Julie Foreman, M.D.

Patient Record of Disclosures

PATIENT NAME:________________________________DOB:_________________

The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of protected health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means or contacts.

We may need to contact you to provide information about treatment plan, treatment alternatives, test results, surgical scheduling, or health care information.

What phone number would you like us to call to contact you?

PHONE #____________________ Secondary Phone #_____________________

May we leave a confidential message on your answering machine or voicemail?

YES NO

You may elect to sign up for text alerts through our secure portal

Cell phones and answering machines are **NOT** secure and private

Whom may we speak with regarding your **GENERAL** information, billing, or payment information?____

____

Whom do you **NOT WANT** notified of any of your health or general information?

____

Record of Disclosures of Protected Health Information

(For office use only)

Date	Disclosed to whom	Reason for disclosure	By whom

Financial Policy

Thank you for choosing Dr. Julie Foreman as your healthcare provider. We are committed to making healthcare transparent and more effective by clarifying your financial responsibility in advance.

I hereby assign and authorize payment of insurance benefits otherwise payable to me, directly to Julie L Foreman LLC, for office or hospital services which are not paid by me at the time of service.

I hereby authorize Julie L Foreman LLC to release and/or receive any medical records or information:

- ❑ Requested by my insurance company or workers' compensation carrier
- ❑ Requested by any hospital or physician I may be referred to by this office
- ❑ Requested from any hospital or physician who has previously rendered me treatment
- ❑ Any of my authorized family members or caregivers

I accept full responsibility for payment of all charges for medical care I receive from Julie Foreman MD, if this assignment of claim is rejected or modified. If after 30 days from date of service my insurance has not processed my claim, I agree to contact my insurance company to assist in expediting payment to prevent my account from becoming delinquent. Julie L Foreman LLC accepts cash, check, VISA, Mastercard, American Express, Discovercard, and CareCredit. I understand that payment of any copays, co-insurances, deductibles, and non-covered services is due at the time of service. I also agree to pay any balances on my account prior to or on my next date of service (in the event of any unprocessed claims older than 30 days). No refunds will be issued until all charges with Julie L Foreman LLC are paid in full. I will assume full responsibility for payment. I further consent to pay all fees associated with collecting any and all unpaid balances in the event that my account is turned over to an outside collection agency.

Julie Foreman MD discloses that she has a financial interest in Lafayette General Surgical Hospital and Oil Center Surgical Plaza. If you require further information, please speak to her directly.

__________________________________ ______________________

Signature of patient or legal guardian Date

__________________________________ ______________________

Printed name of legal guardian Relation to patient

__________________________________ ______________________

Witness Date

Julie Foreman, M.D.

Refraction Service Acknowledgment

The refraction is one of the most important parts of your eye exam. This is the part of the exam where we determine your glasses or contact prescription. The refraction allows us to determine the best possible visual acuity and function of the eye.

Medicare and many insurance plans do NOT cover the refraction. They consider refraction a “vision” service and not a “medical” service. <u>Our fee for the refraction is $30</u>. Unless your plan covers this fee, we are required to collect it, as well as any co-payment on the day of service. If your plan covers the refraction, and we have collected the fee, we will refund your payment in a timely fashion.

I have read the above information and understand the refraction is NOT covered by Medicare and most insurance plans. I accept full financial responsibility for the cost of this service and understand that payment is due at the time of service. I understand that any co-payment, co-insurance, or deductible that may be owed is separate from and not included in the refraction fee.

________________________________ ______________________

Signature of patient or legal guardian Date

________________________________ ______________________

Printed name of legal guardian Relation to patient

___I decline the refraction service today and will not be provided a prescription for glasses or contacts without an up-to-date refraction.

________________________________ ______________________

Signature of patient or legal guardian Date

________________________________ ______________________

Printed name of legal guardian Relation to patient

Julie Foreman, M.D.

Acknowledgment of Notice of Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, coordinate, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change the Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain an updated copy of the Notice of Privacy Practices. If further clarification is needed, I reserve the right to speak with the practice HIPAA Compliance Officer or designee.

I understand that I may request in writing that you restrict how my private health information is used or disclosed to carry out treatment, payment, or health operations. I also understand you are not required to agree to my requested restrictions, but if you do agree you are bound to abide by such restrictions.

____ __________________________

Signature of patient or legal guardian | Date

____ __________________________

Printed name of legal guardian | Relation to patient

Julie Foreman, M.D.

Patient History Form

Patient Name:___________________________________Today's Date: _______________________

Gender: □ Male □Female Age:__________Date of Birth:___________________________________

Are YOU being treated or have YOU ever been treated for any of the following? Please CIRCLE any of the following conditions that you have or have had:

Diabetes	Arthritis (RA/Lupus)	Hypertension	Heart Disease
Stroke	Cancer	Kidney Disease	Thyroid Disease
Sarcoidosis	HIV	Syphilis	

Other known medical conditions:____

Have YOU had any surgery (including EYE surgery) in the past? No Yes

If yes, please list surgeries and dates (if known):____

Do any EYE DISEASES run in your family?

Please circle: Glaucoma Macular Degeneration Retinitis Pigmentosa

Aniridia Keratoconus Amblyopia/Lazy Eye

Other:____

Have YOU been treated for any EYE DISEASES in the past? No Yes

If yes, please list reason and dates (if known):____

Please list ALL eye drops or ointments YOU are NOW using:________________________________

Do you smoke or use tobacco products? No Yes ___Packs per day for___years

Julie Foreman, M.D.

Do you drink alcohol? No Yes How much, how often?___________________

Are YOU allergic to any substance, food, or medication? No Yes

Please list ALL drugs that you are allergic to (and reaction if known):________________________

____

____

____

Are you currently experiencing any of the following? **PLEASE CIRCLE if YES.**

Fever	Chills	Weight loss
Weight gain	Double vision	Hearing loss
Ringing in the ears	Sinus problems	Chest pain
Palpitations	Passing out	Shortness of breath
Productive cough	Wheezing	Abdominal pain
Nausea/vomiting	Bloody stool	Diarrhea
Constipation	Blood in urine	Joint pain
Muscle pain	Rash	Skin cancer
Weakness	Excessive thirst	Heat intolerance
Easy bleeding/bruising	Anxiety	Depression
Hives	Seasonal allergies	Other:______________

PATIENTS, PLEASE DO NOT WRITE BELOW THIS LINE

Physician Comments:

I have reviewed and confirmed the above history: ___________Julie Foreman MD/Date:__________

Julie Foreman, M.D.

Records Release Authorization

SEND RECORDS TO:____

(includes written, electronic, verbal records)

OR

OBTAIN RECORDS FROM:____

(includes written, electronic, verbal records)

Patient Name: ____Date of Birth:______________

__I hereby authorize Dr. Foreman to obtain copies of any and all of my medical records pertaining to my medical history and treatment. This authorization may include hospitals, physicians, nurses, insurance companies and their representatives and any institution, agency and/or individual representing me.

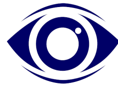
__I hereby authorize Dr. Foreman to release any and all of my medical information and or copies of such records including diagnosis, treatment, examinations, testing, or surgeries rendered to me during the period of my medical care.

I further agree that this authorization shall be valid and effective indefinitely unless and until it is revoked by me in writing and that a photocopy of this authorization may serve as an original.

Dates of records: from:___________to:____________

Request expires:______________________________

Signature:____Date:______________________



Julie Foreman, M.D.

Please circle: Patient/Parent/Guardian