3575 Pecos McLeod Las Vegas, NV 89121
2100 N. Rampart Blvd. Las Vegas, NV 89128
2475 W. Horizon Ridge Henderson, NV 89052
9100 W. Post Rd. Las Vegas, NV 89148
6850 N. Durango Dr. #404 Las Vegas, NV 89149

SHEPHERD EYE CENTER PATIENT INFORMATION FORM

PATIENT INFORMATION

DATE: _____

NAME: _____ PRIMARY DOCTOR: _____

SOCIAL SECURITY NUMBER: _____ SEX (CHECK ONE): ☐ M ☐ F DATE OF BIRTH: _____ MARITAL STATUS: ☐SINGLE ☐MARRIED ☐WIDOWED ☐ DIVORCED

ADDRESS: _____

CITY _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL: _____

EMAIL ADDRESS: _____

EMPLOYER: _____

SPOUSES NAME: _____ SPOUSE'S DATE OF BIRTH _____

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT THAN ABOVE)

NAME: _____

SOCIAL SECURITY NUMBER: _____ SEX (CIRCLE ONE): M F

ADDRESS: _____

CITY _____ STATE: _____ ZIP: _____

DATE OF BIRTH: _____ HOME PHONE: _____ CELL: _____

PRIMARY INSURANCE INFORMATION

NAME OF INSURANCE COMPANY: _____ POLICY # _____

NAME OF INSURED: _____ DATE OF BIRTH OF INSURED _____

RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE INFORMATION

NAME OF INSURANCE COMPANY: _____ POLICY # _____

NAME OF INSURED: _____ DATE OF BIRTH OF INSURED _____

RELATIONSHIP TO PATIENT: _____

ACKNOWLEDGE RECEIPT OF NOTICE OF PRIVACY POLICIES

My signature below acknowledges the receipt of Shepherd Eye Center's *Notice of Privacy Policies*.

_____ _____
Signature Date

_____ _____
Print Name Social Security #

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PATIENT CONTACT

Shepherd Eye Center may contact you regarding appointments, test results, financial matters/billing concerns by telephone at any number associated with your account and leave a message as necessary. This can include wireless telephone numbers, which could result in charges to you. We may also contact you by sending emails, if an email is provided to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automated dialing system if applicable.

My **PREFERRED METHOD OF CONTACT** is:

Telephone number_____ Cell number _____

Email_____ Other _____

Shepherd Eye Center reminds our patients of their appointments by Phone call, text message and email.

RELEASE OF PHI TO SPECIFIED PARTIES

Do we have permission to release your protected health information to anyone involved in your care? □ **YES** □ **NO**

If "YES", list the **name(s)** of the person(s) who has permission for access to your protected health information. Please do not use general descriptions such as **"family", or "friend".** We need name, relationship and phone number. Also, list information they have access to, for example, "entire medical records", "specific dates", "specific types of examination", etc.

Name_____
Relationship_____
Information_____
Telephone_____

Name_____
Relationship_____
Information_____
Telephone _____

I understand that my permission for the release of my protected health information to parties listed above will remain in effect indefinitely, unless revoked in writing.

_____ _____ _____
Patient Name Patient/Parent/Guardian Signature Date

Patient representative signature if patient unable to sign. _____
Relationship_____ Date _____

GUARDIANSHIP AND/OR HOSPICE CARE INFORMATION

Does someone have Power of Attorney or legal guardianship for you? □ Yes □ No
Are you currently under in-patient or out-patient hospice care? □ Yes □ No

If you answered yes, to either of these questions, please provide us with contact information for the guardian and/or the hospice. Shepherd Eye Center also needs a copy of the POA or legal guardianship paperwork if this applies.

Legal Guardian Name_____ Phone _____

_____ _____ _____
Name of Hospice Service Case Manager's Name Telephone Number

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CONSENT TO OBTAIN MEDICATION HISTORY

A medication history is a list of prescription medicines that our practice providers or other providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history. The collected information is stored in our practice electronic medical record system and become part of your personal medical record. Medication history is very important in helping healthcare providers treat your symptoms and/or illness properly and in avoiding potentially dangerous drug interactions. It is very important that you and your provider discuss all your medications in order to insure that your recorded medication history is 100% accurate. Some pharmacies do not make drug history information available, and your drug history might not include drugs purchased without using your health insurance. Also over-the-counter drugs, supplements, or herbal remedies that patients take on their own may not be included.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers. This consent will remain in effect for three years.

Patient/Parent/Guardian Name _____ Signature _____ Date _____

PREFERRED LANGUAGE INFORMATION

1. What language do you usually speak at home, or consider your primary language?_____
   (If English is your answer, skip question #2.)
2. If English is not your primary language, would you say you speak English (circle your answer):
   Very Well Well Not Well Not at all

CULTURAL BACKGROUND INFORMATION

The Federal Government requires that we ask the following questions of our patients. Providing the information below is voluntary and has no impact on your medical eye care at Shepherd Eye Center. ***Please fill out Sections 1 AND 2****.*	
SECTION #1 - **ETHNICITY** (Please check one box in Section 1. Continue with question Section 2 regardless of your answer in Section 1)	
☐ Hispanic or Latino	A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin (regardless of race.)
☐ Non-Hispanic or Latino	
SECTION #2 – **RACE** (Please check one box)	
☐ American Indian or Alaskan Native	A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
☐ Asian	A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
☐ Black or African American	A person having origins in any of the black racial groups of Africa.
☐ Native Hawaiian or other Pacific Islander	A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
☐ White	A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
☐ Other (describe)	
☐	I prefer not to answer these questions.

SHEPHERD EYE CENTER
F I N A N C I A L A G R E E M E N T

Dear Patient:

Thank you for choosing **Shepherd Eye Center** as your eye care provider. The following is our Financial Policy, which will help you with your concerns regarding our billing and payment procedures.

Payment for services is due at the time service is rendered. We accept cash, checks, money orders, debit cards, MasterCard, Visa, Discover and American Express. We will submit an insurance claim on your behalf. If your carrier is not contracted with our practice, we will courtesy bill them with the understanding that whatever the insurance does not pay; the balance is then your responsibility to pay within 30 days of your first billing statement. **IF YOU HAVE A CO-PAY, IT WILL BE COLLECTED AT THE TIME OF SERVICE. Please note that we do not submit co-pays to a secondary carrier. We will give you the appropriate information to do this on your own.**

You are responsible for knowing your insurance benefits. What are covered services in your plan? Does your insurance require a Primary Care Physician (PCP) referral? Does your physician participate in the plan? **If you are an HMO member, you are responsible for obtaining referrals/authorizations from your PCP and/or carrier.** Patients are responsible for deductible balances, co-insurance and non-covered amounts **at the time of service.** Any billed balances are due within 30 days of the statement date.

Please have **ALL INSURANCE CARDS and a PHOTO ID AVAILABLE FOR PHOTOCOPYING AT ALL TIMES.** Any changes of insurance, address, phone number or emergency contact information should be reported immediately.

We appreciate the opportunity to examine and care for your eyes. In the world of health insurance, Medicare and most other carriers will **NOT COVER THE REFRACTION PART OF THE EXAM.** This part determines whether your vision can be improved or not with glasses and is needed to dispense glasses or obtain approval for **ANY** surgery. **Therefore, we want you to be aware there is a $50 fee for the refraction testing due at the time services are rendered.** If you have any questions, please feel free to ask.

Remember that insurance authorizations/referrals for services do NOT guarantee payment. If your insurance does not pay in full within 60 days, we ask that you contact them as charges will then be transferred to you. We require you to pay the balance due even though your insurance carrier may eventually process your claim. A refund will then be mailed to you. Interest on past due balances will accrue at a rate of 1.5% monthly. There will be a $25.00 fee for all returned check items. Should your account become delinquent and be referred to a collection agency, you shall be financially responsible for the costs of collection and/or legal fees. Collection costs are calculated by adding to the principle the greater of $25 or an amount 35% in excess of the balance owed.

I request that payment of authorized Medicare/or any third party benefits be made to the SHEPHERD EYE CENTER on my behalf for any services rendered to me. I authorize any holder of medical information about me to release to the Center for Medicare/Medicaid Services and its agents or any third party payor any information to determine these benefits or the benefits payable for related service.

_____ _____

Printed Name of Patient/Responsible Party Signature of Patient/Responsible Party

_____ _____

Patient Date of Birth Date