PATIENT DATA SHEET **NEW PATIENT: Y or N**

1. PATIENT DEMOGRAPHICS

First Name	Last Name	Middle Initial	☐ Male ☐ Female		
Address	City	State/Zip Code			
Social Security Number	Birth Date / /	Age	Race	Ethnicity	Language
Home Phone ( )	Work Phone ( )	Cell Phone ( )			
Email Address					

2. EMERGENCY CONTACT

In case of emergency contact:		Relation to patient
Home Phone ( )	Work Phone ( )	Other Phone (specify)

3. I WAS REFERRED BY ☐ Doctor ☐ Family ☐ Friend ☐ Self ☐ Second Opinion ☐ Media / Other

Please provide name or media source:

4. MY CURRENT EYE DOCTOR IS:

Optometrist / Ophthalmologist	Address/ Phone

5. EMPLOYMENT INFORMATION

Occupation / Student	PHONE NUMBER
Employer / School	Address

6. INSURANCE INFORMATION .....CO-PAY IS COLLECTED ON ARRIVAL

PRIMARY Insurance	SECONDARY Insurance	Primary Doctor:
1-800 #	1-800 #	Primary Doctor PHONE#:

SELF PAY ACKNOWLEDGEMENT

I am aware of my responsibility to pay Eye Associates of South Texas for any services rendered. Any services will be considered an out-of-pocket expense payable in cash, check or credit card. Care credit is also available.

My refractive screening is complimentary, however, if I am a candidate AND I choose to proceed with surgery, I understand my pre-op exam will be $150.00 which will be deducted from my total surgery fee.

Any unpaid balance will be deferred to a collection agency with an additional fee of 33% added to my balance. In the event of promotional discounts, only one per person and can not be combined with any insurance.

INSURANCE ACKNOWLEDGEMENT

I hereby assign payment of medical insurance benefits to the above-named physician and Eye Associates of South Texas for all services rendered. I understand that I am responsible for all charges whether or not paid by said insurance.

I further understand that I must keep the office updated with current insurance information and any changes that may occur. Should a filed claim be rejected due to inactive coverage, I understand that I will be responsible for all charges due. Should the account go unpaid it will be referred to a collection's agency and an additional 33% collection fee will be added to the total balance.

I consent to the release of any medical information necessary to process any and all insurance claims. I give my consent for a personal photograph for office identification.

_____

Signature *Date*

Medical History: Patient Name:	**DOB:**
Past Surgeries:	
Past Eye Surgeries:	**Last Eye Exam:**
Reason for your Visit Today:	

PATIENT'S MEDICAL HISTORY	
☐ Diabetes Type I II x____yrs	☐ Migraines ever on IMETREX? _____
☐ Hypertension	☐ Asthma
☐ Heart Disease pacemaker? ____	☐ Thyroid Disease Hyper / Hypo?
☐ Heart Attack____/Surgery_____	☐ Hearing Problems hearing aid? _____
☐ Kidney Disease dialysis? ____	☐ Depression/Anxiety
☐ Arthritis (Rheumatoid or Osteo?)	☐ Cancer type?_____)
☐ High Cholesterol	☐ Genetic Condition / Syndrome?
☐ Gastrointestinal Problems _____	☐ Prostate Condition?_____)
☐ Acne (ever on Accutante?)	☐ Smoke (How much?_____)
☐ Dry Mouth	☐ Alcohol (How much?_____)
☐ Pregnant or currently Nursing?	☐ Other _____
Family History	
☐ Genetic condition / syndrome	☐ Rheumatoid Arthritis
☐ Diabetes	☐ Cancer
☐ Hypertension	☐ Other _____
☐ Heart Disease	
CONTACT LENS WEARERS	
What Type and Brand do you wear?	
What is your Contact Lens Power? WEAR Torics?	

Pharmacy Name: **Pharmacy Phone Number:**

	Name of Medicine	How much	Reason for Medicine	Name of Medicine	How Much	Reason for Medicine

WELCOME TO EYE ASSOCIATES

INSURANCE POLICY

In order to serve you properly and keep cost down we feel it is necessary to define our financial policies. We are happy to file the forms necessary to see that you receive the full benefits of your coverage: however, we cannot guarantee any estimated coverage. Because the insurance policy is an arrangement between you and the insurance, we ask that all patients be directly responsible for all charges. Please know that we will do everything possible to see that you receive the full benefits of your policy. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance, and "usual and customary" fees. Additionally, we are not responsible if your insurance company representative tells us something is covered at X%, and then later denies payment or pays less that stated. Our involvement will be limited to supplying factual information to facilitate claim processing. If for some reason your insurance company has not paid their portion within 30 days from the start of treatment you are responsible for the payment at that time. All charges are your responsibility whether your insurance company pays or does not pay. If you should have any questions regarding your charges for each appointment, pleases feel free to ask us.

REFERRALS

If you have an insurance which requires a referral it is your responsibility to obtain the referral from your primary care physician **before your appointment.** Otherwise, the visit will not be covered by insurance and you will be responsible for the payment. Please notify is if your insurance requires pre-authorization for office procedures.

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 not only a necessary and essential portion of your eye exam, but in many cases is the sole reason for the appointment. Please be aware that this is a non-covered service by Medicare and most other insurance companies and is the responsibility of the patient. Our office currently charges $50.00 for this procedure. We appreciate your cooperation in collecting this fee at the time of service.

I have read the above and fully understand my financial responsibility.

Signature:_____ **Date:**_____

ROUTINE EYE EXAMINATION POLICY

It is also important that you understand that most medical insurance plans, including Medicare, do not cover routine eye examinations. A routine eye examination is when no medical eye problem is known or suspected, or if you are just coming in for a glasses check. In this case, you would be responsible for the charges for that visit. Some **vision plans** will cover routine examinations. However, since we are a medical eye doctor, we are **NOT** on most vision plans. Please let us know if you have a question regarding routine eye exam coverage.

I have read the above and fully understand my financial responsibility.

Signature_____ **Date**_____

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OR PRIVACY PRACTICES

I have been given the opportunity to review this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____	_____	_____
Signature of patient or Representative	**Date**	**Description of Representative**

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES - HIPAA

By my signature below, I acknowledge that I have received Eye Associates of South Texas Notice of Privacy Practices.

_____

Patient Name (print)

_____

Patient's Signature

_____ _____

Date **Relationship to Patient**

May we contact you? YES or NO If so, how?

Home Number _____

Work Number _____

Cell Phone _____

Email _____

Who may we give information to regarding your condition, treatment, or diagnosis?

Name Phone Relationship

_____

_____

_____