PLEASE FILL OUT ALL OF THE BLANK FIELDS AND MAKE SURE TO SIGN EVERY SHEET THAT REQUIRES A SIGNATURE. PLEASE FILL IN YOUR SOCIAL, HOW YOU HEARD ABOUT US your pcp's name AND YOUR EMAIL. THE DOCTORS REQUIRE THIS.

THANK YOU

DR'S HEMELT, FAWER AND DOMANGUE

Northlake Eye Center
Patient Information and Insurance Information

PATIENT INFORMATION:

M F NAME_____

TITLE_____ ADDRESS_____

RACE_____ ZIP_____ CITY/STATE_____

PREFERRED PHONE_____ MARITAL STATUS_____

OTHER PHONE_____ BIRTHDATE_____

EMAIL_____ SSN#_____

EMERGENCY CONTACT_____ Ethnicity
HISPANIC or NON HISPANIC

EMERGENCY CONTACT #_____

EMPLOYER_____ PRIMARY DOCTOR_____

HOW DID YOU LEARN ABOUT US? _____

RESPONSIBLE PARTY: ☐ CHECK BOX IF SAME AS ABOVE

NAME_____ M F TITLE_____

ADDRESS_____ BIRTHDATE_____

ZIP_____ CITY/STATE_____ SSN#_____

PHONE_____ EMAIL_____

EMPLOYER_____ EMPLOYMENT STATUS: FT PT RETIRED

Northlake Eye Center
Patient Information and Insurance Information

INSURANCE INFORMATION: PLEASE DOUBLE CHECK THIS INFO, IT IS VERY IMPORTANT

PRIMARY INS_____	ID#_____
NAME OF INSURED_____	DOB_____
	RELATIONSHIP_____
SECONDARY INS_____	ID#_____
NAME OF INSURED_____	DOB_____
	RELATIONSHIP_____
TERTIARY INS_____	ID#_____
NAME OF INSURED_____	DOB_____
	RELATIONSHIP_____
VISION INSURANCE_____	ID#_____
NAME OF INSURED_____	DOB_____
	RELATIONSHIP_____
GUARANTOR_____	SS#_____
ADDRESS_____	DOB_____
ZIP_____ CITY/STATE_____	RELATIONSHIP_____

ARE YOU ON HOSPICE Y OR N

If you require a REFERRAL, you must have it prior to seeing the doctor.

We will submit your claims using the insurance information we have on file the day of service.

If you want us to ONLY bill your vision insurance AND NOT your medical insurance you must let us know before you see the doctor. Once a claim is submitted it will not be resubmitted to a different insurance company.

IMPORTANT NOTIFICATION
RE: YOUR EYEGLASS PRESCRIPTION

Your insurance plan may not cover services required to determine your new eyeglass prescription.

If you are not sure if this service is covered and you would like a prescription for your new eyeglasses **you will be expected to pay for this service ($25)** at the end of your visit. If we are reimbursed by your insurance company, your account will be issued a credit which can be used for future visits or a refund check can be issued upon your request.

If we have had prior experience with your insurance company and know they will pay for the service then we will not require payment as we will anticipate payment from the insurance company.

To avoid confusion at checkout, please inform the technician if you plan to take an eyeglass prescription from us today. _____ (INITIAL)

HIPPA ACKNOWLEDGEMENT OF
RECEIPT OF NOTICE

I HEREBY ACKNOWLEDGE THAT I RECEIVED/HAD AN OPPURTUNITY TO REVIEW A COPY OF THIS MEDICAL PRACTICE'S NOTICE OF PRIVACY PRACTICES.

SIGNED:_____ DATE:_____

PRINT:_____ LEGAL GUARDIAN:_____

PRINT:_____

Family History

	Relationship		Relationship
Macular Degeneration		Cancer	
Cataract		Diabetes	
Glaucoma		Heart Disease	
Ocular Cancer		Hypertension	
Other Ocular		Stroke	
		Sickle Cell	
		Migraines	

Please List Any **EYE MEDICATIONS/ EYE VITAMINS** Currently Taking:

Please List **ALL** Other Prescription Medications Currently Taking:

Please List All Food and Drug Allergies and Their Reaction:

Primary Care Doctor/Rheumatologist/Endocrinologist: _____

Name of Pharmacy: _____

If You Wear Contact Lenses Please Write Down the Brand and Power for Each Eye:

Past Medical History (Please Circle All That Apply)

Diabetes	Stroke	Sickle Cell	Epilepsy
Hypertension	Cancer- Type:	Ulcerative Colitis	Nutritional Deficiency
Heart Disease	_____	Depression/Anxiety	Headaches/Migraines
Heart Stent or Pacemaker	HIV/AIDS	Skin Condition	Hearing Disorder
Heart Attack	Hepatitis	Lupus	Vocal Problem
High Cholesterol	Alcoholism	Rheumatoid Arthritis	Smelling Defect
Graves' Disease	Asthma	Thyroid Disease	Tasting Defect
Blocked Carotid Artery	Lyme Disease	Organ Transplant	Liver Disease
Temporal Arteritis	Arthritis	Parkinson's	
Anemia	Gall Bladder Disease	Multiple Sclerosis	
A-Fib	GERD	Kidney Failure	
Premature Birth	Dementia/Alzheimer's	COPD	
Birth Defect	Sleep Apnea/Machine	Myasthenia Gravis	

Please List any other Medical History and ALL Surgical History:

_____

_____

_____

Do you drink alcohol? Yes No How often? _____

Do you smoke? Yes No Former

When was your last complete eye exam? _____

Past Ocular History (Please Circle All That Apply)

Cataracts	Iritis/Uveitis	Double Vision	LASIK
Surgery? Year_____	Eye Turns In/Out	Dry Eye Syndrome	Year_____
Glaucoma	Surgery? Year_____	Retinal Detachment	PRK
Surgery? Year_____	Facial Palsy	Eye/Year_____	Year_____
Diabetic Retinopathy	Eyelid Tumor	Retinal Tear	RK
Laser/Surgery?	Eyelid Cancer	Eye/Laser?_____	Year_____
Macular Degeneration	Droopy eyelid	Tear Duct Disorder	Cosmetic Facial Surgery
Laser/Injections?	Cancer in Eye	Floaters	Corneal Surgery
Lazy Eye	Facial Pain	Flashes of Light	Eye/Year_____
Retinal Vein Occlusion	Conjunctivitis (Pink Eye)	Night Blindness	
(Stroke in the eye)	Orbital Tumor/Disease	Total Blindness	
Retinal Artery Occlusion	Optic Neuritis	Color Blindness	
Severe Eye Injury	Optic Nerve Damage		

NORTHLAKE EYE CENTER
FINANCIAL ASSIGNMENT AND AGREEMENT
PLEASE READ CAREFULLY AND SIGN

1. PAYMENT IS EXPECTED AT THE TIME OF SERVICE. You are responsible for paying any co-payments, co-insurance, deductibles and non-covered services at the time of the visit. If we are a participating provider with your health plan, we will file claims on your behalf. It is your responsibility to provide this office with accurate insurance information and to know whether you have coverage with multiple insurance plans. It is also your responsibility to know if you have separate vision coverage.
If your insurance requires a referral to a specialist from your primary care physician, you are responsible for obtaining that referral prior to the appointment. If you choose to be seen without the referral, then you will be responsible for the office visit and any additional charges which may arise from testing. This fee will be required at the time of service.
It is your responsibility to know if this office participates with your health plan. This office will take great care to correctly bill your insurance according to guidelines established by the AMA's Current Procedural Terminology (CPT). In the event your insurance(s) refuses full payment, you will be held responsible for the remaining balance.

2. Patient statements are mailed monthly. Balances are due at the time the statement is received. Past due balances may be outsourced to a third party collection agency. If payment arrangements are needed, please contact our billing department.

3. There is a $30.00 charge on NSF checks. The check amount and the NSF fee must be paid by cash. Once paid, you may be required to make future payments by credit/debit card or by cash.

4. Most insurances will pay for a standard intra-ocular lens during cataract surgery. If you choose to opt for one of the specialized intra-ocular lenses, then you are responsible for the full cost of the lens. The cost of the lens must be paid prior to your surgery.

5. Any fees which are not covered by your insurance in conjunction with your surgery, co-insurance, deductibles, must be paid prior to surgery.

6. If you are self-pay, you are required to pay in full at the time of service.

7. Any outstanding balance must be paid prior to appointments or ordering contact lenses.

I request that payment of authorized Medicare and/or commercial insurance benefits be made on my behalf to Northlake Eye Center, Terrell M. Hemelt, M.D., Martine Domangue, M.D. and/or Jessica Fawer, O.D. for services furnished to me by that supplier. I permit a copy of this authorization to be used in place of the original and authorize any holder of medical information about me to release to the Health Care Financing Administration or its agents any information to determine these benefits payable for related services.

SIGNATURE_____ DATE_____

NORTHLAKE EYE CENTER, APMC

2243 Gause Blvd E.
Slidell, LA 70461
(985) 643-6355
Terry Hemelt, MD
Martine Domangue, MD
Jessica Fawer, OD

IMPORTANT IF YOU HAVE ROUTINE AND MEDICAL INSURANCE!

****PLEASE READ THIS CAREFULLY SO THAT WE WILL FILE YOUR CLAIM WITH THE CORRECT INSURANCE COMPANY****

Many patients have both routine and medical insurance plans. At Northlake Eye Center, we can accept and file to either your routine or medical insurance plan, but not both. It is **EXTREMELY** important that you inform us which insurance plan you would like us to file your claim with. It is also important to understand that there are some potentially vision threatening eye conditions that may be identified during your eye exam. Most of these conditions require additional testing that can be done on today's visit. These additional tests **ARE NOT** covered by your vision insurance plan, HOWEVER, they **ARE** covered by your medical insurance. Therefore, if you plan to have us file to your vision plan and you don't want us to do any additional testing you must let us know in advance below. Please read the three choices below and place your initials in the box to indicate how you would like us to proceed.

☐ USE MY **MEDICAL INSURANCE** TODAY.

☐ USE MY ROUTINE EYE INSURANCE **UNLESS** THE DOCTOR NEEDS TO DO ADDITIONAL TESTING THEN **USE MY MEDICAL INSURANCE INSTEAD**.

☐ FILE MY ROUTINE EYE INSURANCE TODAY.

☐ I DON'T HAVE ANY INSURANCE; I WILL PAY FOR MY EXAM MYSELF.

PLEASE FILL IN THE MAIN REASON FOR YOUR VISIT WITH US TODAY:

_____

_____

_____ _____ _____

NAME SIGNATURE DATE