
Vomiting	YES	NO
Other_____	YES	NO

NEUROLOGICAL

Numbness	YES	NO
Weakness	YES	NO
Headaches	YES	NO
Paralysis	YES	NO
Other_____	YES	NO

MUSCULOSKELETAL

Muscle aches	YES	NO
Joint pain	YES	NO
Swollen joints	YES	NO
Other_____	YES	NO

ENDOCRINE

Diabetes	YES	NO
Thyroid problems	YES	NO
Other_____	YES	NO

ALLERGIC/IMMUNOLOGIC

Hay fever	YES	NO
Allergies	YES	NO
Other_____	YES	NO

PSYCHIATRIC

Depression	YES	NO
Anxiety	YES	NO
Other_____	YES	NO

EARS, NOSE, MOUTH, THROAT

Allergies/ Hay Fever	YES	NO
Other_____	YES	NO

RESPIRATORY

Asthma	YES	NO
Shortness of breath	YES	NO
Wheezing Coughing	YES	NO
Other_____	YES	NO

DERMATOLOGIC

Skin rashes	YES	NO
Excessive dryness	YES	NO
Other_____	YES	NO

HEMATOLOGIC/LYMPHATIC

Blood disorders	YES	NO
Leukemia	YES	NO
Other_____	YES	NO

If you answered YES to any of the above or added a condition not listed, please explain:

_____

Please list all medications you are taking including eye drops:

_____

Do you have allergies to any medications? YES___NO ___

Confidential Patient Questionnaire (continued)

Family and Social History: Do any of the following ocular or medical conditions run in your family? If YES, please specify the type of family relationship:

___Glaucoma _____

___Diabetes_____

___High blood pressure_____

__Stroke_____

___Macular degeneration_____

__Other (please explain)_____

Do you smoke?___YES___NO

If YES, how many cigarettes/packs per day?_____

Do you consume alcohol?___YES___NO

If YES, how often? _____

How did you hear about us? Please check any that apply:

__*A friend or Family Friend*_____

___*Internet (please name site)*_____

___*Other (please name)*_____

___*Physician referral (please name)*_____

Patient Financial Responsibility

Refraction:

Refraction is the process of determining the eye's refractive error or the need for corrective glasses and/or contact lenses. Refraction is sometimes necessary depending on the patient's diagnosis and/or complaints presented. For example, if a patient experiences blurred vision or a decrease in visual acuity on the eye chart, refraction would be necessary to determine if this is due to a need for glasses or a medical problem. Refraction is also necessary to prove the need for cataract surgery to insurance carriers. We must prove that your vision cannot simply improve with a glasses prescription. Refraction is often an essential part of an eye exam; however, MEDICARE and some INSURANCE CARRIERS do not cover the charge for refraction.ONLY the doctor or technician is qualified to tell you if this procedure is necessary and they will inform you of the necessity BEFORE it is done. It is important to understand that if you decline this procedure, we may not be able

The cost of refraction:

Our office policy is to charge $100 for this procedure (glasses or contact lens prescription or prism lenses) and is in addition to the office visit co-pay and/or deductible. Payment is due at the time services are rendered. NOTE: This fee is due and payable whether or not you receive a written glasses prescription. Sometimes the change in vision is not significant enough to warrant the cost of purchasing new glasses.

Non-covered services:

I understand that *Office of Dr.M.Fouladvand MD PLLC* contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services that 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. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with *Office of Dr.M.Fouladvand MD PLLC*, to obtain necessary health care service plan authorizations. Patients with HMO referral plans are responsible to bring their referral at time of service. If no referral, you may be billed.

Some insurance carriers may not cover fundus photography and retina imaging service. Dr. Fouladvand uses these tests to diagnose or monitor disease progression. When this service is performed, our office will submit charges to your insurance, if the insurance denied you are responsible for the bill for a fee of $ 100.

Financial agreement:

I agree that in return for the services provided to the patient by Office of Dr.M.Fouladvand MD PLLC, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Office of Dr.M.Fouladvand MD PLLC for payment.If an account is sent for collection, I agree to pay any such collection expenses. 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 Office of Dr.M.Fouladvand MD PLLC, If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Office of Dr.M.Fouladvand MD PLLC. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

Acknowledgement:

I have read the above information and understand my financial responsibilities as a patient of *Office of Dr.M.Fouladvand MD PLLC.*

Please sign or initial here _____

Release of information:

Office of Dr.M.Fouladvand MD PLLC 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 or HIV, to any person or corporation (1) which is or may be liable or under contract to Office of Dr.M.Fouladvand MD PLLC for reimbursement services rendered, and (2) any health care provider for continued patient care. Office of Dr.M.Fouladvand MD PLLC, 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.

I grant Office of Dr.M.Fouladvand MD PLLC permission to take photographs/film of myself or dependent child to be used and distributed for educational, clinical and/or scientific purposes. The use of these photos/films can include presentations, meetings, publications as well as patient education. The photographs may include identifiable features of the face or body.

Patient Consent Form
Use and Disclosure of Health Information Protected under HIPAA

Pursuant to the information contained in the Notice of Privacy Practices, I give permission for the use and disclosure of Protected Health Information (PHI) in order to carry out Treatment, Payment, and Healthcare Operations (TPO).

I am aware that I have the right to review the Notice of Privacy Practices prior to signing this consent. Should the Notice of Privacy Practices be revised, I am aware that I may obtain a copy of the revised form by contacting the Medical Director of this facility.

I give my consent for this organization to contact me by calling my home or other designated location in order to leave a message (mechanically or with another person) or to speak to me directly regarding any matter which will help with the conduct of Treatment, Payment, and Healthcare Operations.

Further, I give my consent for the use of mail or e-mail to designated locations, including my home, to assist the organization in carrying out the described activities of Treatment, Payment, and Healthcare Operations.

I hereby consent to the use and disclosure of my PHI for the purpose of Treatment, Payment, and Healthcare Operations (TPO). This consent is good until revoked in writing, except to the extent that disclosures have been made in reliance upon my prior consent.

Services are provided without regard to sex, race, color, religion, national origin, or disability.

Dated:_____Patient Name:_____

Patient Signature:_____

Patient Representative: _____(if applicable)