

**RICK LEONI II, MD ~ JULIE FOREMAN, MD**

**PATIENT INFORMATION FORM**

**TODAY'S DATE:** \_\_\_\_\_

**Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_ **MI:** \_\_\_\_\_

**Birth Date:** \_\_\_\_\_ **Social Security #:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Gender:**    Male    Female    **Marital Status:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Phone #'s:** Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

**Employer:** \_\_\_\_\_

**Nearest Relative for Emergencies:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

\_\_\_\_\_ **Phone:** \_\_\_\_\_

**Referring Physician:** \_\_\_\_\_

**Family Physician:** \_\_\_\_\_

**Insurance:** Medicare    Medicaid    Private    Other \_\_\_\_\_

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**In consideration of the services rendered to me, the patient, I agree that I am solitarily liable for, and hereby guarantee payment of all charges incurred in my treatment, including any charges not paid, for any reason, by any payer or insurance company. I understand that payment of copay, co-insurance, deductible, and non-covered services is due at the time of service.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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**Are you allergic to anything, including medicines?**        **NO**        **YES**

**List them:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

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**PATIENT RECORD OF DISCLOSURES**

**PATIENT NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

In general, 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, such as sending correspondence to the individual's office instead of the individual's home.

**I wish to be contacted in the following manner (check all that apply):**

Home phone      The Number is \_\_\_\_\_  
    Leave message with detailed information  
    or  
    Leave message with callback numbers only

Cell phone      The Number is \_\_\_\_\_  
    Leave message with detailed information  
    or  
    Leave message with callback numbers only

Work phone      The Number is \_\_\_\_\_  
    Leave message with detailed information  
    or  
    Leave message with callback numbers only

Leave message with spouse / relative in the home.  
Leave message with child / sibling or caregiver.  
Leave message with \_\_\_\_\_  
Mail to my home address, which is \_\_\_\_\_  
Mail to my work/office address, which is \_\_\_\_\_  
Send to this Fax number \_\_\_\_\_  
Other \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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**Record of Disclosures of Protected Health Information**

(For office use only)

<b>Date</b>	<b>Disclosed to whom</b>	<b>Reason for disclosure</b>	<b>By whom</b>

**RICK LEONI II, MD ~ JULIE FOREMAN, MD**  
**Ophthalmology**

203 Rue Louis XIV, Suite A  
Lafayette, LA 70508

Phone: 337-981-2393  
Fax: 337-981-9470

\_\_\_\_\_  
Printed Patient Name

\_\_\_\_\_  
Date of Birth

**FINANCIAL POLICY**

Thank you for choosing Dr. Leoni II and Dr. Foreman as your health care providers. We are committed to making healthcare less stressful and more effective by clarifying financial responsibilities in advance. The following is a statement of our financial policy, which we ask that you read and sign prior to your office visit or procedure.

I hereby assign and authorize payment of insurance benefits otherwise payable to me, directly to Leoni 2Med, LLC, for office or hospital services which are not paid by me at the time of service.

I hereby authorize Leoni 2Med, 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 understand that I am ultimately responsible for payment of all charges for medical care I receive from Rick Leoni II, MD or Julie Foreman, MD, if this assignment of claim is rejected or modified. If 30 days commence after the date of service and 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. Leoni 2Med, LLC accepts cash, check, VISA, Mastercard, American Express and Discovercard. I understand that payment of copay, co-insurance, deductible, and non-covered services is due at the time of service. No refunds will be issued until all charges with Leoni 2Med, LLC are paid in full.

Rick Leoni II, MD and Julie Foreman, MD have a financial interest (less than 2% ownership) in Lafayette General Surgical Hospital and Oil Center Surgical Plaza. If you require further information, please speak with them directly.

\_\_\_\_\_  
Signature of patient or legal guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of legal guardian

\_\_\_\_\_  
Relation to Patient

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

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Printed Patient Name

\_\_\_\_\_  
Date of Birth

**Notice of Refraction Service Acknowledgement**

One of the most important parts of your eye exam is the refraction. This is the part of the exam by which we determine if your vision can be helped by a glasses prescription. It is also how we determine the best possible visual acuity and function of the eye.

Unfortunately, this refraction is NOT a covered service by Medicare and many insurance plans. They consider refraction as a “vision” service and not a “medical” service. Our fee for the refraction is \$30. Unless your plan automatically covers this fee, we are required to collect it; as well as, any co-payment on the day of service. If your plan ends up covering the refraction, we will refund your payment in a timely fashion.

I have read the above information and understand that 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. I understand that without the refraction, Dr. Leoni or Dr. Foreman may not be able to fully assess the health and function of my eyes. I also understand that they will not be able to provide 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

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Printed Patient Name

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Date of Birth

**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, 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 at the address above to obtain a current copy of the Notice of Privacy Practices.

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.

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Signature of patient or legal guardian

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Date

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Printed name of legal guardian

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Relation to Patient



## Patient History Form

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Gender:    Male    Female    Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

1. Are YOU being treated or have YOU ever been treated for any of the following? Please answer NO or YES for each line and provide any pertinent additional information in the space provided.

Diabetes            No    Yes    NIDDM    IDDM Duration \_\_\_\_\_ Control \_\_\_\_\_

Arthritis            No    Yes    Rheumatoid    Lupus    Other \_\_\_\_\_

Hypertension        No    Yes    Control \_\_\_\_\_

Heart Disease        No    Yes    \_\_\_\_\_

Stroke                No    Yes    Date \_\_\_\_\_

Cancer                No    Yes    Site \_\_\_\_\_

Thyroid Disease     No    Yes    \_\_\_\_\_

Other known medical conditions: \_\_\_\_\_

2. Have YOU ever had surgery in the past?                    No    Yes

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

\_\_\_\_\_

\_\_\_\_\_

3. Have YOU ever been hospitalized in the past?            No    Yes

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

\_\_\_\_\_

4. Please list ALL vitamins, over-the-counter medications, and health food supplements YOU are NOW taking or take on a regular basis: \_\_\_\_\_

\_\_\_\_\_

5. Please list ALL eye drops or ointments that YOU are NOW using: \_\_\_\_\_

6. Do you smoke or use tobacco products?    No    Yes    \_\_\_Packs per day for \_\_\_ years.

7. Do you drink alcohol?    No    Yes    How much? \_\_\_\_\_

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

8. Are YOU allergic to any drugs or have you had drug reactions?      No      Yes  
Please list ALL drugs that you are allergic to (and reaction, if known): \_\_\_\_\_

Do you currently have any of the following symptoms? (Please answer NO or YES for each line) and provide pertinent additional information in the space provided.

- |   |    |     |       |
|---|----|-----|-------|
| Unexplained weight loss, fatigue, weakness          | No | Yes | _____ |
| Skin rashes or sores                                | No | Yes | _____ |
| Headache  | No | Yes | _____ |
| Hearing loss or ringing in the ears                 | No | Yes | _____ |
| Sinus trouble, nasal allergy, or nose bleeds        | No | Yes | _____ |
| Chest pain or irregular heartbeat                   | No | Yes | _____ |
| Shortness of breath or persistent cough             | No | Yes | _____ |
| Wheezing or asthma                                  | No | Yes | _____ |
| Heartburn, stomach pain, or vomiting                | No | Yes | _____ |
| Diarrhea, blood in stools                           | No | Yes | _____ |
| Pain on urination, blood in urine                   | No | Yes | _____ |
| Muscle aches, joint pain, swollen joints            | No | Yes | _____ |
| Numbness or tingling of extremities                 | No | Yes | _____ |
| Dizziness, fainting, blackouts, seizures            | No | Yes | _____ |
| Muscle weakness or paralysis                        | No | Yes | _____ |
| Memory loss or confusion                            | No | Yes | _____ |
| Depression or mood changes                          | No | Yes | _____ |
| Excessive urination or thirst                       | No | Yes | _____ |
| Bruising, bleeding, or anemia                       | No | Yes | _____ |
| Trouble with vision (blurring, double vision, etc.) | No | Yes | _____ |

Other: \_\_\_\_\_

Are the symptoms listed above being treated by another physician?      No      Yes

**Patients – Please do not write below this line.**

Physician Comments: \_\_\_\_\_

I have reviewed and confirmed the above history.

Date: \_\_\_\_\_

\_\_\_\_\_  
Rick Leoni II, MD

\_\_\_\_\_  
/ Julie Foreman, MD