ROSWELL R. PFISTER M.D.P.C.   SARAH ALVAREZ , O.D.Ph.D.

2198 COLUMBIANA ROAD, SUITE 100
VESTAVIA HILLS, AL 35216

OFFICE: (205)877-2837   FAX: (205) 877-1777

PAYMENTS

WE ACCEPT CASH, CHECK, VISA, DISCOVER AND MASTERCARD. ALL MEDICARE AND BLUE CROSS CHARGES ARE FILED FOR YOU. MEDICARE AND BLUE CROSS WILL PAY THE DOCTOR DIRECTLY. SOME COMMERCIAL CARRIER INSURANCE MAY PAY THE PATIENT DIRECTLY. THE PATIENT IS ULTIMATELY RESPONSIBLE FOR PAYMENT OF ANY MONEYS OR SERVICE DEEMED NOT COVERED BY THEIR INSURANCE CARRIER. ALL CO-PAYS, DEDUCTIBLES, PHARMACEUTICALS, AND CONTACT LENSES ARE PAYABLE ON THE DAY OF YOUR VISIT OR AT THE THE TIME THEY ARE DISPENSED. IN THE EVENT THE ACCOUNT IS NOT PAID IN FULL, THE UNDERSIGNED WILL BE LIABLE FOR COLLECTION COSTS, ATTORNEY'S FEES, COURT COSTS, AND HEREBY WAIVE ALL RIGHTS OF EXEMPTION UNDER THE CONSTITUTION AND LAWS OF THE STATE OF ALABAMA

NOT-COVERED ROUTINE SERVICE POLICY

AS YOUR PHYSICIAN, I WANT TO PROVIDE YOU THE BEST CARE POSSIBLE. THERE MAY BE CERTAIN SERVICES THAT I FEEL ARE NECESSARY FOR THE MAINTENANCE OF GOOD HEALTH THAT ARE NOT COVERED BY YOUR MEDICARE OR BLUE CROSS CONTRACT, OR OTHER COMMERCIAL CARRIER INSURANCE. WE WILL BE HAPPY TO FILE THESE CHARGES WITH YOUR INSURANCE, AT YOUR REQUEST, BUT YOU WILL BE EXPECTED TO PAY FOR THESE SERVICES IN FULL AT THE TIME THEY ARE RENDERED.
EXAMPLES ARE:
A. ROUTINE EYE EXAMS
B. NON-THERAPEUTIC CONTACT LENS
C COLOR VISION TESTS
D. CONTACT LENS FITTINGS
E. CONTRAST SENSITIVITY TESTING

LET ME ASSURE YOU THAT I WILL ONLY ORDER WHAT I FEEL IS NECESSARY FOR YOUR TREATMENT AND CARE.

I HAVE READ YOUR POLICY AND AGREE TO PAY FOR SERVICES NOT COVERED BY MY CONTRACT AS I INDICATED BY MY SIGNATURE BELOW.

________________________   ____________________________________

D A T E   P A T I E N T S I G N A T U R E

NOTICE OF PRIVACY POLICY OF
ROSWELL R. PFISTER, M.D.P.C
d/b/a/ Pfister Vision C orrection Center
Drs. Pfister, Alvarez

This notice describes how medical information concerning you may be used and disclosed. It also explains how you can get access to this information. Please review it carefully.

We will not release your medical or financial information to anyone without your written permission with the following exceptions:

Information about you with your permission has to be released to:

1. To lawyers or courts in response to a subpoena. By law, we most comply.
2. To your insurance company or other payers of your medical expenses.
3. To other healthcare provides who are taking care of you or are performing tests on you.
4. To family members or friend who are involved in your care, unless you specifically request not to do so.
5. To healthcare analysts or for research for the purpose of improving the quality of care for all patients we serve. In this case, all information which identifies you as the person will be removed.

All electronic transmission will be done in a secure manner, always encrypted software.

You have the right to inspect and copy your medical and financial records at a reasonable time and at reasonable copy costs. If you feel that the medical information we have about you is incorrect or incomplete, you may ask us to amend it.

If you believe your privacy rights have been violated, you may file a complaint in writing to our privacy officer, Clint Parkinson, at this office.

Federal regulation requires that we obtain your signature that you have read and agree with this policy.

_______________________________________ _____________________________

Signature Date

I have read and wish to make the following changes in this policy.

_____________________________________ _______________________________

Signature Date

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NAME:______________________________________ DOB:_______________ AGE:______
Address__________________________________ City______________ State ____ Zip______
Home #:____________________ Work #____________________ Cell#__________________
Email________________________ Can we email or text a confirmation for appointments? Y/N
SSN __________________ Referred by________________ Occupation________________
Your Physicians Name________________________ Date of Last Exam _______

PHYSICAL PROBLEMS: MEDICATION TAKEN:

__________________________________   __________________________________
__________________________________   __________________________________
__________________________________   __________________________________
__________________________________   __________________________________

MEDICINE OR OTHER ALLERGIES: ____
GENERAL HEALTH:
CHECK IF YQU HAVE OR HAVE HAD:
__HIGH BLOOD PRESSURE __EYE DISEASE __DIABETES _SINUSITIS __DIZZINESS
__EYE INJURY __MIGRAINES __EYE SURGERY __EPILEPSY __GLAUCOMA
__HEART PROBLEMS __DOUBLE VISION __CROSSED EYESm__TUNNEL VISION
___ TEMPORARY LOSS OF VISION __ OTHER _____________________
DO YOU SMOKE? Y/N   PACKS PER DAY ______
ALCOHOL CONSUMPTION __WINE __BEER __ ALCOHOL ___X DAYS

CHECK IF ANY OF YOUR BLOOD RELATIVES HAVE OR HAVE HAD
_HEART DISEASE __HIGH BLOOD PRESSURE _DIABETES __CANCER __LUNG DISEASE
__THYROID _CATARACTS __GLAUCOMA __LAZY EYE __CROSSED EYE __BLINDNESS

EYE DOCTOR'S NAME: __________________________ DATE OF LAST EXAM___________
YOUR MAIN VISUAL COMPLAINT/ PROBLEM
____

EYE PROBLEMS: EYEDROPS TAKEN:
__________________________________   __________________________________
__________________________________   __________________________________
__________________________________   __________________________________

CHECK IF YOUR EYES ARE BOTHERING YOU IN THE FOLLOWING WAYS:
__DOUBLE VISION __FLOATERS __LIGHT SENSITIVITY __NIGHT VISION __BURN __DRY
__BLUR __GRITTINESS __FLASHING __ACHE __HALO __ITCH __REDNESS __TEARING
__HEADACHES
DO YOU WEAR CONTACT LENS? Y/N SOLUTION USED____________________________
FILLED BY WHOM?____
ARE YOU INTERESTED IN CONTACTS? Y/N
ARE YOU INTERESTED IN REFRACTIVE SURGERY? Y/N

____
PATIENT'S SIGNATURE OR PARENT/GUARDIAN   DATE   DOCTOR'S SIGNATURE

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NAME____DATE_________________

ADDRESS_______________________________________,CITY____________________

STATE ____ ZIP__________ HOME PHONE (___)_____________

CELL (___)__________________

EMPLOYER_____________________________ WORK PH0NE (___)_____________

DATE OF BIRTH______________ AGE_____ SEX_______ SS# _________________

EMAIL____

EMERGENCY CONTACT____________________________

RELATION__________________ TEL#______________________

NAME OF RESPONSIBLE PARTY_______________________________________

ADDRESS OF RESPONSIBLE PARTY:

____

CITY _________________STATE____ ZIP_________

RELATIONSHIP TO PATIENT __________________ BIRTHDATE_________________

WERE YOU INJURED ON THE JOB? NO YES

DATE INJURED_______________________________________

PRIMARY INSURANCECOMPANY

____

CONTRACT #__________________________________ GROUP #_________________

SECONDARY INSURANCE COMPANY

NAME____

CONTRACT#___________________________________ GROUP# ________________

PATIENT OR AUTHORIZED PERSON'S SIGNATURE: I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW: I FURTHER AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE UNDER SIGNED PHYSICIAN OR SUPPLIER FOR SERVICES DESCRIBED BELOW.

____

DATE PATIENT SIGNATURE