



Patient Medical History Questionnaire

Name: _____ Date Today: ____/____/____

Age: _____ Date of Birth: ____/____/____ Gender: Male ____ Female ____ Weight: _____ Height: _____

Review of Systems: Please check any of the following health problems which you have or have had:

Cardiovascular

- Heart disease
- Heart attack/chest pain
- High blood pressure
- Stroke
- Congestive Heart Failure
- Heart valve problems

Respiratory

- Lung Disease
- Tuberculosis
- Sleep Apnea

Hematologic/Lymphatic

- Anemia
- Bleed/bruise easily

____ Other (please list):

____ Cancer (please list):

Endocrine

- Diabetes
- Thyroid disease

Gastrointestinal

- Ulcers
- Colitis/diverticulitis
- Liver disease/hepatitis

Musculoskeletal/Skin

- Arthritis
- Joint replacement

____ No Medical Problems

Ear/Nose/Throat

- Sinus disease

Genitourinary

- Kidney problems
- Bladder problems
- Prostate problems

Neurologic/Psychiatric

- Seizures/convulsions
- Alzheimer's
- Parkinson's disease
- Mental health problem

Immune/Allergic

- Immune deficiency
- Environmental allergy

Past Medical History: (Please list any surgery, injuries, operations or hospitalizations *other than eyes*)

Medications: (Please list all medications that you are currently taking with the strength and how often, *including eyedrops, over the counter medications and nutritional supplements*)

Allergies: (Please list any allergies to any medications or medical tests)

Name: _____ Date Today: ____/____/____

Primary Medical Physician: _____ Telephone Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Other physicians involved in your care: _____

Previous Eye Care: _____

Social History: (Please include how long) Smoking _____ Alcohol _____ Other _____

Individuals living in your household: _____ Pets: _____

Occupation: _____ Hobbies: _____

Family History: (Please indicate any diseases that run in your family and who had the disease)

- | | | |
|------------------------|-----------------------------|--------------------------|
| ___ Cancer | ___ Diabetes | ___ Hypertension |
| ___ Heart disease | ___ Arthritis | ___ Neurologic disorder |
| ___ Thyroid disease | ___ Other medical problems: | |
| ___ Retinal detachment | ___ Glaucoma | ___ Macular degeneration |
| ___ Cataracts | ___ Other eye disorders: | |

Eye History: Have you ever been diagnosed with:

- | | | | |
|--------------------------|--------------------------|-------------------------|-----------------------|
| ___ Cataracts | ___ Macular degeneration | ___ Glaucoma | ___ Retinal disorders |
| ___ Diabetic retinopathy | ___ Corneal problems | ___ Other eye problems: | |

Eye Surgery/Eye Trauma: (Please list what and when)

Right Eye: _____

Left Eye: _____

Where did you get your last pair of glasses/contact lenses? _____ When? _____

Contact lens wearers: Type of lens: _____ How long worn? _____ Replaced how often? _____
How long do you usually wear them each day? _____ Do you ever wear them overnight? _____ If so, how often? _____
Cleaning/Soaking system _____ Does water ever come in contact with your lenses? _____

Present eye problems or concerns you have: _____



PATIENT INFORMATION

NAME (Last, First Middle)				MRN	SSN#	BIRTHDATE	SEX
LOCAL ADDRESS			CITY, STATE ZIP		SECONDARY/BILLING ADDRESS (if Applicable)		
HOME PHONE	DAY PHONE	EMAIL ADDRESS		REFERRING PHYSICIAN	CITY, STATE ZIP		
MARITAL STATUS	STUDENT STATUS <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE		
PRIMARY EMPLOYER				SECONDARY EMPLOYER (if Applicable)			
ADDRESS				ADDRESS			
CITY, STATE ZIP				CITY, STATE ZIP			
WORK PHONE				WORK PHONE			

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)				SSN#	BIRTHDATE	SEX	
LOCAL ADDRESS			CITY, STATE ZIP		SECONDARY/BILLING ADDRESS (if Applicable)		
HOME PHONE	DAY PHONE	EMAIL ADDRESS		CITY, STATE ZIP			
MARITAL STATUS	STUDENT STATUS <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE		
RELATIONSHIP TO PATIENT							

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY			POLICY#		
NAME OF INSURED			GROUP#		
ADDRESS OF INSURANCE COMPANY			COPAY AMT \$		
CITY, STATE ZIP		PHONE	DEDUCTIBLE \$		
RELATIONSHIP TO PATIENT			EFFECTIVE DATE	EXPIRATION DATE	

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY			POLICY#		
NAME OF INSURED			GROUP#		
ADDRESS OF INSURANCE COMPANY			COPAY AMT \$		
CITY, STATE ZIP		PHONE	DEDUCTIBLE \$		
RELATIONSHIP TO PATIENT			EFFECTIVE DATE	EXPIRATION DATE	

SIGNATURE OF PATIENT/GUARDIAN

DATE



Agnone, Morrison & Associates
Eye Physicians and Surgeons, Inc.

Charlotte M. Agnone, MD, FACS
Jennifer A. Morrison, MD
114 Morey Drive
Marysville, OH 43040
937-578-2200 (Phone)
937-578-4089 (Fax)
www.amaEyes.com

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/14/03 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

The following categories describe some examples that our practice may use and disclose your medical information. These are some examples and therefore, not every permitted use and disclosure is listed.

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose medical information about you in connection with our healthcare operations. These uses and disclosures are necessary to run the practice and make sure that our patients receive quality health care. For example, we may use medical information to review our treatment, services and to evaluate the performance of our staff in caring for you. We may also disclose medical information to doctors, nurses, technicians, medical students and other practice personnel for review and learning purposes.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us written authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Appointment Reminders: We may use and disclose your medical information to contact you as a reminder that you have an appointment for treatment or medical care.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Person Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

PATIENT RIGHTS

Access: You have the right to inspect and obtain a copy of your medical information. This includes your medical and billing records. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. To inspect or obtain a copy of your medical information, you must submit your request in writing to the name and address listed at the end of this Notice.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations (you must make your request in writing). Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative.

Amendment: You have the right to request that we amend your health information (your request must be in writing and it must explain why the information should be amended). We may deny your request under certain circumstances.

Electronic Notice: You are entitled to receive a paper copy of this Notice. You may ask us to give you a copy at any time.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services (we can provide you with the address).

Contact Officer: Pamela J. Andrews, OCS
Telephone: 937-578-2200
Fax: 937-578-4089
Address: Agnone Morrison & Associates
114 Morey Drive
Marysville, OH 43040

Notice amended 1/1/08)



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ACKNOWLEDGMENT OF HIPAA NOTICE OF PRIVACY PRACTICES

I, _____ (Print Name of Patient), acknowledge that I received a copy of AGNONE, MORRISON & ASSOCIATES, Eye Physicians and Surgeons, Inc. Notice of Privacy Practices.

Patient's Signature

Date of Signature

amaEyes' Signature

Date of Signature

If the patient did not acknowledge receipt of Privacy Notice above, you must document below your efforts to obtain the patient's acknowledgement and the reason why it was not obtained:

amaEyes' Signature

Date of Signature



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FINANCIAL POLICY

OUR PRIMARY PROFESSIONAL RELATIONSHIP is with our patients. We participate in most insurance plans but our allegiance is to our patients first. We expect our patients to take final responsibility for the cost of their medical care. If your insurance company does not respond to our claims, then we will ask for your assistance.

CO-PAYMENTS, COINSURANCE, and DEDUCTIBLES will be collected at the time of service, if required by our contract(s) with your insurance. We accept cash, personal checks, MasterCard and VISA. Co-payments are charged at the (specialist) office visit rate. If you arrive in the office unprepared to pay these required sums, we will need to reschedule your appointment. Patients without insurance (self-pay) are expected to pay in full at the time of service. We do not accept postdated checks. We do not accept attorney letters promising payment after settlement of accident and/or injury claims.

WE FILE INSURANCE CLAIMS for you with Medicare, Medicaid, and insurance carriers with whom we participate. We will make every effort to file with your 2nd and 3rd carrier for you. Please tell us if you do not want us to file an insurance claim. Charges for a first visit typically run between \$150.00 and \$250.00; they can be higher or lower.

BRING YOUR CURRENT INSURANCE CARD(s) to each visit. Tell us when you change your medical insurance(s). Also, please tell us of address and/or telephone number(s) changes.

HMOs MAY REQUIRE AUTHORIZATION from a primary care physician for specialist visits. You must obtain this BEFORE your visit. We regret that we cannot obtain these authorizations for you. If you need an authorization but have not obtained one, we will need to reschedule your appointment.

MEDICAID PATIENTS must bring a current Medicaid card to each visit. If you have a spend-down that is not yet met, bring that amount with you.

THE BILLING OFFICE phone number is 937-578-2893.

**The Purpose of Our Ophthalmology Practice is to Heal Our Patients;
 The Purpose of Our Ophthalmic Business is to Keep Us in the Practice of Ophthalmology.**

The following policies are in place to allow us to remain in the practice of ophthalmology:

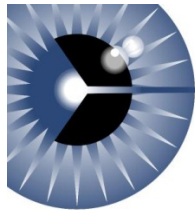
- \$30.00 charge for NSF checks.
- \$25.00 charge for appointment cancelled with less than 48 hours notice.
- Charges for completion of disability, FMLA, etc. forms are \$20.00 for the first page and \$5.00 for each additional page, payable in advance.
- \$20.00 charge for statement if co-payment, coinsurance and/or deductible not made at time of service.
- 40% of balance charge if payment not forthcoming and account transferred to collection agency.
- Records copying & mailing charges per State of Ohio guidelines.

Detailed explanations of the above policies are available upon request.

I, _____ (Name of Patient), have read the above FINANCIAL POLICY in full. I understand and agree to comply with the FINANCIAL POLICIES of AGNONE, MORRISON, & ASSOCIATES, INC. I authorize AGNONE, MORRISON, & ASSOCIATES, INC., to release any medical information needed for insurance claims submission, and I assign to it the insurance payment for its services. I understand that I am financially responsible for charges not covered by insurance.

 Signature of Patient or Responsible Party

 Date



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RECORDS RELEASE/REQUEST

TO _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

I HEREBY AUTHORIZE THE RELEASE OF MY _____

OR COPIES OF SUCH AND REQUEST THAT THEY BE TRANSFERRED TO:

AGNONE, MORRISON & ASSOCIATES EYES
PHYSICIANS AND SURGEONS, INC.
114 MOREY DRIVE
MARYSVILLE, OH 43040
PHONE-937-578-2200
FAX-937-578-4089

NAME OF PATIENT: _____

SS#: _____ DOB: _____ / _____ / _____

PATIENTS SIGNATURE _____

DATE _____ / _____ / _____