PATIENT DEMOGRAPHICS

HOW DID YOU LEARN ABOUT HOUSTON EYE ASSOCIATES?

( ) Physician ( ) Optometrist ( ) Patient

( ) Other

Referral was by (Please provide their name and address so we can thank them):

_____

_____

PATIENT DEMOGRAPHICS

Name*

_____ _____ _____

First Name Middle Name (optional) Last Name

Address*

_____

Address, City, State, Zip

Home Phone Number

_____

Work Phone Number

_____

Cell Phone Number

_____

Date of Birth*

_____ / _____ / _____

Month/Day/Year

Sex

( ) Male ( ) Female

Marital Status

( ) Single ( ) Married ( ) Divorced ( ) Widowed

Employer

Employer Address

Address Line 1

Address Line 2

City State ZIP code

Phone Number

Family Doctor Name

Address

Address Line 1

Address Line 2

City State ZIP code

Phone Number

Email Address

In the future may we confidentially communicate with you through this email address?

( ) Yes ( ) No

PARENT/GUARDIAN INFORMATION (if patient is a minor)

Parent/Guardian Name

Address

Address Line 1

Address Line 2

City | State | ZIP code

Home Phone Number

Work Phone Number

Cell Phone Number

Date of Birth*

_____ / _____ / _____

Month/Day/Year

Relationship to Patient

[ ] Child

[ ] Other:

_____

Other Parent/Guardian's Name:

_____ _____ _____

First Name Middle Name (optional) Last Name

Home Phone Number

_____

Work Phone Number

_____

Cell Phone Number

_____

Employer

_____

RESPONSIBLE PARTY (if different from above)

Contact Person

_____ _____ _____

First Name Middle Name (optional) Last Name

Address

_____

Address Line 1

Address Line 2

City

Employer/Company/Agency Name

Phone Number

Notice of Payment Policies and Procedures

PAYMENT POLICY: It is customary to pay for professional services when rendered. For your convenience, we accept major credit cards, checks, or cash.

INSURANCE: Please read and sign below if you have insurance with Medicare, Medicaid, an HMO/PPO/POS or State Agency or Worker's Comp, and the Physician is contracted with your carrier. Present your insurance card along with any required referrals/authorization to the Receptionist/Registrar.

MEDICAL/SURGICAL BENEFITS ASSIGNMENT AND RELEASE OF MEDICAL BENEFITS INFORMATION AGREEMENT: I request payment of my authorized insurance benefits be made for charges on my behalf to Houston Eye Associates for any unpaid medical/surgical procedures performed now or in the future. I also authorize Houston Eye Associates to release medical information to my insurance company(ies) or agent, now or in the future, for claim consideration purposes. I understand that payment for services does ultimately remain my responsibility.

NON-COVERED SERVICES: The filing of a claim for any service rendered DOES NOT GUARANTEE PAYMENT from your insurance company. You will be financially responsible for these services. Also, having more than one insurer DOES NOT necessarily mean that your services are covered 100%. Secondary insurers will pay as a function of what your primary carrier pays. We may bill your secondary as a courtesy. You are responsible for any balances after your insurance(s) has cleared.

DIVORCE DECREES: This office is NOT a party of your divorce decree. Adult patients are responsible for their bills at the time of service. The responsibility for minors rests with the accompanying adult.

MINOR PATIENTS: For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved Credit Card, or payment by cash or check at the time of service has been verified.

EYE EXAM: I agree to and understand that my eye(s) must be dilated in order for the doctor to thoroughly check the retina of the eye. I agree to and understand that my eye may need to be patched as part of the treatment of my condition. I understand that if my pupils are dilated or my eye is patched after the exam, I

may not be able to safely operate a motor vehicle and that the staff and doctors of Houston Eye Associates suggest that I evaluate my need for alternative transportation and the decision is solely mine, therefore I will not hold Houston Eye Associates responsible.

NO SHOW POLICY: We understand that sometimes you may need to cancel your appointment. Please cancel your appointment at least 24 hours in advance, when possible. This allows us to accommodate other patients who are seeking an appointment. If you do not cancel your clinic appointment, this will be documented as a "No-Show" appointment and you will be charged $45. If you do not cancel your surgery appointment 24 hours in advance and do not present to the office for your surgery this will be documented as a "No-Show" appointment and you will be charged $200.

The contents of this document will remain in effect unless revoked by me in writing.

Name of Patient (Print):

_____

Name of Witness (Print):

_____

Patient Signature:

_____

Witness Signature:

_____

Patient Representative Signature:

_____

Relationship of Patient Representative to Patient:

_____

PATIENT HISTORY RECORD

MEDICAL HISTORY: Please answer the following questions: (Select NO or YES)

1. Have you ever had any eye disease (e.g. glaucoma, cataract, retinal detachment, “lazy” eye, etc.)?

   ☐ Yes ☐ No

   If yes, please list:

   _____

   _____

2. Have you ever had any EYE surgery (including injections and lasers)?

   ☐ Yes ☐ No

   If yes, please list:

   _____

   _____

3. Have your ever been treated for any medical conditions (e.g. diabetes, high blood pressure, arthritis, infections, etc.)?

   ☐ Yes ☐ No

   If yes, please list:

   _____

   _____

4. Have you ever had any OTHER surgery (including injections and lasers)?

   ☐ Yes ☐ No

   If yes, please list:

   _____

5. Have you ever been hospitalized?

( ) Yes ( ) No

If yes, please provide the date and reason:

6. Do you take any EYE medication(s)?

( ) Yes ( ) No

If yes, please list with the dosage:

7. Do you take any OTHER medications?

( ) Yes ( ) No

If yes, please list with the dosage:

8. Do you have any drug or food allergies or sensitivities?

( ) Yes ( ) No

If yes, please list:

FAMILY HISTORY

Do any medical or eye diseases run in your family (e.g. diabetes, high blood pressure, cancer, glaucoma, macular degeneration, etc.)?

( ) Yes ( ) No

If yes, please list:

_____

_____

SOCIAL HISTORY

Do you smoke?

( ) Yes ( ) No

If yes, how much?

_____

Do you drink alcohol?

( ) Yes ( ) No

If yes, how much?

_____

What is your occupation?

_____

REVIEW OF SYSTEMS

Do you currently have any of the following problems (Select NO or YES)

1. Chronic fever, unexplained weight loss/gain, fatigue, night sweats?

( ) Yes ( ) No

If yes, please explain:

---

2. Skin problems (e.g. rashes, excessive dryness, etc.)?

( ) Yes ( ) No

If yes, please explain:

---

3. Ear/Nose/Throat problems (e.g. hearing loss, sinus problems, sore throat, etc.)?

( ) Yes ( ) No

If yes, please explain:

---

4. Respiratory problems (e.g. shortness of breath, wheezing, coughing, etc.)?

( ) Yes ( ) No

If yes, please explain:

---

5. Heart problems (e.g. chest pain, irregular heartbeat, etc.)

( ) Yes ( ) No

If yes, please explain:

---

6. Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea, vomiting)?

( ) Yes ( ) No

If yes, please explain:

---

7. Urinary problems (e.g. pain or discomfort, blood in urine)?

( ) Yes ( ) No

If yes, please explain:

---

8. Do you take Flomax?

( ) Yes ( ) No

9. Musculoskeletal problems (e.g. muscle aches, joint pain, swollen joints, etc.)?

( ) Yes ( ) No

If yes, please explain:

---

10. Neurological problems (e.g. numbness, weakness, headaches, dizziness, etc)?

( ) Yes ( ) No

If yes, please explain:

---

11. Bleeding or bruising problems?

( ) Yes ( ) No

If yes, please explain:

---

12. Psychiatric problems (e.g. depression, anxiety, etc.)?

( ) Yes ( ) No

If yes, please explain:

_____

13. Any other conditions/problems – please list:

_____

_____

I verify that the information provided is complete and accurate.

Patient Signature:

_____

**Please bring this paperwork to your appointment.

REFRACTION POLICY

During your visit, a refraction may be performed to determine your need for glasses or to evaluate if any further visual improvement can be achieved. This is a necessary and essential portion of your eye exam and in some cases it is the sole reason for the appointment.

The Centers for Medicare and Medical Services (CMS) use a system – The Resource Based Relative Value Scale (RBRVS) – to determine the fees for all Medicare services, including the refraction. Most other insurance companies use this same system to set their payment schedules. However, the refraction is considered a NON-COVERED service by Medicare and some insurance companies.

Please be aware it is the responsibility of the patient to pay for the refraction. Effective January 16, 2012 our office charges $98.00 for this procedure, but provides a prompt pay price of $59.00 to the patient when paid at the time of service. The refraction fee, based on the RBRVS is in addition to the fee for the eye exam and is in addition to the patient's co-pay.

We appreciate your cooperation in paying this fee at the time services are rendered.

I have read the above information and understand I may be charged a prompt pay price of $59.00 at the time of service. If billing is required, the full charge of $98.00 will be billed.

CONTACT LENS POLICY

The glasses prescription you receive from Houston Eye Associates is NOT a contact lens prescription. A qualified contact lens fitter must fit the contact lenses. Our Optical Department or one of your choice may fit the contact lenses. There is a fee for this service, which varies greatly depending on the type of contact lenses that are right for you, if you have been fitted before, and other individual factors. After your contact lens fitting is completed and services incurred are paid for, you will receive a copy of your contact lens specification.

I have read and understand the above refraction and contact lens policy.

Patient or Guardian's Signature:

_____

NOTICE OF PRIVACY PRACTICES

1. **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.** The notice is provided in two layers: This layer briefly summarizes how we handle your health information, and the attached bottom layer provides further details of our privacy policies and procedures.
2. **How we may use and disclose your health information.** We use health information about you for treatment, to get paid for treatment, for administrative purposes, and to evaluate the quality of care that you receive. For example, your health information may be shared with other providers to whom you are referred. The information may be shared by paper, mail, electronic mail, fax, or other methods. If you sign an authorization to disclose information, you can later revoke it to stop any future disclosures.
3. **Your rights**. In most cases, you have the right to look at or get a copy of your health information that we use to make decisions about you. You may request that we limit disclosure to family members, other relatives, caregivers, or close personal friends who may or may not be involved in your care. If you request copies, we may charge you a cost-based fee. You also have the right to request a list of certain types of disclosures of your information that we have made. If you believe that your health information is incorrect or information is missing, you have the right to request that we correct the existing information or add the missing information.
4. **Our legal duty.** We are required by law to protect the privacy of your health information, provide this notice about our privacy practices, follow the privacy practices that are described in this notice, and seek your acknowledgement of receipt of this notice. We may change our privacy policies at any time. Before we make a significant change in our policies, we will change our notice. The notice will be prominently displayed at all HEA locations and on our website. You can also request a copy of our notice at any time. For more information about our privacy policies, contact our privacy officer.
5. **Privacy complaints:** if you are concerned that we have violated your privacy rights, our privacy policies, or if you disagree with a decision we made about access to your health information, you may contact our privacy officer. You may send a written complaint to the U.S Department of Health and Human Services. Our privacy officer can provide you the appropriate address upon the request.

If you have any questions or complaints, please contact: Houston Eye Associates, Privacy Officer, 2855 Gramercy Street, Houston, Texas 77025. Phone number: (713) 558-8755.

Acknowledgement of receipt of Notice of Privacy Practices: Please sign and print your name and provide the date below to acknowledge that you have received the Notice of Privacy Practices.

Signature: _____

Printed Name: _____ Date: _____