Patient Demographic Form

the koetting associates

MRN **Date**

PATIENT INFORMATION

Last Name **First Name** **Middle Initial** **Nickname/AKA**

Date of Birth **Social Security Number** **Gender** ❑ Male ❑ Female

Marital Status ❑ Married ❑ Single ❑ Divorced ❑ Life Partner ❑ Separated ❑ Widowed ❑ Other

DUE TO RECENT REFORMS MANDATED BY THE GOVERNMENT, DOCTORS ARE REQUIRED TO ASK ALL PATIENTS FOR THEIR RACE AND ETHNICITY REGARDLESS OF YOUR INSURANCE TO MEET MEANINGFUL USE REQUIREMENTS.

If Race, Ethnicity, or Language is incorrect please correct below:

Race:_____

- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black/African American
- ☐ Declined
- ☐ Nat Hawaiian/Pacific Islander
- ☐ Other Race_____
- ☐ White

Ethnicity:_____

- ☐ Declined
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Primary Language:_____

Home Address **Apt #** **City** **State** **Zip Code**

Home Phone **Work Phone** **Other Phone** ❑ Cell ❑ Pager ❑ Fax

Employer/Occupation **Employer Phone**

PHYSICIAN REFERRAL INFORMATION

Primary Care Physician **Referring Physician**

How did you hear about us?

- ❑ Billboard
- ❑ Employer
- ❑ Family Member
- ❑ Friend
- ❑ Health Fair Event
- ❑ Insurance
- ❑ Magazine
- ❑ Mail
- ❑ News
- ❑ Physician
- ❑ Radio
- ❑ Television
- ❑ Web site
- ❑ Yellow Pages
- ❑ Other

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient ❑ Self (if self, skip to Emergency / Next of Kin) ❑ Spouse ❑ Parent ❑ Other

Last Name **First Name** **Middle Initial**

Date of Birth **Social Security Number**

Home Address **Apt #** **City** **State** **Zip Code**

Home Phone **Work Phone** **Other Phone** ❑ Cell ❑ Pager ❑ Fax

Employer **Employer Phone**

EMERGENCY / NEXT OF KIN CONTACT INFORMATION

Last Name **First Name** **Relationship to Patient**

Address **Apt #** **City** **State** **Zip Code**

Home Phone **Work Phone** **Other Phone** ❑ Cell ❑ Pager ❑ Fax

Co-payments are paid at the time of the visit. I am responsible to be knowledgeable of my insurance coverage, deductible, and co-pays for any services provided by The Koetting Associates. I understand that I am financially responsible for payment of any services rendered to me by The Koetting Associates. I have read and accept the terms of this policy.

I authorize the release of medical record information to: 1) the above named insurance companies, 2) any physician who has participated in my health care, and 3) to any physician to whom I may subsequently be referred.

Signature_____ **Date**_____

Medical History Questionnaire

Patient's First Name _____ Last _____ Date_____ Acct

		YES	NO	?	Please Explain and List Medications
Medical History					
	Current Medications	☐	☐	☐	_____
	Allergies to Medications	☐	☐	☐	_____
	Major Injuries or Surgeries	☐	☐	☐	_____
Family History					
	Glaucoma	☐	☐	☐	_____
	Diabetes	☐	☐	☐	_____
	Macular Degeneration	☐	☐	☐	_____
Social History					
	Do you drive?	☐	☐	☐	_____
	Do you use tobacco products?	☐	☐	☐	_____
Review Of Systems					
Eyes					
	Eye Injuries	☐	☐	☐	_____
	Eye Surgery	☐	☐	☐	_____
	Glaucoma	☐	☐	☐	_____
	Chronic Infection of Eye or Lid	☐	☐	☐	_____
	Flashes/Floaters in Vision	☐	☐	☐	_____
Ears, Nose & Throat					
	Sinus Problems	☐	☐	☐	_____
	Allergies (other than to medications)	☐	☐	☐	_____
	Hay Fever	☐	☐	☐	_____
Neurologic					
	Headaches	☐	☐	☐	_____
	Migraines	☐	☐	☐	_____
	Seizures	☐	☐	☐	_____
Vascular					
	Diabetes	☐	☐	☐	_____
	High Blood Pressure	☐	☐	☐	_____
	Heart Problems	☐	☐	☐	_____
Respiratory					
	Emphysema	☐	☐	☐	_____
	Asthma	☐	☐	☐	_____
Endocrine					
	Thyroid or Other Glands	☐	☐	☐	_____
Gastrointestinal					
	Chronic Intestinal Disorders	☐	☐	☐	_____
Bones & Joints					
	Rheumatoid Arthritis	☐	☐	☐	_____
Genitourinary					
	Kidney Disorder	☐	☐	☐	_____
Lymphatic/Hematologic					
	Anemia	☐	☐	☐	_____
	HIV	☐	☐	☐	_____
	Hepatitis	☐	☐	☐	_____
Psychiatric					
	Psychiatric Disorders	☐	☐	☐	_____
Integumentary					
	Skin Disorders	☐	☐	☐	_____

Other general health or eye problems not covered:

_____

_____ _____

Doctors Signature Review Date

Document Number:	**Form PR-1.B**	Page 1 of 1
Document Name: **Acknowledgement of Receipt - Notice of Privacy Practices**		

I acknowledge that I have been provided the Notice of Privacy Practices (NPP) of The Koetting Associates. The NPP tells me how The Koetting Associates may use or disclose my Protected Health Information (PHI) and about my rights and the legal duties of The Koetting Associates regarding my PHI.

I understand that if I have any questions the NPP provides me with the name or title and telephone number of a person or office to contact for further information.

Date			
Individual Name			
Date of Birth		Social Security #	
Signature of Individual or Personal Representative	**X**		
Printed Name of Personal Representative, if any			
Personal Representative Authority to Act for the Individual (Documentation may be requested):			

******** DO NOT SIGN BELOW THIS LINE ********

Identity of the Individual verified, Documentation on file
Identity and Authority to Act of Personal Representative verified, Documentation on file

Confirmed by The Koetting Associates Representative

Signature	Printed Name

or

The Koetting Associates made a good faith effort to obtain a written acknowledgment of receipt of the NPP but was unable to because:

The Koetting Associates Representative:	
Signature	Printed Name

Patient's Communication Preferences Regarding PHI

Patient Name _____ Date _____

Telephone Communication Preferences

Home # _____ Mobile # _____

Work # _____ Other _____

E-Mail Communication Preferences

Email Address _____ ☐ Ok to Email you regarding your care or glasses/contact order

In order to best serve our patients and communicate regarding their services and financial obligations we will use all methods of communication provided to expedite those needs. By providing the information above I agree that The Koetting Associates or one of its legal agents may use the telephone numbers provided to send me a text notification, call using a pre-recorded/ artificial voice message through the use of an automated dialing service or leave a voice message on an answering device.
If an email address has been provided, The Koetting Associates or one of its legal agents may contact me with an email notification regarding my care, our services, or my financial obligation.

_____

Mail Communication Preferences

May we send mail to your home address? ***(If no, please provide an alternate mailing address below.)***

_____

_____

Other than you, your insurance company, and health care providers involved in your care, whom can we talk with about your health care information? (Check all that apply)

		Name:	**Telephone:**
☐	Spouse	_____	_____
☐	Caretaker	_____	_____
☐	Child	_____	_____
☐	Parent	_____	_____
☐	Other	_____	_____

Do you have any health information that you would like to be kept confidential from any person or persons? If so, please specifically describe the information and person or persons below:

_____

_____

I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information.

I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information.

_____ _____

Patient or Personal Representative Signature **Date**

_____ _____

Printed Name **Relationship to Patient**

Warning about Email and Text Messaging

There is the potential that email sent over the Internet and text messages sent over a mobile network are not secure methods of communication. They may be intercepted and read by unauthorized persons. If this is of concern to you, you should not request confidential communications by email or text message. If you request confidential communications by email or text message you agree that you have been informed of and understand the risks involved with using email or text message, accept full responsibility if use of email or text message results in a breach of your unsecured PHI and will hold The Koetting Associates harmless from any and all liability, loss, damages, costs or expenses arising from communicating with you by email or text message according to your request.

Financial Policy

Patient Name_____ **Date**_____

We are committed to meeting your healthcare needs. Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this in a cost effective manner, we ask that you adhere to the following guidelines.

1. You are ultimately responsible for payment of charges for services you receive from our office. Any check payment dishonored by your bank will result in a **return check charge** being added to your account.
2. Please provide us with your current address, telephone number, and insurance information. You may be asked to update this information yearly.
3. It is your responsibility to contact your insurance carrier to confirm that our physicians participate in your plan. If you see a doctor that is not currently on your plan, you will be responsible for payment in full.
4. If your plan requires a referral, it is **your responsibility** to obtain this prior to being seen by the doctor.
5. All copays and charges not covered by insurance are due at time of visit.
6. **A minimum of a 50% Deposit is required on all eyeglass orders.**
7. We would greatly appreciate if you could give 24 hour notice if you are unable to keep your appointment. This allows us to offer this time to another patient who needs to be seen.
8. Medicare and most private insurances do NOT pay for eye refraction or vision exams for the purpose of prescribing, fitting, checking, or changing glasses or contacts. Therefore, examinations for glasses or contact testing are expected to be paid in full at the time of service.
9. In the event the balance on your account becomes 60 days delinquent after insurance payments, your account may be sent to our collection agency. You would be responsible for the collection fees incurred.
10. Please be prepared to show us your insurance card at every visit so we can be prepared for possible changes in your coverage.

Patient Signature_____ Date_____

POS® Reorder # 1503351