HOUSTON EYE DOCTOR

WELCOME TO OUR OFFICE

Patient Information

Last _____
First _____MI _____
Date of Birth _____Age _____
Sex M F
Street _____
City _____ State _____
Zip Code _____
Home Phone _____
Work Phone _____
Cell Phone _____
Email Address _____
How do you prefer to be contacted?
(Indicate #1 and #2 Choice):
Home #___Work #___Cell #___Text___Email____
Patient's SSN _____
Employer (or School) _____
Occupation (or Grade) _____
Spouse (or Parent's Name) _____
Spouse (or Parent's Work) _____

VERY IMPORTANT! NEW PATIENTS ONLY:
Who may we thank for referring you to our office?
Name of friend or relative _____

If not referred, how did you choose our office?
❑ Another Dr.
❑ Insurance List
❑ Saw Sign/Building
❑ Newspaper/Radio/TV
❑ Yellow Pages: Which directory? _____
❑ Web Page: Which Web Site? _____
❑ Other _____

Lifestyle Questions

Do you……(check box if your answer is yes)
❑..work at a computer? If yes, please complete computer questionnaire.
❑..think you might benefit from thinner, lighter lenses?
❑..have interest in a "test drive" of the latest contact lens designs
❑..spend time outdoors? How much? __Hrs/week
❑..have prescription sunwear?
❑..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 more than 1 pair of current Rx eyewear?
❑..have children?
❑..have family members in need of eyecare?

Have you ever experienced, been diagnosed or treated for any of the following?

❑ Blurry Vision	❑ Burning
❑ Cataracts	❑ Corneal Abrasions
❑ Crossed eye/Eye turn	❑ Double Vision
❑ Eye Infections	❑ Eye Injury
❑ Flash of light	❑ Floaters/Spots
❑ Glaucoma	❑ Grittiness
❑ Headaches	❑ Iritis/Uveitis
❑ Itchiness	❑ Lazy Eye
❑ Macular Degeneration	❑ Occasional dryness
❑ Retinal Detachment	❑ Sunlight Sensitivity
❑ Tearing	❑ Trouble seeing at night
❑ Uncomfortable glasses	

❑ Other eye disorders_____

The mission of Houston Eye Doctor is to contribute to a lifetime of healthy vision, proving each patient with the highest quality vision care and consequent quality of life. We will seek continuing education to remain at the forefront of our profession and will offer the latest eye care technology, professional services, and products. The visual needs and wellness of each patient will always be our first priority. Everything we do shall communicate this.

HOUSTON EYE DOCTOR

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

Patient Medical History

Name of Family Physician_____
Town_____
Date of Last Physical Check-up_____

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills)_____
_____
_____

Allergies to medications? ❑ Yes ❑ No
If so, what medications?_____
_____

Have you had any surgeries? ❑ Yes ❑ No
Do you use cigarettes/tobacco, alcohol, or other substances? ❑ Yes ❑ No

Have you ever been diagnosed or treated for the following health problems?	**Yes**	**No**
Allergies	❑	❑
Arthritis	❑	❑
Blood/Lymph	❑	❑
Bronchitis	❑	❑
Cancer	❑	❑
Cholesterol	❑	❑
Diabetes	❑	❑
Digestive	❑	❑
Ears/Nose/Throat	❑	❑
Endocrine	❑	❑
Eczema/Rashes	❑	❑
Fatigue	❑	❑
Fevers	❑	❑
Genitourinary	❑	❑
High Blood Pressure	❑	❑
Integumentary (Skin)	❑	❑
Kidney	❑	❑
Muscle/Bone	❑	❑
Neurological	❑	❑
Psychological	❑	❑
Respiratory	❑	❑
Sinus	❑	❑
Throat Infections	❑	❑
Thyroid	❑	❑
Unusual weight losses/gains	❑	❑

Patient Eye History

Date of Last Eye Exam_____
By Whom?_____

Have you ever tried contact lenses? ❑ Yes ❑ No

Do you currently wear contact lenses? ❑ Yes ❑ No
What kind?_____
Solutions used_____

Are you satisfied with the vision and comfort of your contact lenses? ❑ Yes ❑ No

Would you prefer clear contact lenses or colored contact lenses? ❑ Clear ❑ Colored

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

Is there a family medical history of any of the following:
❑ No ❑ Yes (Please check boxes)

	Relationship (Mother's or Father's side)
Blindness	❑_____
Cataracts	❑_____
Corneal Problems	❑_____
Diabetes	❑_____
Glaucoma	❑_____
Heart Disease	❑_____
Lazy Eye	❑_____
Macular Degeneration	❑_____
Retinal Problems	❑_____

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.

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 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.

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

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.

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 in upon order placement. There is a $25.00 restocking fee on all cancelled or returned boxes of contact lens.**

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.**

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, _____Date _____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

_____ _____

Patient/Guardian Signature Date

About Your Insurance

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 both types of 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 your insurance cards to our staff

MEDICAL VS. VISION EXAM

What is the difference between a Medical Eye Exam and a Vision 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 examination are divided into two categories: Vision and Medical

Vision Exam

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 at another visit. In that case, your medical insurance would be billed. Routine vision eye exams do not qualify for prescribing medications. Yearly diabetic eye exams will not be billed to insurance under vision coverage.

Medical 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, diabetic retinopathy, macular degeneration and many other potentially sight-threatening diseases

Patient Initials _____ Date_____