RICK LEONI II, MD ~ JOE GANNON, MD

PATIENT INFORMATION FORM **TODAY'S DATE: ____________________**

Last Name:________________________________First Name:_________________MI: _____

Birth Date:______________________ Social Security #: _____________________________

Address: ____

____ Language: English Other_____________

Gender:____Male____Female Marital Status:__________________________________

Email Address:_______________________________________Ethnicity:_________________

Phone #'s: Home___________________Work__________________Cell_________________

Contact Preference:____Home Ph _ __Work Ph____Mobile Ph____Portal____Email

Employer:____

Nearest Relative for Emergencies: ____

Address:______________________________________ Relationship: _ _________________

____ _ Phone: _________________________

Referring Physician: ____

Family Physician: ____

Insurance: Medicare Medicaid Other____

Please initial:

___ To the best of my knowledge that above information is complete and accurate.

___ I hereby assign my insurance benefits to be paid directly to Leoni 2Med LLC.

___ I authorize Leoni 2Med LLC to obtain/have access to my medication history.

___ I authorize Leoni 2Med LLC to contact me by mobile phone.

Signature:____Date: ____________________

RICK LEONI II, MD ~ JOE GANNON, MD

Ophthalmology

203 Rue Louis XIV
Lafayette, LA 70508

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

Printed Patient Name ______________________ Date of Birth ______________________

PERMISSION TO DISCUSS/DISCLOSE PROTECTED HEALTH INFORMATION

By the following list, I hereby give Leoni 2 Med, LLC/Rick Leoni II, MD/Joe M. Gannon, MD limited permission to disclose and release to a family member, other relative, or close personal friend, or any other person identified by me, the protected health information directly related to such person's involvement with my care or payment related to my health care.

I understand that Leoni 2 Med, LLC/Rick Leoni II, MD/Joe M. Gannon, MD may call home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out practice operations, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

____

Patient Signature Date

NAME	PHONE #	RELATIONSHIP

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FINANCIAL POLICY

Thank you for choosing Leoni Eye Clinic 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/Joe M. Gannon, 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. I will assume full responsibility for payment. If my account is turned over to an outside collection service, I agree to pay all fees associated with collecting unpaid balances.

Rick Leoni II, 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

** Please sign only one section**

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 $40. 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 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 **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.

______________________________ ______________________________

Signature of patient or legal guardian **Date**

______________________________ ______________________________

Printed name of legal guardian **Relation to Patient**

MEDICATION LOG

PATIENT NAME: **TODAY'S DATE:**

MEDICATION	DOSE/FREQUENCY/TIME	PURPOSE	PRESCRIBING PHYSICIAN	DATE	DATE	DATE

Patient Signature

Rick Leoni II, MD / Joe M. Gannon, MD

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 anything 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.

Symptom	No	Yes	
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 / Joe M. Gannon, MD