SAM N. COHLMIA, M.D.
eyecare

Date: _____

Name: _____

Dear Patient;

Enclosed you will find new patient forms to be completed prior to your first visit. It is essential that these forms be completed before arriving for your appointment on:

_____

On the day of your appointment, please bring:

1. **The two enclosed "patient information" forms, Filled out completely.**
2. **Your Insurance cards.**
3. **A list of medications that you are currently taking.**
4. **The address and phone number of your referring &/or primary care physician.**

If you have insurance coverage that requires a referral from your primary care physician, it is your responsibility to obtain this prior to your appointment. Please bring a copy of the referral with you, if you can. If you do not obtain your referral prior to your appointment, you may need to be rescheduled for another day.

We will be happy to file your insurance as a courtesy to you. **If you are a self pay patient, payment is due at the time of service. Please come prepared to pay your insurance co-payment at the time of service.**

We do accept Visa, Mastercard, personal check and cash as forms of payment.

*****PLEASE REMOVE YOUR CONTACT LENSES ATLEAST 24 HOURS PRIOR TO YOUR SCHEDULED APPOINTMENT TIME, OR YOU MAY HAVE TO RESCHEDULE. *****

If you are unable to keep your scheduled appointment, please kindly call our office and reschedule. Your cooperation is greatly appreciated. We look forward to meeting you and serving your entire ophthalmologic needs.

Sincerely,

Dr. Sam Cohlmia & Staff

9449 E 21ST
WICHITA, KS 67206
TEL 316-264-8932
FAX 316-264-1257
TOLL FREE 866-565-2020
www.samcohlmia.com

PLEASE READ AND SIGN THE FOLLOWING

I hereby authorize **WICHITA OPHTHALMOLOGY, P.A** to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to same all payments for medical service rendered to me. A photocopy of this authorization and assignment shall be as binding as the original.

Patient Signature _____ Date _____

Parent/Guardian Signature _____ Date _____
(If patient is a minor)

MEDICARE PATIENTS ONLY

ONE TIME AUTHORIZATION

I request that payment of authorized Medicare Benefits be made to **WICHITA OPHTHALMOLOGY, P.A** for any services furnished me by **Sam N. Cohimia, M.D** I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient Signature _____ Date _____

MEDIGAP AUTHORIZATION FORM

I hereby authorize payment of my Medigap benefits to **WICHITA OPHTHALMOLOGY,P.A** for all claims filed on my behalf. This authorization applies to all services until it is revoked by me or my representative.

Patient Signature _____ Date _____

Medicare Number _____

Medigap Insurer _____ ID # _____

Address _____ Telephone # _____

City _____ State _____ Zip _____ Effective Date _____

PATIENT INFORMATION

General Information

Last Name:	First Name:	Middle Initial:	Date:
Address:	City:	State:	Zip code:
Social Security Number:	Date of Birth:	Age:	Sex: ☐ M ☐ F
Home Phone Number: ( )	Cell Phone Number: ( )	Marital Status: Single ( ) Married ( ) Divorced ( ) Widowed ( )	
Email address:			

Employment Information of Patient or Parent if Patient is Minor

Employer:	Occupation:	Work Phone: ( )	
Employer's Street Address:	City:	State:	Zip code:
Parent's Name (or Custodial)		Telephone #:	

Emergency Contact

Last Name:	First Name:	Home Phone: ( )	
Relationship:	Cell Phone: ( )	Work Phone: ( )	

Billing Information

Person Responsible for this Account (if different from patient): Last Name:	First Name:	Home Phone: ( )	
Social Security #:	Date of Birth:	Relationship:	
Employer:	Occupation:	Work Phone: ( )	

Insurance Information

Primary Insurance Name:		Office Phone: ( )	
Subscriber Name:	SS#:	**Date of Birth:**	Relationship to Patient:
Policy Number:	Group Number:	Employer:	
Address:	City:	State:	Zip code:
Secondary Insurance Name:		Office Phone: ( )	
Policy Number:	Group Number:		

Referred to this Practice By:

Primary Care Physician:	Phone #: ( )
Who Referred you to our office:	

Release Authorization

I hereby authorize any insurance company, organization, employer, hospital, physician or pharmacist to release any information requested with regard to processing my claims. I give authorization for payment of insurance benefits to be made directly to **Wichita Ophthalmology, P.A.** and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I understand that no guarantees have been made to me regarding the outcome of this care. I agree a photocopy of this agreement shall be valid as the original. I certify that the information, I furnish is true and correct. I know it's a crime to fill out this form with facts that I know are false or leave out facts that are important.

SIGNATURE:	**DATE:**
X	

PATIENT HISTORY RECORD

Patient Name: _____ DOB: _____ Today's Date: _____

I was referred by: _____ Optometrist: _____

Family Physician: _____ Other Physicians: _____

Please answer the following questions about your medical status and history:

1. Please mark any medical conditions/diseases you currently have or have had:
   ☐ diabetes, ☐ high blood pressure, ☐ arthritis, ☐ bleeding problems, ☐ respiratory, ☐ heart disease, thyroid,
   ☐ cancer – list type: _____ ☐ other: _____
2. Have you ever had a heart attack? ☐ Yes ☐ No If YES, when: _____
3. Have you ever had a stroke? ☐ Yes ☐ No If YES, when: _____
4. Mark any eye problems you have been diagnosed with: ☐ Cataracts, ☐ Glaucoma, ☐ Macular Degeneration, ☐ Retinal Detachment, ☐ Wandering or "lazy" eye, ☐ other: _____
5. EYE SURGERIES: _____
6. OTHER SURGERIES: _____

ALLERGIES: ☐ **No known allergies.** ☐ **YES** If YES, list type of medicine/food & reaction.

Medication/Food Reaction

CURRENT MEDICATIONS: List prescription & over-the-counter medications and dosage.

FAMILY AND SOCIAL HISTORY:

- List any medical/eye diseases which run in your family: ☐ Diabetes, ☐ Glaucoma, ☐ Cataracts, ☐ Thyroid, ☐ Macular Degeneration, ☐ Heart Disease, ☐ High Blood Pressure, ☐ Respiratory, ☐ Arthritis.
  ☐ Cancer – list type: _____ ☐ Other: _____
- Do you smoke? ☐ Yes ☐ No If YES, how much? _____
- Do you drink alcohol? ☐ Yes ☐ No If YES, how much? _____

EYE SURGERIES/Updates by Dr. Cohlmia: (office use only) _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge I have received a copy of **WICHITA OPHTHALMOLOGY,P.A** Notice of Privacy Practices.

I give **WICHITA OPHTHALMOLOGY, P.A** permission to leave a message on my answering machine or with a third person who answers my telephone concerning a scheduled appointment reminder.

Check one: ☐ Yes ☐ No

If yes: **Telephone Number to be called:** _____

Alternate Number to be called: _____

We often are contacted by a patient's family member or friend and asked to report on the patient's condition, or to provide information concerning charges and payment for services provided. If you are present at the time a family member requests such information, we may ask you whether you want us to share information with your family member or friend. If you are not present at the time such a request is made by a family member (e.g., over the phone), we will follow your prior instructions in determining whether we should share any information. If you have not provided any such instruction, we will contact you before providing any specific response to an inquiry from a family member or friend.

Concerning payment: I give permission for **WICHITA OPHTHALMOLOGY, P.A** to discuss insurance, billing and accounting issues with the following person:

Name: _____ Relationship: _____

Please check the following:

☐ Do not share information with family members except in emergency situations

☐ Share information with my spouse only, unless I specifically direct you not to share certain information with my spouse.

My spouse's name is: _____

☐ Share information with the following family members or friends upon their request, unless I specifically direct you not to share certain information:

NAME	RELATIONSHIP
_____	_____
_____	_____

_____ _____

Signature of Patient or Patient Representative Relationship to Patient

_____ _____

Type Patient Name Date

Wichita Ophthalmology, P.A.
Notice of Privacy Practices

Dear Patient,

We are required by law to provide the Notice of Privacy Practices and obtain your acknowledgement of its receipt prior to providing any service to you. We are required to maintain the privacy of your protected health information (PHI). This Notice applies to all records and services received at Wichita Ophthalmology. This Notice will describe the way in which we may use and disclose your PHI. The Notice also describes your rights and certain obligations that we have regarding the use and disclosure of your PHI.

The following is a brief summary of the contents of the Notice. Please feel free to ask any questions you may have concerning its contents.

Your Rights Regarding Your Health Information. This section describes the following rights you have with respect to your PHI and tells how you may exercise these rights:

Right to inspect and copy
Right to request amendment
Right to an accounting of disclosures
Right to request restrictions on certain uses and disclosures
Right to request alternative means of communication
Right to receive a paper copy of our Notice of Privacy Practices

How To File Complaints Concerning Our Privacy Practices. This section tells you what you can do if you believe any of your rights have been violated. You will not be penalized for filing any complaint

How We May Use and Disclose Health Information About You Without Your Specific Authorization. This section describes the different ways we may use of disclose your health information without first obtaining from you a specific authorization. Federal law specifically permits these types of uses and disclosures because it is assumed you would want us to use or disclose your information for these purposes, or because such use or disclosure is recognized as critical to the proper functioning of our health care system.

You will be asked to acknowledge your receipt of this Notice, and your acknowledgement will be maintained in your permanent record. You should keep this copy of the Notice. Another copy of this Notice will not be provided automatically at any later visit, but you may request a copy of the Notice at any time. Also, the Notice is posted at our facility and on our website for your review. If there is a material revision to the Notice at some later date, you again will be provided with a copy of the Notice and asked to sign an acknowledgment.

Maintaining the privacy of your health information is very important to us. Again, if you have any questions concerning the Notice of Privacy Practices, please do not hesitate to ask.