Magnante eye care
A UNITY HEALTHCARE PARTNER

PATIENT'S INFORMATION

Date: _____ Social Security#: _____

Patient Name: _____
Last Name Suffix First Name MI

Permanent Mailing Address: _____
Street City/State Zip Code

Physical Address: _____
(If different than mailing) Street City/State Zip Code

Home Phone: _____ Cell Phone: _____

Sex: ☐ M ☐ F DOB: _____

Gender Identity: ☐ Female-to Male/ Transgender Male ☐ Male-to-Female/ Transgender Female ☐ Non-Binary/ Genderqueer ☐ Others

Employer Name: _____ Employer Phone: _____

Employer Address: _____
Street/Mailing City/State Zip Code

☐ Full-Time ☐ Part-Time ☐ Retired ☐ Not Employed ☐ Self-Employed ☐ Active Military Duty

E-mail Address: _____

Primary Care Physician: _____

PCP City: _____ PCP Phone: _____

Marital Status: _____

Race: _____ Ethnicity: ☐ Hispanic ☐ Not Hispanic

REFERRAL INFORMATION

How were you referred to us?

☐ Physician ☐ ER / Urgent Care ☐ Family Member/Friend ☐ Employer ☐ Website ☐ TV ☐ Newspaper ☐ Radio

If physician or medical facility referral, please list the name: _____

Physician/Facility City: _____ Physician/Facility Phone: _____

INSURANCE INFORMATION

Primary Insurance Co.: _____

Subscriber's Full Name: _____

Subscriber's Address: _____
(If different than patient) Street City/State Zip Code

Subscriber's Sex: ☐ M ☐ F Subscriber's DOB: _____ Subscriber's SS#: _____

Subscriber's Relationship to the patient: _____

Subscriber's Employer: _____ Employer's Phone: _____

Subscriber's Employer Address: _____

Secondary Insurance Co.: _____

Subscriber's Full Name: _____

Subscriber's Address: _____
(If different than patient) Street City/State Zip Code

Subscriber's Sex: ☐ M ☐ F Subscriber's DOB: _____ Subscriber's SS#: _____

Subscriber's Relationship to the Patient: _____

Subscriber's Employer: _____ Employer's Phone: _____

Subscriber's Employer Address: _____

PARENT INFORMATION
(If minor child)

Father's Name: _____
Last Name Suffix First Name MI

Father's Home Phone: _____ Father's Cell Phone: _____

Father's Mailing Address: _____
(If not listed as subscriber) Street City/State Zip Code

Father's DOB: _____ Father's SS#: _____

Father's E-mail: _____

Father's Employer: _____
(If not listed as subscriber)
Employer's Address: _____

Mother's Name: _____
Last Name First Name MI

Mother's Home Phone: _____ Mother's Cell Phone: _____

Mother's Mailing Address: _____
(If not listed as subscriber) Street City/State Zip Code

Mother's DOB: _____ Mother's SS#: _____

Mother's E-mail: _____

Mother's Employer: _____
(If not listed as subscriber)
Employer's Address: _____

UNITY HEALTHCARE, LLC
HIPAA RELEASE OF INFORMATION

Name: _____ DOB _____

Due to HIPAA rules and regulations, we are not permitted to discuss your medical information with anyone, including your family, without your consent or unless an exception to the rule applies (e.g. provider-to-provider discussions related to your treatment or to collect payment).

If you want to allow us to communicate with any person, please complete the following. You may change your mind at a later date.

Please list individuals (other than providers) we may speak with regarding your care:

Name:	Relationship:	Phone:
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

A photocopy of this authorization shall be considered as valid as the original. **This Release of Information will remain in effect until terminated by the patient in writing.**

Patient Signature: _____ Date ___/___/____

Rev 12/17

UNITY HEALTHCARE, LLC
DISCLOSURE AND RELEASE AUTHORIZATION FORM

CONSENT TO TREAT: I request and give consent to my Unity Healthcare, LLC ("Unity") physician to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as my physician, in his/her professional judgment, deems necessary or beneficial. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me. _____ Initials

OWNERSHIP DISCLOSURE: I acknowledge that Unity and indirectly, Unity's physicians, have an ownership interest in Unity Surgical Center ("USC"), and InnerVision Advanced Medical Imaging Center ("InnerVision"). I understand that I am free to determine which facility to utilize for health care services and neither Unity nor my physician shall discriminate in the care provided to me should I desire to use a facility other than USC and InnerVision. I have been informed of the information in writing by my physician's office in advance of the date of my procedure. _____ Initials

RELEASE OF MEDICAL INFO AND AUTHORIZATION TO PAY INSURANCE BENEFITS: I authorize Unity and my physician to release information from my medical records to my insurance carrier(s), governmental agency, or my employer in the case of work-related injuries, for the purpose of processing claims for medical/workers compensation benefits and state on such claims that my signature is on file. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my physician, on my behalf. _____ Initials

FINANCIAL AGREEMENT: I understand and agree to all of the following: _____ Initials

a. All accounts are the full responsibility of the patient and/or the patient's responsible party guarantor.
b. No conditional payments accepted and payments with attempted conditions will be applied to any amounts owed.
c. Unity will assist me in obtaining insurance benefits when those benefits are assigned to my/the patient's provider, and I have provided complete information regarding my/the patient's primary and secondary health insurance, as applicable.
d. I am responsible to make sure insurance payments are processed and paid promptly to my physician, and for my prompt payment of any amounts owed to Unity that are deemed "Patient Responsibility" under my insurance contract (for those payors with which Unity is a participating provider or "in-network"). Otherwise, it is my responsibility if my insurance does not cover such services, or Unity is a non-participating provider or "out-of-network".
e. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts. I agree that reasonable attorney fees shall be interpreted as 40% of any balance due at the time the account is sent to an attorney or collection agency for collection, or $300.00, whichever is greater.
f. Tippecanoe County, Indiana, shall be the preferred venue for any legal action related to this financial agreement and I agree to waive my right to a trial by jury.
g. This financial agreement is being entered into individually and as an authorized agent for my spouse, if any. This financial agreement may be assigned by Unity to an attorney who purchases Unity's delinquent accounts and the terms of this agreement shall remain binding.

TELEPHONE CONTACTS: I authorize Unity and its affiliates and agents to contact me at the phone numbers I have provided (whether such is a cell phone or a land line), including providing me with automated appointment reminders and other automated calls related to the services provided to me. If a machine or voice mail is reached, I understand a message may be left for me. (If you are receiving treatment from multiple Unity providers, it may result in multiple calls.) _____ Initials

NOTICE OF PRIVACY PRACTICES: I acknowledge that I have been offered a copy of the Unity Notice of Privacy Practices and understand that my protected health information ("PHI") may be used by Unity as described in such Notice. _____ Initials

INDIANA LAW AND JURISDICTION: I understand that I am being provided treatment in the State of Indiana and I agree that if I should have any claim with regard to my care or treatment, such will be decided in accordance with Indiana law and such action will be brought and decided in a Court in the State of Indiana. _____ Initials

NOTICE OF NONDISCRIMINATION: Unity complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex or gender identity. _____ Initials

OTHER PROVIDERS: I understand in addition to the attending physician, other physicians, such as radiologists and pathologists, and other providers such as laboratories and other medical professionals, may be involved in my care, and may separately bill me for their services. _____ Initials

PHOTO CONSENT: I consent to have my photographs taken by the provider or designated associate if required, and permit use of photographs for medical records, education, and lectures. _____ Initials

CANCELLATIONS OR MISSED APPOINTMENTS: A fee may be charged for any appointments not cancelled at least twenty-four (24) hours in advance or missed for any other reason. These are generally not payable by insurance. _____ Initials

MEDICARE CERTIFICATION: (IF APPLICABLE) I certify that the information given by me, or by Unity on my behalf, in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my treating physician to release information from my medical record to the Social Security Administration and/or Medicare program or its intermediaries or carriers, or the Professional Standards Review Organizations for the purpose of processing of claims for medical benefits and state on such claims that my signature is on file. I request that payment of such authorized benefits be made directly to Unity or my treating physician on my behalf. _____ Initials

Patient Name/Signature:_____ Date: _____

Parent/Guardian Signature:_____ Date: _____

REV 5/20/19

Have you had in the past or do you currently have any of the following?

Patient Name: _____ Date of Birth: _____

Eyes	Yes	No
Previous Surgery	☐	☐
Lasik	☐	☐
Contact lens	☐	☐
RK	☐	☐
Pain	☐	☐
Double Vision	☐	☐
Glaucoma	☐	☐
Cataracts	☐	☐
Macular Degeneration	☐	☐
Dry Eyes	☐	☐
Flashes/Floaters	☐	☐
Ear, Nose, Throat	☐	☐
Hard of hearing	☐	☐
Ringing in ears	☐	☐
Vertigo	☐	☐
Difficulty swallowing	☐	☐
Cardiovascular	☐	☐
Chest pain	☐	☐
Dizziness	☐	☐
Fainting spells	☐	☐
Shortness of breath	☐	☐
Irregular heart beat	☐	☐
Difficulty lying flat	☐	☐
Pacemaker/Defibrillator	☐	☐
Constitutional	☐	☐
Fatigue/Weakness	☐	☐
Fever	☐	☐
Weight Loss/Gain	☐	☐
Respiratory	☐	☐
Cough	☐	☐
Congestion	☐	☐
Wheezing	☐	☐
Asthma	☐	☐
Gastrointestinal	☐	☐
Heartburn	☐	☐
Nausea/Vomiting	☐	☐
Jaundice/Hepatitis	☐	☐
Name of person or physician who referred		
Immunologic	☐	☐
Hives	☐	☐
Itching	☐	☐
Runny nose	☐	☐
Sinus pressure	☐	☐
HIV	☐	☐

Genitourinary	Yes	No
Pain/Difficulty	☐	☐
Blood in urine	☐	☐
Kidney Stone/Past	☐	☐
Sexually transmitted disease	☐	☐
Psychiatric	☐	☐
Anxiety/Depression	☐	☐
Mood swings	☐	☐
Difficulty sleeping	☐	☐
Endocrine	☐	☐
Increased thirst	☐	☐
Increased hunger	☐	☐
Increased urination	☐	☐
Increased sweating	☐	☐
Fingernail changes	☐	☐
	☐	☐
Blood/Lymph Nodes	☐	☐
Easy brusing	☐	☐
Gums bleed easily	☐	☐
Prolonged bleeding	☐	☐
Heavy aspirin use	☐	☐
Muscoskeletal	☐	☐
Stiffness	☐	☐
Arthritis	☐	☐
Joint Pain/Swelling	☐	☐
Skin	☐	☐
Rash/Sores	☐	☐
Lesions	☐	☐
Hives/Eczema	☐	☐
Skin Cancer	☐	☐
Neurologic	☐	☐
Seizures	☐	☐
Weakness/Paralysis	☐	☐
Numbness	☐	☐
Tremors	☐	☐

Patient Name: _____ Date of Birth: _____

Height: _____ Weight: _____

Primary Care Physician: _____

Cardiologist: _____

Optometrist: _____

Preferred pharmacy and location: _____

Name of person or physician who referred:

Please list **ALL** drug allergies: _____

_____

Please list **ALL** medications and reason you are taking them, including supplements.

Medication	Reason	Medication	Reason

Please list ALL surgeries especially heart surgeries: _____

_____

Family History **Grandparents**

	Yes	No	Self	Father	Mother	Brother	Sister	Maternal	Paternal
Arthritis									
Blindness									
Cancer									
Cataract									
Diabetes									
Glaucoma									
Heart									
Hight Blood Pressure									
Kidney									
Lazy Eye									
Macular Degen									
Retinal Desease									

	Yes	No			
Do you Smoke?	☐	☐	How many cigarettes per day? _____		
Do you drink alcohol?	☐	☐	How many drinks per day? _____		
Do you live at home?	☐	☐	Other:		
	☐	☐		Yes	No
Do you drive during the day?	☐	☐	With difficulty?	☐	☐
Do you drive at night?	☐	☐	With difficulty?	☐	☐
Do you use a computer or tablet?	☐	☐			
Do you still work?	☐	☐	Occupation: _____		

Patient or representative Signature: _____ Date: _____