TEXAS EYE CARE NETWORK

PATIENT INFORMATION					
Patient Name: Last	First	M.I.	DOB	AGE	M F
Social Security #	Marital Status: Single		Married	Divorced	Widowed
Address:	City:		State:	ZIP:	
E-mail	Work Phone #		Home Phone #		
Occupation:	Employer:		Employer Phone #:		
Ethnicity: Hispanic Non-Hispanic		Race:			
Emergency Contact Name:		Relation:		Phone #:	
Emergency Contact Name:		Relation:		Phone #:	

PRIMARY INSURANCE INFORMATION		
Primary Insured's Name	Date of Birth	Phone Number
Primary Insured's Social Security #:	Patient's Relationship to Primary Insured: ❒Self ❒Spouse ❒Child ❒Parent	
Primary Insured's Employer:	Insurance Plan Name:	
Insurance ID number:	Group number:	

SECONDARY INSURANCE INFORMATION		
Primary Insured's Name	Date of Birth	Phone Number
Primary Insured's Social Security #:	Patient's Relationship to Primary Insured: ❒Self ❒Spouse ❒Child ❒Parent	
Primary Insured's Employer:	Insurance Plan Name:	
Insurance ID number:	Group number:	

OTHER INFORMATION	
Allergies:	
Referring Doctor:	**Optometrist:**
Pharmacy:	**Pharmacy Phone#:**
Reason for Today's Visit:	

Filing your insurance is not a guarantee of payment, if payment is not received you as a patient will be ultimately responsible for all unpaid services.

BY SIGNING THIS FORM, I ACKNOWLEDGE THE ABOVE AND UNDERSTAND THAT IT IS MY RESPONSIBILITY TO PROVIDE THE PHYSICIAN WITH ALL CORRECT INSURANCE INFORMATION IF THE CLAIM IS DENIED FOR ANY REASON I WILL BE FINANCIALLY RESPONSIBLE FOR ALL FEES INCURRED IN MY VISIT OR PROCEDURE.

Patient Name

Wintess Print Name and Relationship

Patient signature Date

Witness signature Date

No Show Policy: If you cannot make you appointment, please call within 24 hours of your appointment to reschedule or cancel.

If you do not call you are considerd a **NO SHOW** and $25 will be charged to your account.

5/23/18

TEXAS EYE CARE
NETWORK

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. Our Notice of Privacy Practices will be made available for your review at our check-in counter upon your request. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that this Notice is available for the patient to review upon request.
- The practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.
- The patient grants access to Texas Eye Care Network to electronically access their medication.

This Consent was signed by: _____ Date: _____
Printed Name – Patient or Representative
Relationship to Patient (if other than patient) _____

Due to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the following information must be filled out by each patient annually.

I authorize Texas Eye Care Network to release my medical or insurance information as necessary to process my medical claims and coordinate or manage my health care.

In the event a family member or caregiver attends my office visit and is in the exam room at the time of my evaluation and/or treatment, I give Dr. Majka and his staff members my permission to discuss freely my condition, treatment or diagnosis with that person. **YES / NO**

HOME PHONE _____ May we leave a message? **YES / NO**
CELL PHONE _____ May we leave a message? **YES / NO**

TO WHOM MAY WE DISCUSS FINANCIAL ISSUES RELATING TO TREATMENT & DIAGNOSIS? _____
_____

Phone: _____ Signature: _____
(Patient or Representative)

TEXAS EYE CARE
NETWORK

FINANCIAL & INSURANCE POLICY

Texas Eye Care Network is committed to excellent patient care and accepts a wide range of medical insurances. For your convenience, our Insurance and Authorization teams make every effort to coordinate your eligibility and benefits with your insurance provider prior to your appointment with us.

Our desire is to provide your care with excellence and efficiency. We kindly request that you help this process by taking the following steps:

- Please bring all current active insurance cards to every scheduled appointment.
- Keep us up to date with your phone number, address, and primary care physician
- If your (primary or secondary) insurance changes or becomes inactive, please contact our insurance department as soon as possible prior to your appointment.

The following policies regarding insurance are necessary for us to work effectively and will ultimately improve your care. Please take note that:

- **ALL** co-payments and fees will be collected at time of service. This amount is based on an estimate from your insurance company. Your total financial obligation will be determined by your insurance company and will appear on your explanation of benefits (EOB). (NOTE: this excludes self-pay and uncovered services). If the estimated amount is less, you will be billed the difference. If the estimated amount is more, you will be refunded the difference.
- **Co-payments** are collected at check-in prior to being seen. Any additional amounts owed (co-insurances, deductibles, diagnostic testing fees) will be collected at check out at the end of your visit.
- For billing purposes, **we must have your social security number on file**. **Without this information, we are unable to bill your insurance and you will be considered self-pay** (fees will be collected at time of service)
- **If your insurance plan requires a referral or authorization**, we will make every effort to obtain this prior to your visit. Without this referral or authorization on file prior to the appointment, we are unable to bill your visit to your insurance. You will be given the option to have the visit rescheduled or to be considered self-pay (fees will be collected at time of service).
- **Refraction** (the examination that determines the prescription for eyeglasses or contact lenses) is considered a non-covered service by Medicare. Many commercial insurances follow suit and consider it a non-covered service as well. Consequently, the refraction fee is separate from the medical examination fee covered by insurance. Our fee for refraction is **$85.00** and is collected at the time of your visit, in addition to any co-payments or deductible amounts due for the medical portion of your examination.

BY SIGNING THIS FORM, I ACKNOWLEDGE THE ABOVE AND UNDERSTAND THAT IT IS MY RESPONSIBILITY TO PROVIDE TEXAS EYE CARE NETWORK WITH ALL CORRECT INSURANCE INFORMATION. IF AUTHORIZATION CANNOT BE OBTAINED OR INSURANCE ELIGIBILITY CANNOT BE DETERMINED, THE VISIT WILL BE CONSIDERED SELF-PAY. ALL PAYMENTS DUE WILL BE COLLECTED AT THE TIME OF SERVICE.

_____ _____

Print Patient Name Print Responsible Party Name and relationship

_____ _____

Patient Signature Date Witness or Responsible Party Date

TEXAS EYE CARE
NETWORK

INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize the doctors at Texas Eye Care and/or such assistants as may be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

_____ _____

Patient (or person authorized to sign for patient) Date

_____ _____

Witness Date

Medical History Form

Date of Exam:

Patient Name:_____ Date of Birth _____ Male / Female

Name of Family Doctor: _____ Last Health Exam Date: _____

Eye History

Previous eye diagnosis:_____

_____

_____

Previous eye surgery:_____

_____

Previous eye injury:_____

_____

Do you wear glasses? YES / NO Contact Lens? YES / NO If so, Hard Lenses / Soft Lenses

Pertinent Medical History:

List all important medical history or problems you have had: _____

_____

_____

Have you had any surgeries? YES / NO If yes please explain: _____

_____

Medications:

Please list all medication ***allergies***: _____

_____

List all current EYE drops/medications	List all other medications
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Smoking Status (circle one): Current Smoker / Former Smoker / Never Smoker

Alcohol Status (circle one): Current Drinker / Former Drinker / Never Drinker

Height _____ Weight _____

Family History:

Glaucoma?	_____ YES	_____ NO	Diabetes	_____ YES	_____ NO
Macular Degeneration	_____ YES	_____ NO	High Blood Pressure	_____ YES	_____ NO
Retinal Detachment	_____ YES	_____ NO	High Cholesterol	_____ YES	_____ NO
Blindness	_____ YES	_____ NO	Thyroid Disease	_____ YES	_____ NO
Arthritis	_____ YES	_____ NO	Other _____		

(Personal Medical History on backside)

Personal Medical History Form

Date of Exam:

Constitutional

Fatigue	____ YES	____ NO
Malaise	____ YES	____ NO
Chills	____ YES	____ NO
Fever	____ YES	____ NO
Night Sweats	____ YES	____ NO
Appetite Changes	____ YES	____ NO
Weight Changes	____ YES	____ NO

HEENT

Head Injury	____ YES	____ NO
Decreased Hearing	____ YES	____ NO
Tinnitus	____ YES	____ NO
Earache	____ YES	____ NO
Hay Fever	____ YES	____ NO
Sinus Pain	____ YES	____ NO
Stuffiness	____ YES	____ NO
Discharge	____ YES	____ NO
Dry Mouth	____ YES	____ NO
Sore Throat	____ YES	____ NO
Dentures	____ YES	____ NO
Difficulty Swallowing	____ YES	____ NO

Endocrine

Polydipsia	____ YES	____ NO
Nervousness	____ YES	____ NO
Diabetes	____ YES	____ NO
Hypoglycemia	____ YES	____ NO
Goiter	____ YES	____ NO
Hair Loss	____ YES	____ NO
Heat/COD Intolerance	____ YES	____ NO
Weight Changes	____ YES	____ NO

Neurological

Alzheimer's	____ YES	____ NO
Dizziness	____ YES	____ NO
Epilepsy	____ YES	____ NO
Headaches	____ YES	____ NO
Migraines	____ YES	____ NO
MS	____ YES	____ NO
Neuropathy	____ YES	____ NO
Paralysis	____ YES	____ NO
Parkinson's Disease	____ YES	____ NO
Seizures	____ YES	____ NO
Stroke	____ YES	____ NO
TIA	____ YES	____ NO
Tremors	____ YES	____ NO

Cardiovascular

Angina	____ YES	____ NO
Heart Attack	____ YES	____ NO
High Cholesterol	____ YES	____ NO
High Blood Pressure	____ YES	____ NO
Low Blood Pressure	____ YES	____ NO
Murmur	____ YES	____ NO
MVP	____ YES	____ NO
Thrombophlebitis	____ YES	____ NO
Varicose Veins	____ YES	____ NO

Respiratory

COPD	____ YES	____ NO
Wheezing	____ YES	____ NO
Cough	____ YES	____ NO
Hemoptysis	____ YES	____ NO
Asthma	____ YES	____ NO
TB	____ YES	____ NO
SOB	____ YES	____ NO

Gastrointestinal

Diarrhea	____ YES	____ NO
Constipation	____ YES	____ NO
Stool Changes	____ YES	____ NO
Hemorrhoids	____ YES	____ NO

Dermatological

Rash	____ YES	____ NO
Lumps	____ YES	____ NO
Itching	____ YES	____ NO
Dryness	____ YES	____ NO

Psychiatric

Depression	____ YES	____ NO
Mania-Depression	____ YES	____ NO
Mania	____ YES	____ NO
Anxiety	____ YES	____ NO
Panic Attacks	____ YES	____ NO
Past Suicide Attempts	____ YES	____ NO

Gastrointestinal Cont.

Indigestion	____ YES	____ NO
Difficult Swallowing	____ YES	____ NO
N/V	____ YES	____ NO

Genitourinary

Blood	____ YES	____ NO
BPH	____ YES	____ NO
Difficult Urination	____ YES	____ NO
Enlarged Prostate	____ YES	____ NO
Increased Frequency	____ YES	____ NO
Frequent UTIs	____ YES	____ NO
Incontinence	____ YES	____ NO
Kidney Stones	____ YES	____ NO

Musculoskeletal

Arthritis	____ YES	____ NO
Swelling	____ YES	____ NO
Stiffness	____ YES	____ NO
Muscle Aches	____ YES	____ NO
Muscle Weakness	____ YES	____ NO
Leg Cramps	____ YES	____ NO
Back Pain	____ YES	____ NO
Joint Pain	____ YES	____ NO

Haematologic

Easy Bruisibility	____ YES	____ NO
Excessive Bleeding	____ YES	____ NO
Enlarged Lymph Node	____ YES	____ NO
Anemia	____ YES	____ NO

Other _____

_____

_____

_____

_____

Patient Signature

AUTHORIZATION FOR RELEASE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION TO RESPONSIBLE PARTY

This Authorization grants permission to the responsible party(ies) named below to: make or confirm appointments; have access to x-ray, laboratory, or test findings; have access to telephone communication and answering machine messages as well as other common means of communication; pick up sample medications; be made aware of my diagnosis, prognosis, and treatment plans; have access to my financial health information and medical records.

I hereby authorize Texas Eye Care Network to use and disclose my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that once this information is released to the Responsible Party(ies) named below, the released information may no longer be protected by federal privacy regulations.

Patient Name:_____ **Date of Birth:**_____

1) Name:_____ Relationship to patient:_____

Address_____

Phone:_____

2) Name:_____ Relationship to patient:_____

Address:_____

Phone:_____

The patient or patient's representative must read and initial the following statements:

1. I understand that this authorization will: ***(Must check one)***
   ( ) expire 1 year from the date signed by the patient or patient's representative; or
   ( ) be effective for the lifetime of the patient unless revoked

2. I understand that I may revoke this authorization at any time by notifying in writing; however, if I do revoke the authorization, it will not have any effect on any actions taken by ***Texas Eye Care Network*** prior to their receipt of the revocation.

3. I understand that my treatment cannot be conditioned on whether I sign this authorization.

_____ _____

Signature of patient or patient's representative Date
(*Form **MUST** be completed before signing or will not be valid)*

Printed Name of Patient's Representative: _____

***YOU MAY REFUSE TO SIGN THIS AUTHORIZATION**