



TO OUR PATIENT

We would like to take this opportunity to welcome you to our practice and thank you for choosing SureVision Eye Centers for your eye care needs.

Your appointment with Dr. Lawrence Gans is scheduled on _____

Your arrival time is _____

The office is located at 7934 North Lindbergh Boulevard in Hazelwood, MO 63042.

The St. Charles location is 2127 Bluestone Drive, St. Charles, MO 63303

The Creve Coeur location is 612 North New Ballas Road, Creve Coeur, MO 63141

In order to decrease your wait time in the office we are enclosing the following forms

1. Patient information
2. Consent to treat
3. Patient confidentiality, and
4. Health history

Please take a few moments to read, complete and sign each of these forms and mail them back to us in the enclosed self-addressed postage-paid envelope at least five days before your scheduled appointment. If you cannot mail the forms back to us in the allotted time frame, please bring them with you to your appointment and plan to arrive 15 minutes early so we have adequate time to input the information.

Please bring your insurance cards as well as a valid photo I.D. to your appointment. If you are currently enrolled in an HMO insurance, you will need to notify your primary care doctor's office before your scheduled appointment and obtain a referral for your visit. If you are unsure if you need a referral, call your insurance company before your appointment and check. All appointments without a necessary referral will need to be rescheduled.

If you have any questions or if you need to reschedule your appointment, please call our office at one of the numbers listed below.

Office Locations

Address	Phone	Toll-free
7934 North Lindbergh Boulevard, Hazelwood, MO 63042	(314) 921-2020	(866) 305-2044
612 North New Ballas, Creve Coeur, MO 63141	(314) 863-9966	(877) 718-2020
1 Professional Drive, Suite 260, Alton, IL 62002	(618) 465-2020	(866) 443-6192
2127 Bluestone Drive, St. Charles, MO 63303	(636) 949-3924	



PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

This Consent was signed by: _____
Printed Name – Patient or Representative

Relationship to Patient (if other than patient): _____

Date: ____/____/____

Witnessed by: _____
Printed Name – Practice Representative

I agree to have my health information disclosed to the following person(s):

Name

Relationship to Patient

Name

Relationship to Patient



PATIENT INFORMATION

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NAME LAST FIRST MIDDLE INITIAL			DATE / /	
STREET ADDRESS		APT. #	SOCIAL SECURITY # - -	
			SPECIAL NEEDS <input type="checkbox"/> WHEELCHAIR <input type="checkbox"/> HEARING IMPAIRED <input type="checkbox"/> WALKER	
STATE	ZIP CODE	BIRTH DATE	AGE	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
HOME PHONE		WORK PHONE		MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED
EMPLOYER NAME/ADDRESS			POSITION/DEPARTMENT	
SPOUSE'S NAME			SPOUSE'S WORK PHONE ()	
EMERGENCY CONTACT – NAME AND PHONE NUMBER			YOUR E-MAIL ADDRESS	

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GUARANTOR (FINANCIALLY RESPONSIBLE PERSON) NAME _____		RELATIONSHIP TO PATIENT <input type="checkbox"/> SELF <input type="checkbox"/> PARENT <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER		
SOCIAL SECURITY # - -				
STREET ADDRESS		BIRTH DATE	PHONE ()	
CITY		STATE	ZIP CODE	
SEND WORKERS COMP BILL TO		AUTHORIZED BY NAME PHONE ()		

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WHOM MAY WE THANK FOR TELLING YOU ABOUT OUR PRACTICE?		<input type="checkbox"/> FRIEND/FAMILY <input type="checkbox"/> NEWSPAPER <input type="checkbox"/> M.D. <input type="checkbox"/> RADIO <input type="checkbox"/> OPTOMETRIST <input type="checkbox"/> OTHER <input type="checkbox"/> SCREENING <input type="checkbox"/> YELLOW PAGES		
STREET ADDRESS		CITY	STATE	ZIP CODE
PRIMARY CARE DOCTOR		PHONE ()		
STREET ADDRESS		CITY	STATE	ZIP CODE

Agreement of Responsibility

I understand that professional services are rendered to the patient and the patient is responsible for charges incurred for these services. Payment for annual deductibles and co-insurance may be collected at the time of service. I understand that I am financially responsible for charges not covered by my insurance company.

Consent to Treat

I voluntarily consent to such care and treatment as prescribed by the physician as is necessary in his/her medical judgment.

Release of Information/Assignment of Benefits

I authorize use of this form on all my insurance submissions and authorize release of information needed to process a claim to all my insurance companies. I permit a copy of this authorization to be used in place of the original. I authorize the provider to act as my agent in helping me obtain payment from my insurance companies. I understand the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement on disputed claims. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand I will receive a monthly statement for any balance due by me.

Medicare Authorization

Medicare No. _____

I request payment of authorized Medicare benefits be made on my behalf to SureVision Eye Centers – Midwest, LLC for any services furnished me by that physician/supplier. I authorize the holder of medical information about me to release to Medicare and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If “other health insurance” is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and the uncovered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Medigap Authorization

Insurance Co. _____

Policy No. _____

Fill out if you have a Medigap insurance policy for which you wish to assign benefits. A Medigap or Medicare Supplemental policy is a health insurance policy or other health benefit plan, offered by a private company, to those entitled to Medicare benefits. It is designed to pay certain costs that Medicare does not pay. By law, this excludes a policy or plan offered by an employer to employees or former employees, as well as a policy or plan offered by a labor organization to members or former members.

This Agreement is in effect until revoked in writing by the patient.

Name: _____ Date: ____/____/____

Signature: _____



NAME _____

Date of Birth _____

Have you or do you currently have any of the following medical problems?	YES	NO	If yes, please explain
Heart (heart attack, high blood pressure, congestive heart failure, pacemaker, heart surgery, high cholesterol, etc)			
Dermatologic (acne, rosacea, eczema, psoriasis, etc)			
Gastrointestinal (Crohn's disease, colitis, inflammatory bowel disease, GERD, Ulcer)			
Genitourinary (enlarged prostate, endometriosis, ovarian cyst, current pregnancy, etc)			
Ear, Nose, Throat (chronic sinus disease, deafness, tonsillitis, etc)			
Hematologic (sickle cell anemia, Leukemia, Lymphoma, etc)			
Immunologic (Sjögren's syndrome, Rheumatoid arthritis, seasonal allergies, Lupus, Myasthenia gravis, etc)			
Infectious diseases (Hepatitis B, Hepatitis C, HIV, Aids, etc)			
Endocrine (Diabetes- type I or II, hypothyroidism, hyperthyroidism, pituitary tumor, etc)			
Musculoskeletal (osteoarthritis, fibromyalgia, osteoporosis, etc)			
Cancer (skin cancer, bladder cancer, breast cancer, chemotherapy, radiation, etc)			
Neuropsychiatric (cluster headaches, migraine headaches, multiple sclerosis, Alzheimer's, dementia, depression, mood swings, etc)			
Pulmonary (asthma, emphysema, cystic fibrosis, COPD, etc)			

Please explain or list any other medical problems:

Patient Signature: _____ Date: _____

Tech initials: _____

