Patient Information

Name: _____ Date: _____

SSN: _____ Date of Birth: ____/____/____ Age: _____ Male: ☐ Female ☐

Home Phone: _____ Cell Phone: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Patient Employer: _____

Person Responsible for Bill - Insurance Guarantor

Patient's relationship to person responsible for bill: ☐ Self ☐ Spouse ☐ Child ☐ Dependent

Name: _____ Phone: _____

Address: _____

***If subscriber to insurance is other than "Self", Date of Birth of Insurance Subscriber:** ____/____/____

Emergency Information

Please list a local friend or relative that we may contact in case of an emergency.

Name: _____

Relationship to Patient: _____ Phone: _____

Confidential Patient Contact Person:

Based upon your written consent here-in the person specifically listed below is the only person to whom information will be released other than you, the patient.

Name: _____ Relationship: _____

Address: _____ Phone: _____

Chief complaint for being seen today?

_____

_____

Medical History

Primary Care Physician: _____

Referring Physician: _____

Preferred Pharmacy: _____ Location: _____

Drug Allergies:

_____

_____

Past Surgical Procedures / Dates

_____

_____

Social History

Occupation: _____ Hobbies: _____

Marital Status: ☐ Single ☐ Married/Partner ☐ Separated ☐ Divorced ☐ Widowed

Do you smoke? ☐ Yes ☐ No

When did you quit? _____

How Many Years? _____

How many packs a day? _____

Average of drinks per day: ☐ 1 ☐ 2-3 ☐ 4+

Are you at high risk for HIV/AIDS: ☐ Yes ☐ No

Have you been HIV tested? ☐ Yes ☐ No

HIV test results: ☐ Pos ☐ Neg

Are you pregnant or nursing? ☐ Yes ☐ No

Were you hospitalized in the last 6 months? ☐ Yes ☐ No

If yes, please explain: _____

Are you under the care of a doctor? ☐ Yes ☐ No

If Yes, please explain: _____

To expedite your visit today, please take the time to answer the following brief medical history question. Use the space on the right to explain if medications are used and to clarify your answers:

Medical History

High Blood Pressure? □ Yes □ No Explain: _____

Elevated Cholesterol? □ Yes □ No Explain: _____

Heart Disease? □ Yes □ No Explain: _____

Skin Disorders? □ Yes □ No Explain: _____

Crohn's/Grave's Disease? □ Yes □ No Explain: _____

Prostate/Kidney Disorders? □ Yes □ No Explain: _____

Bleeding Disorders? □ Yes □ No Explain: _____

Infections Disease? □ Yes □ No Explain: _____

Diabetes? Type? □ Yes □ No Explain: _____

Rheumatoid Arthritis? □ Yes □ No Explain: _____

Seizures? □ Yes □ No Explain: _____

Stroke? □ Yes □ No Explain: _____

Asthma? □ Yes □ No Explain: _____

COPD? □ Yes □ No Explain: _____

Anxiety? □ Yes □ No Explain: _____

Depression? □ Yes □ No Explain: _____

Women's Health Disorders? □ Yes □ No Explain: _____

Cancers? □ Yes □ No Explain: _____

Please list all medications you are currently using:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan, to issue payment check(s) directly to **Texas Eye Surgeons, PA** for medical services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance.

Patient Receiving Specialized Services and/or Procedures

As a courtesy to me, **Texas Eye Surgeons, PA**, has obtained information regarding specific benefits covered and payable under my health insurance plan from a representative of my health insurance company and has explained those benefits to me. I understand that Texas Eye Surgeons, PA has acted in good faith in this effort and that the benefit information provided to **Texas Eye Surgeons, PA** by my health insurance company may not be accurate.

I acknowledge that the benefit information obtained by **Texas Eye Surgeons, PA** on my behalf was qualified by a representative of my health insurance company with the following statements:

This is an estimate of the benefits provided under the patient's insurance contract;

Any payment is subject to the coordination of benefits with any other insurance that may cover the services rendered and the coverage being in effect on the date of service;

Verification of eligibility or benefits is not a guarantee of coverage or payment and is subject to any policy provisions and exclusions that are in effect at the Tim services are rendered.

Medical Insurance does NOT cover Refractions and other Advanced Diagnostic Testing. Please see next section.

Patient, Parent or Guardian Signature Date

Patient Name (Please Print)

Required Advanced Diagnostic Testing

The health of your eyes is important to us! To thoroughly check for eye diseases, such as Keratoconus, Glaucoma or Macular Degeneration, special testing is necessary. Texas Eye Surgeons incorporates the most advanced technology allowing us to better assess the status of your eyes, while making your eye exam with us as efficient as possible. For most surgical treatments, these tests are required. Advanced diagnostics become part of your permanent medical record and can be used to monitor progression and/or onset of eye disease(s). As part of your eye exam with us, we will be utilizing the following non-invasive medical imaging:

- **Optomap Ultra-Widefield Retinal Imaging** – Facilitates early protection from vision impairment or blindness and, early detection of life-threatening diseases like cancer, stroke and cardiovascular disease.
- **Advanced Corneal Topography** – Highly comprehensive imaging and analysis of the front and back surface of the cornea significantly improving the detection of corneal irregularities and asymmetries key to your vision.
- **Refraction** – A measurement to determine your refractive state (how well you're able to see) resulting in a prescription for eyeglasses and helping determine optimal surgical outcomes.

We require advanced diagnostic tests as part of your comprehensive eye exam. They are not covered by insurance. **The out-of-pocket fee for ALL advanced diagnostic testing is $125.**

I have read the above and understand this is an out-of-pocket expense that insurance does not cover.

Patient, Parent or Guardian Signature Date

Patient Name (Please Print)

Financial Policy

Thank you for choosing Texas Eye Surgeons for your eye care needs. Our primary mission is to deliver the best and most comprehensive care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

You may choose from: Cash, Check, Visa, MasterCard, American Express, or Care Credit.

Texas Eye Surgeons charges $35 for returned checks. Payment by check for all surgical procedures must be made a minimum 7 days prior to surgery.

It is customary to pay for professional services when rendered. As a courtesy, we will bill your insurance company on your behalf. Your insurance is a contract between you and your insurance carrier. You will receive an explanation of benefits from them itemizing your responsibilities. You will be responsible for any co-payments, deductibles or non-covered services as determined by your insurance company. Any balance remaining after your health plan pays will be due upon receipt of a statement.

If you have not met your deductible, you will be responsible for 100% fo your visit.

If, however, Texas Eye Surgeons is not a participating provider in your insurance plan, you will be responsible for filing your own claims and will be responsible for paying in full at the time service.

In accordance with our contract with your insurance provider, we are responsible for collecting and you are responsible for paying, co-payments prior to your exam.

Texas Eye Surgeons will verify your insurance eligibility prior to your appointment however, this is not a guarantee of payment by your insurance company.

There will be a $150 fee for after-hours appointments. There is a $35 fee for medical records. There is a $10 fee for forms to be completed.

The adult accompanying a minor and his/her parents (or guardian) are responsible for payment upon completion of your exam or consultation.

If you have any questions, please do not hesitate to ask. We are here to help you get the quality care you want or need.

Patient, Parent or Guardian Signature Date

Patient Name (Please Print)

*However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

Patient Consent for Use and Disclosure of Protected Health Information (PHI)

With my consent, **Texas Eye Surgeons, PA** may use and disclose protected health information (**PHI**) about me to carry out treatment, payment and healthcare operation (**TPO**). Please refer to **Texas Eye Surgeons, PA** Notice of Privacy for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Texas Eye Surgeons, PA** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Texas Eye Surgeons, PA,** 4108 W. 15th Street Ste. #300, Plano, TX 75093.

With my consent, **Texas Eye Surgeons, PA** may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, **Texas Eye Surgeons, PA** may e-mail to my home or other designated location anytime that assist the practice in carrying out **TPO**, such as appointment reminder cards and patient statements. I have the right to request that **Texas Eye Surgeons, PA** restrict how it uses or discloses my **PHI** to carrying out **TPO**. However, the practice is not required to agree to my requested restrictions but, if it does, it is bound by this agreement.

By signing this form, I am consenting to Texas Eye surgeons, PA use and disclosure of my **PHI** to carry out **TPO**. I am acknowledging that I have received **Texas Eye Surgeons, PA NOTICE OF PRIVACY PRACTICES**.

I may revoke my consent in writing except to the extent that practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, **Texas Eye Surgeons, PA** may decline to provide treatment to me.

Signature of Patient / Guardian Date

Print Name of Patient / Guardian Date