RICK LEONI II, 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

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 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 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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______________________________ ______________________________

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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 understand that Leoni 2Med, LLC DOES NOT PARTICIPATE WITH ANY VISION INSURANCE. I understand that only my medical insurance will be billed. 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, 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.

We request at least 24 hours advanced notice for cancellations. It is our policy to charge $50.00 for any appointment missed without proper advanced notice.

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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______________________________ ______________________________

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Notice of Refraction Service Acknowledgement

Refraction is an essential piece of medical information that is used to assess the health of your eyes. Your ophthalmologist uses this information to aid in diagnosing medical and visual conditions to help develop your unique plan of care. The doctor determines if a refraction is needed. This is a NON-Covered service by Medicare and most private insurance plans (BCBS, Humana, Aetna, etc).

By signing below, I accept full responsibility for this service and the $40 fee which will be collected at the time of service.

Dilation Consent

Dilation is necessary to perform a complete eye exam. Dilation drops enlarge the pupil allowing the ophthalmologist to view the retina and other posterior eye structures. This may reveal the presence of a serious systemic condition(s) as well as the presence of eye condition(s). Dilation drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. You may require driving assistance until the drops wear off. Rare adverse reactions may require immediate medical attention such as angle-closure glaucoma, allergic reactions, increased blood pressure, tachycardia, and dizziness.

Please inform our office immediately if any of these rare adverse reactions occur.
I hereby authorize Dr Leoni and/or such assistant designated by him to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

______________________________ ______________________________

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
VACCINATIONS:						
FLU?	**YES / NO**	**DATE:**				
PNEUMONIA?	**YES / NO**	**DATE:**				
PHARMACY NAME:						
PHARMACY PHONE:						

Patient Signature

Rick Leoni II, 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	______________________________
HIV	☐ 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