

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.

DATE

PATIENT SIGNATURE

**NOTICE OF PRIVACY POLICY OF
ROSWELL R. PFISTER, M.D.P.C
d/b/a/ Pfister Vision Correction 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 must comply.
2. To your insurance company or other payers of your medical expenses.
3. To other healthcare providers 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

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

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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 EYES 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 GRITTIENESS 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 PHONE (____) _____
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 INSURANCE COMPANY

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