BCS EYE ASSOCIATES
KRISHNA SHANMUGAM, M.D.

PATIENT INFORMATION

Patient Name (First, Middle Initial, Last): _____

Address (Street, City, State, and Zip): _____

Home Phone: _____ **Cell Phone:**_____ **Email:**_____

Social Security: _____ **Date of Birth:** _____ **Sex:** _____

Height _____ **Weight** _____ **Age** _____

MEDICAL HISTORY

Primary Eye Care Doctor Name & Phone Number: _____

Primary Care Physician & Phone Number: _____

Referring Doctor's Name & Phone Number: _____

Pharmacy: _____ **Pharmacy Location (Street Address):**_____

Systemic Illnesses:

- ▫ No history of Illnesses
- ▫ Anemia
- ▫ Arthritis
- ▫ Arrhythmia
- ▫ Asthma
- ▫ Bleeding Disorder
- ▫ Cancer
- ▫ Thyroid Disease
- ▫ Congestive Heart Failure
- ▫ COPD
- ▫ Diabetes
- ▫ Eczema
- ▫ Fribromyalgia
- ▫ Headache
- ▫ Hearing Loss
- ▫ Hepatitis
- ▫ High Blood Pressure
- ▫ High Cholesterol
- ▫ HIV
- ▫ Kidney Disease
- ▫ Kidney Stones
- ▫ Liver Disease
- ▫ Lung Disease
- ▫ Lupus
- ▫ Migraine
- ▫ Polymyalgia
- ▫ Psychiatric Disorder
- ▫ Skin Cancer
- ▫ Stroke

Other_____

Infections (Mark all that apply):

- ▫ Overall Healthy
- ▫ Meningitis
- ▫ Wound Infection
- ▫ Shingles
- ▫ Toxoplasmosis
- ▫ Syphillis
- ▫ Histoplasmosis
- ▫ Chicken Pox
- ▫ MRSA

Other_____

General Surgeries/Operations (Please list):

_____

_____

Ocular History (Mark all that apply):

- ▫ Overall Healthy
- ▫ Amblyopia (Lazy eye)
- ▫ Aphakia
- ▫ Astigmatism
- ▫ Cataracts
- ▫ Diabetic Retinopathy
- ▫ Dry Eyes
- ▫ Glaucoma
- ▫ Hyperopia (Far Sighted)
- ▫ Iritis
- ▫ Keratoconus
- ▫ Macular Degeneration
- ▫ Myopia (Near Sighted)
- ▫ Optic Neuritis
- ▫ Retinal Detachment
- ▫ Trauma

Other_____

Ocular Illnesses (Mark all that apply):

- ▫ Overall Healthy
- ▫ AIDS
- ▫ Diabetes
- ▫ Herpes
- ▫ Rheumatoid Arthritis
- ▫ Hypertension
- ▫ Hypothyroidism
- ▫ Lupus
- ▫ Multiple Sclerosis
- ▫ Hyperthyroidism
- ▫ Graves Disease
- ▫ Sjogrens

BCS EYE ASSOCIATES
KRISHNA SHANMUGAM, M.D.

Ocular Surgeries (Mark all that apply, and indicate which eye):

▫ No prior ocular surgery	▫ Foreign Body Removal	▫ Punctal Plugs	▫ Trabeculectomy (Glaucoma Surgery)
▫ Cataract Surgery	▫ Blepharoplasty	▫ Retinal Laser Surgery	▫ RK
▫ LASIK	▫Strabismus/ Muscle Surgery	▫ Vitrectomy	▫ Corneal Transplant
▫ PRK			

Other_____

Current Medications - Including Any Eye Drops (Please list below or bring a copy of pharmacy list):

_____

_____

_____

_____

Have you ever taken prostate medicines / alpha blockers?
Please circle: Flomax, Tamsulosin, Hytrin, Cardura, Saw Palmetto, Doxazosin, Terazosin, Uroxatral, Rapaflo

Allergies to Medication	**Reaction**	**Severity**
_____	_____	Mild/Moderate/Severe
_____	_____	Mild/Moderate/Severe
_____	_____	Mild/Moderate/Severe

Problems with Anesthesia ▫ No ▫ Yes, reaction:_____

Have you ever had the Pneumonia Vaccine (This is a question required by the government): ▫ No ▫ Yes

Have you ever had a fall? (This is a question required by the government): ▫ No ▫ Yes

Social History (Mark all that apply):

Smoking: ▫ Current Every Day Smoker ▫ Current Some Day Smoker ▫ Former Smoker ▫ Never Smoked

Alcohol Use: ▫ Yes ▫ No If yes, how much and how often? _____

Family History

▫ Glaucoma	Mother / Father / Brother / Sister / Grandmother / Grandfather/_____
▫ Macular Degeneration	Mother / Father / Brother / Sister / Grandmother / Grandfather/_____
▫ Blindness	Mother / Father / Brother / Sister / Grandmother / Grandfather/_____
▫ Diabetes	Mother / Father / Brother / Sister / Grandmother / Grandfather/_____
▫ Cancer	Mother / Father / Brother / Sister / Grandmother / Grandfather/_____
▫ Heart Disease	Mother / Father / Brother / Sister / Grandmother / Grandfather/_____
▫ High Blood Pressure	Mother / Father / Brother / Sister / Grandmother / Grandfather/_____
▫ Unknown Family History	

Review of Systems

Eyes
- ▫ Poor Vision
- ▫ Eye Pain
- ▫ Tearing
- ▫ Redness
- ▫ Vision Loss

Respiratory
- ▫ Cough
- ▫ Congestion
- ▫ Wheezing
- ▫ Shortness of Breath

Blood/Lymph Nodes
- ▫ Easy Bruising
- ▫ Gums Bleed Easily
- ▫ Prolonged Bleeding
- ▫ Heavy Aspirin Use

BCS EYE ASSOCIATES
KRISHNA SHANMUGAM, M.D.

- ▫ Cataracts
- ▫ Macular Degeneration
- ▫ Dry Eyes
- ▫ Flashes / Floaters

Ear, Nose & Throat
- ▫ Hard of Hearing
- ▫ Ringing in Ears
- ▫ Stuffy Nose
- ▫ Earache

Cardiovascular
- ▫ Chest Pain
- ▫ Dizziness
- ▫ Fainting Spells
- ▫ High Blood Pressure
- ▫ Irregular Heart Beat
- ▫ Difficulty Lying Flat

Constitutional
- ▫ Fatigue
- ▫ Chills
- ▫ Fever
- ▫ Weight Gain
- ▫ Weight Loss

Gastrointestinal
- ▫ Heartburn
- ▫ Nausea / Vomiting
- ▫ Constipation / Diarrhea

Genito-Urinary
- ▫ Pain / Difficulty Urinating
- ▫ Blood in Urine
- ▫ Incontinence
- ▫ History of STD's

Psychiatric
- ▫ Anxiety
- ▫ Mood Swings
- ▫ Difficulty Sleeping
- ▫ Depression

Endocrine
- ▫ Increased Thirst
- ▫ Increased Hunger
- ▫ Increased Urination
- ▫ Increased Sweating
- ▫ History of Diabetes

Musculoskeletal
- ▫ Stiffness
- ▫ Arthritis
- ▫ Joint Pain / Swelling

Skin
- ▫ Rash/ Sores
- ▫ Lesions
- ▫ Hives / Eczema

Neurological
- ▫ Seizures
- ▫ Weakness / Paralysis
- ▫ Headache
- ▫ Tremors

Immunologic/Allergic
- ▫ Hives
- ▫ Itching
- ▫ Hay Fever/ Allergies
- ▫ Sinus Pressure

Other Signs or Symptoms Not Listed Above: _____

FINANCIAL POLICY

We are committed to providing you with the highest level of service and quality of care. If you have medical insurance, we strive to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our Financial Policy. Ultimately, any and all financial liability rests with the patient and their family.

Our office participates with most major medical insurance plans. We provide MEDICAL and SURGICAL services to our eye care patients. We DO NOT participate in ANY VISION PLANS. If you have a managed care plan that requires a referral to see a specialist, you must obtain a referral for your visit in our office to be covered under your medical insurance. If you do not have the proper referral and still wish to be seen, you are required to pay for your visit prior to your examination.

PATIENT RESPONSIBILITY: It is **YOUR** responsibility to:

- Contact your insurance company to obtain co-payment/co-insurance/deductible information and to verify that our physicians are participating, IN-NETWORK providers with your insurance
- Provide our practice with correct and current insurance information on or before the date of service
- Bring all current insurance cards to every visit
- Obtain your insurance referrals and understand your insurance policy

BCS EYE ASSOCIATES
KRISHNA SHANMUGAM, M.D.

Co-payments, Co-insurance and Deductibles are collected at the time of service as REQUIRED by our contract with your insurance company. We accept cash, personal checks, MasterCard, Visa, Discover, and American Express. Co-payments are charged at the "Specialist" office rate. If you arrive unprepared to pay these required fees, we will need to reschedule your appointment. We do not accept postdated checks, and we do not accept attorney letters promising payment after settlement of accident and/or injury claims.
Self-Pay Patients: (Patients who have no form of medical insurance) are required to pay fees in full at the time of service prior to seeing the doctor. Fees are based on the cost of a basic exam and testing as indicated by the doctor. Full payment is required prior to all surgical procedures. We do not accept postdated checks, and we do not accept attorney letters promising payment after settlement of accident and/or injury claims.

SPOUSE / GUARDIAN / NEXT OF KIN INFORMATION

Emergency Contact (Name)_____

Relationship to Patient:_____**Spouse**____**Guardian**____**Parent**____**Other:** _____

Cell Phone: _____ **Email:** _____

Address (Street, City, State, & Zip): _____

INSURANCE

If Patient is NOT the Primary Card Holder Please Fill in The Primary Holder Information Below

Policy Holder (Name)_____ **DOB:**_____

Relationship to Patient:_____**Spouse**____**Guardian**____**Parent**____**Other:** _____

Cell Phone: _____ **Email:** _____

Address (Street, City, State, & Zip): _____

BCS EYE ASSOCIATES
KRISHNA SHANMUGAM, M.D.

CONSENT FOR TREATMENT

I HEREBY AUTHORIZE BCS Eye Associates, Inc. to examine and treat me, or the individual for whom I am responsible.

During the course of diagnosis or treatment, eye drops may be used to dilate the pupils. These drops may cause temporary blurred vision and glare. Driving an automobile, or operating machinery, is not advised until the effects of the drops have worn off.

I authorize BCS Eye Associates, Inc. to release information acquired the course of my examination and treatment to my insurance carriers.

I further understand that I have primary responsibility for payment of my charges.

X _____
Signature of Patient (or guardian)

FOR OUR MEDICARE PATIENTS

After you are seen by the doctor, BCS Eye Associates, Inc. will submit a completed insurance form to Medicare. Their guidelines permit us to obtain a one-time signature that is valid for this and future visits to our office. By signing below, the notation "SIGNATURE ON FILE" will appear *in lieu* of your signature on all Medicare forms submitted for you by our office.

X_____
Signature of Medicare Beneficiary

BCS EYE ASSOCIATES
KRISHNA SHANMUGAM, M.D.

Medical Information Release

Printed Patient Name: _____

Patient Signature: _____

During the course of your care in our office, you may wish to have a family member, or afriend, assist you in scheduling appointments, setting up procedures, or obtaining medical information.

An authorization is necessary for our staff to release any information regarding your care.

Please list below any person(s) to whom you authorize the release of information regarding your care with BCS Eye Associates, Inc.

Name	Relationship to Patient	Date of Authorization	Revoke
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐

BCS EYE ASSOCIATES
KRISHNA SHANMUGAM, M.D.

CREDIT POLICY AND FINANCIAL AGREEMENT

- Each patient, *and not their insurance company*, is responsible for the payment of all charges. Payment is customarily made at the time that services are rendered, unless special arrangements are made in advance. If one of our doctors is a participating physician for your primary insurance plan, payment for any deductibles, co-pay amounts and non-covered services will be due at the time of service.

- It should be remembered that eye examinations, or certain other ophthalmic services, are not always covered by every insurance company. Even within the same insurance plan there may be many individual variations. It is your responsibility to know whether or not your insurance plan will cover the services that you receive in our office. It is simply not possible for the staff of this office to know how each and every individual insurance plan works.

- A refraction (the measurement of your eyes for a glasses prescription by either the doctor, or one of the ophthalmology technicians) is typically *not a covered benefit of your insurance plan*. In the course of your examination, when it is necessary to perform a refraction, it is with the understanding that you will be held financially responsible for this charge.

- This office accepts assignment for Medicare patients. However, each patient is responsible for payment of all non-covered costs. Examples of non-covered Medicare services would be:the refraction for glasses that is part of almost every comprehensive eye examination, the annual Medicare deductible, and any remaining balance of Medicare allowable fees not covered by a supplemental insurance plan. It is important to understand that when a participating physician accepts assignment from Medicare, it does not mean that whatever Medicare pays is to be considered payment in full. Medicare has never paid 100% of any charge. Many other insurance companies follow this same basic philosophy. The Stark II legislation, recently passed by the United States Congress, prohibits this office from extending courtesy discounts and/or professional write-offs.

- Payment on all accounts billed is expected within 30 days. If payment is not received within30 days, a monthly administrative fee may be added to your account to partially defray postage and other office costs generated by multiple billings.

- By signing below, I agree to the above terms and I agree to pay any collection costs and/or reasonable attorney's fees, if a delinquent balance is placed with a collection agency and/or attorney for collection, or suit.

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to BCS Eye Associates, Inc. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges, whether or not these charges are paid by my medical insurance. I hereby authorize BCS Eye Associates, Inc. to release any and all information necessary to secure payment.

Signed_____Date _____

NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. You have the right to obtain a paper copy of this Notice upon request.

Patient Health Information
Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We Use Your Patient Health Information
We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment, and Health Care Operations
Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.
Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.
Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses
We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures
We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:

Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
Research: We may use or disclose information for approved medical research.
Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
Judicial and Administrative Proceedings: We may disclose information in response to an appropriate subpoena or court order.
Law Enforcement Purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.
Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
Serious Threat to Health or Safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Military and Special Government Functions: If you are a member of the Armed Forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
Workers' Compensation: We may release information about you for Workers' Compensation or similar programs providing benefits for work-related injuries or illness.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights
You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.
Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.
Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.

Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.

Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.
Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices
We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints
If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person named below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person
If you have any questions, requests, or complaints, please contact:

Privacy Officer
BCS Eye Associates
3201 University Drive East Suite 445
Bryan, TX 77802

I,_____,
hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed: _____

Date: _____

If not signed, reason why acknowledgment was not obtained:

_____

Staff witness seeking acknowledgment:

_____ Date:_____