HOUSTON EYE DOCTOR

WELCOME TO OUR OFFICE

PATIENT INFORMATION

First _____ MI _____
Last _____
Date of Birth _____ Sex M F
Street _____
City _____ State _____ Zip _____
Home Phone _____
Day Phone _____
Cell Phone _____
Email _____
How do you prefer to be contacted?
☐ Home ☐ Day ☐ Cell ☐ Text ☐ Email
Patient's Full SSN _____
Employer/School _____
Occupation/Grade _____
Emergency Contact ☐ Spouse ☐ Parent ☐ Other
Full Name _____
Phone _____
Email

MEANINGFUL USE

Race ☐ Nat. Am. ☐ Asian ☐ Blk/Afr. Am. ☐ Hisp.
☐ Nat. HI./Pac. Isl. ☐ White ☐ Other/Decline
Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino
Preferred Language

LIFESTYLE QUESTIONS

Do you…? (Please check all that apply)
☐ work at a computer?
☐ think you might benefit from thinner, lighter lenses?
☐ have interest in a "test drive" of the latest contact lens designs?
☐ spend time outdoors? Hours/week? _____
☐ have prescription sun wear?
☐ prefer not to wear your glasses at times?
☐ want information on Laser Vision Correction surgery?
☐ have interest in a non-surgical approach to vision correction?
☐ have children?
☐ have family members in need of eye care?

VERY IMPORTANT! NEW PATIENTS ONLY:

Who may we thank for referring you to us:
_____
Who may we thank for referring you to us:
☐ Another Doctor
☐ Insurance List
☐ Saw Sign/Building
☐ Newspaper/Radio/TV
☐ Google
☐ Yelp
☐ Facebook
☐ Other:

MEDICAL INSURANCE *(in regards to policy holder)*

Primary Insurance _____
Member ID _____ Group _____
Full Name _____
Patient Relation to Policy Holder ☐ Self ☐ Spouse
☐ Parent ☐ Other _____
Date of Birth _____ Full SSN _____

Secondary Insurance
Member ID _____ Group _____
Full Name _____
Patient Relation to Policy Holder ☐ Self ☐ Spouse
☐ Parent ☐ Other _____
Date of Birth Full SSN

VISION INSURANCE *(in regards to policy holder)*

Primary Insurance _____
Member ID _____ Group _____
Full Name _____
Patient Relation to Policy Holder ☐ Self ☐ Spouse
☐ Parent ☐ Other
Date of Birth _____ Full SSN _____

Secondary Insurance _____
Member ID _____ Group _____
Full Name _____
Patient Relation to Policy Holder ☐ Self ☐ Spouse
☐ Parent ☐ Other _____
Date of Birth Full SSN

HOUSTON EYE DOCTOR

The information in this confidential case history form is critical to the evaluation of your vision and health.

MEDICAL INFORMATION

Name of Medical Doctor _____ City _____

Phone _____ Fax _____ Date of Last Physical Exam _____

List any medications you take (including oral contraceptives, aspirin, over the counter medications, home remedies, vitamins, eye drops, etc: _____

_____

Allergies to medications? ☐ No ☐ Yes, Explain: _____

Have you had any surgeries? ☐ No ☐ Yes Are you pregnant or nursing? ☐ No ☐ Yes

Do you use cigarettes/tobacco, alcohol, or other substances? ☐ No ☐ Yes _____

If **you (S)** or your **family (F)** have any of the following *medical* conditions/symptoms, it's **highly recommended by our doctors** to have a thorough **Comprehensive Medical Eye Exam**: (Please check all that apply; **S=Self, F=Family**)

S	F		S	F		S	F	
☐	☐	Flashes/Floaters in Vision	☐	☐	Loss of Vision	☐	☐	Burning eyes
☐	☐	Sandy or Gritty Eye Feeling	☐	☐	Loss of Side Vision	☐	☐	Headaches
☐	☐	Glare/Sunlight Sensitivity	☐	☐	Double Vision	☐	☐	Migraines
☐	☐	Trouble seeing at night	☐	☐	Mucous Discharge	☐	☐	Eye Dryness
☐	☐	Distorted Vision/Halos	☐	☐	Stye	☐	☐	Eye Redness
☐	☐	Eye Foreign Body Sensation	☐	☐	Allergies/Hay Fever	☐	☐	Itchy Eyes
☐	☐	Excess Tearing/Watering	☐	☐	Sinus Congestion	☐	☐	Asthma
☐	☐	Eye Pain or Soreness	☐	☐	Dry Throat/Mouth	☐	☐	Diabetes
☐	☐	Chronic Eye or Lid Infection	☐	☐	High Blood Pressure	☐	☐	Cancer
☐	☐	Rheumatoid Arthritis	☐	☐	Allergic/Immunologic	☐	☐	HIV
☐	☐	Vascular/Heart Disease	☐	☐	Macular Degeneration	☐	☐	Blindness
☐	☐	Retinal Detachment/Disease	☐	☐	Crossed Eye	☐	☐	Cataract
☐	☐	Arthritis	☐	☐	Glaucoma	☐	☐	Other

Please If **you (S)** or your **family (F)** have any of the following *other* conditions/symptoms: (Please check all that apply; **S=Self, F=Family**)

S	F		S	F		S	F	
☐	☐	Uncomfortable glasses	☐	☐	Kidney Disease	☐	☐	Lupus
☐	☐	Fever, Weight Gain/Loss	☐	☐	Thyroid Disease	☐	☐	Seizures
☐	☐	Integumentary (Skin)	☐	☐	Chronic Bronchitis	☐	☐	Running Nose
☐	☐	Blurred Vision	☐	☐	Emphysema	☐	☐	Post-Nasal Drip
☐	☐	Tired Eyes	☐	☐	Heart Pain	☐	☐	Chronic Cough
☐	☐	Genitals/Bladder	☐	☐	Diarrhea	☐	☐	Bleeding Problems
☐	☐	Muscle Pain	☐	☐	Constipation	☐	☐	Psychiatric
☐	☐	Joint Pain	☐	☐	Anemia	☐	☐	Other

VISION INFORMATION

Date of Last Eye Exam _____ By Whom? _____

Do you wear or have worn contacts? ☐ No ☐ Yes: which? ☐ Rigid ☐ Soft ☐ Extended Wear ☐ Other

Are you satisfied with the vision/comfort of your contact lenses? ☐ No ☐ Yes

Would you prefer clear or colored contact lenses ☐ Clear ☐ Color

If you wear bifocals, do you the lines or head tilting bother you? ☐ No ☐ Yes

NOTICE OF PAYMENT POLICIES AND PROCEDURES

PAYMENT POLICY: It is customary to pay for professional services when rendered. For your convenience, we accept most major credit cards, debit cards, care credit, checks, and 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/authorizations to the Receptionist/Registrar. Be sure to present your identification with your insurance card. ***Please be aware your insurance will be billed on your date of service; any unused benefits may be lost.***

MEDICAL 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 Insight Vision Care for any unpaid medical procedures performed now or in the future. I also authorize, Houston Eye Doctor, 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 are financially responsible for these services. Also, having more than one insurer **DOES NOT** necessarily guarantee that your services are covered 100%. Secondary insurers may pay a portion of what your primary carrier does not. We may bill your secondary as a courtesy. **You are responsible for any balances after your insurance(s) has cleared.**

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 at the time of service has been verified.

PRESCRIPTION RELEASE: Unfortunately, neither eyeglasses nor contact lens prescriptions may be released without having all outstanding balances paid in full.

CONTACT LENS POLICY: The eyeglass prescription you receive from Insight Vision Care is NOT a contact lens prescription. A qualified contact lens fitter must fit the contact lenses on you. **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, services and products ordered are paid for; you may receive a copy of your contact lens specification. We realize that contact lens prescriptions may take additional visits before the prescription is finalized, but due to time restraints on filing your insurance benefits for contact lenses, our office policy is as follows: ***On the date of your initial fitting for contact lenses, your insurance benefits will be maxed out for the value of the contact lens benefit; this may leave a small balance on your account. This balance will need to be collected in order to ensure the contact lenses are ordered upon your request. This policy is in place to ensure that you do not lose any portion of your insurance benefit.*** **All contact lens orders must be paid in full upon order placement. There is a $25.00 restocking fee on all cancelled or returned boxes of contact lens, but they cannot be REFUNDED once ordered.**

OFFICE FINANCIAL POLICY: Co-payments and Deductibles are to be paid in full at the time services are rendered. There is a $39 fee for all returned checks.

APPOINTMENT POLICY: If you are more the 15 minutes late for your appointment, you will be asked to reschedule. Also, a $25 fee will be assessed to your account if you no show or fail to give 24-hour notice of cancellation. Payment of this fee will be required in order to receive any future services or products. An outstanding cancellation charge is subject to collection if left unpaid.

CANCELLATION OF GLASSES: Glasses are ordered the day of your appointment or when current prescription is available. Glasses will not be ordered until payment is made. Once these orders are placed, modifications can only be made to the purchased glasses if allowed by the Optical Lab, but they cannot be CANCELLED or REFUNDED**. All glasses will take 10-12 business days for completion.**

EYE EXAM: I agree to and understand that my eye(s) may 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 Doctor suggest that I evaluate my need for alternative transportation and the decision is solely mine, therefore I will not hold Houston Eye Doctor responsible. ☐ I decline dilation

I have read this disclosure and agree, consent, and understand the terms set forth. The contents of this document will remain in effect unless revoked by me in writing.

_____ _____

Name of Patient (Print) Date

_____

Signature of Patient/Patient Representative

HOUSTON EYE DOCTOR

HIPAA Consent Form and Patient Privacy

I, _____, do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

_____ _____

Print Patient Name Patient DOB

☐ I authorize Houston Eye Doctor to release my health information to:

_____ _____

Person/Entity Relationship/Entity Type

☐ I do not wish to release my information to anyone at the moment. I will request to sign this form again when I wish to release my information

_____ _____

Patient/Guardian Signature Date

About Your Insurance

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company, not Houston Eye Doctor.

If your insurance company has not reimbursed our office in full within 60 (or 90) days, you are responsible for providing payment in full to Houston Eye Doctor.

What is the difference between a Basic Eye Screening and Comprehensive Medical Eye Exam?

Insurance coverage for eye exams varies. Some plans only cover routine, well eye exams. Other plans will not pay for your exam unless you have a medical eye condition or disease. Some plans require a referral from your primary care physician. Be sure to check your policy(s) to determine your coverage prior to your appointment.

For insurance purposes, eye examinations are divided into two categories: Vision and Medical

Basic Eye Screening

These are routine or "Well Vision" exams for people who have no eye disease or symptoms of disease. Your eyes will be examined for any needed correction (glasses or contact lenses) or any potential indicators of eye disease. If you doctor finds anything abnormal during your vision exam, further testing of a medical nature may be needed. In that case, your medical insurance would be billed. Routine vision eye exams do not qualify for prescribing eye drop medications. Yearly diabetic eye exams will not be billed to insurance under vision coverage.

Comprehensive Medical Eye Exam

This is a medically necessary comprehensive examination for the diagnosis and treatment of diseases and conditions of the eye performed by a physician/surgeon. This exam evaluates the reasons for the symptoms and assesses any treatment needed. Some conditions evaluated with medical eye exams include cataracts, glaucoma, diabetes, hypertension, allergies, family history, macular degeneration and many other potentially sight-threatening diseases

There are two types of health insurance that will help pay for your eye care services and products. You may have both and our practice accepts both:

Vision Care Plans (such as VSP, VCP, and Eyemed)

Medical Insurance (such as Blue Cross Blue Shield and Medicare)

Vision care plans only cover routine vision exams along with eye glasses and contact lenses. Vision only plans only cover a basic screening for eye disease. They do not cover diagnosis management, or treatment of eye diseases.

Medical insurance must be used if you have any eye health problem or systemic health problem that has ocular complications. Your doctor will determine if these conditions apply to you, but some are determined by your case history.

If you have medical and vision insurance plans, it may be necessary for us to bill some services to one plan and other services to the other. We will use **coordination of benefits** to do this properly and to minimize your out-of-pocket expenses.

We will bill your insurance plan for services if we are a participating provider for that plan. We will try to obtain advanced authorization of your insurance benefits so we can tell you what is covered. If some fees are not paid by your plan, we will bill you for any unpaid deductibles, co-pay, or non-covered services as allowed by the insurance contract.

I have read and agree with these policies.

_____ _____

Patient signature (guardian) Date

Please provide both your medical and vision insurance cards to our staff