

PATIENT FINANCIAL POLICY

To reduce confusion and misunderstanding between our patients and practice, Texan Eye Care has adopted the following policies. Please discuss any questions regarding these policies with our office manager or billing office representative. For your convenience we accept Visa, MasterCard, and Discover.

Your Insurance

- Texan Eye Care contracts with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service.
- If you have insurance coverage with a plan for which Texan Eye Care does not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of service.
- In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- We will bill your health plan for services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

Minor Patients

- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

I have read and understand the financial policy of the practice, and I agree to be bound by the terms. I also understand and agree that the practice may amend such terms from time to time.

CONSENT TO TREAT

I have requested medical services from Texan Eye Care on behalf of myself and/or my dependents. 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 a part of the treatment of my condition. I understand that if my pupils are dilated or my eye is patched after the eye exam, I may not be able to safely operate a motor vehicle and that the staff and doctors of Texan Eye Care request and strongly urge that I arrange alternate transportation.

ASSIGNMENT OF BENEFITS

I understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. I understand that if I fail to provide all necessary information to file my insurance claim, I will be required to pay all charges in full at the time services are rendered. A photocopy of this assignment is to be considered as valid as the original. I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) to Texan Eye Care for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby further authorize Texan Eye Care to (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of one year. This order will remain in effect until revoked by me in writing.

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have been made aware of and/or reviewed 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.

Patient/Responsible Party Signature

Date

Witness

Date

Name: _____ Age: _____ Date: _____

HISTORY WORKSHEET

Please check all that apply

- I am having trouble with my **distance** vision in my **right** eye.
- I am having trouble with my **distance** vision in my **left** eye.
- I am having trouble with my **near** vision in my **right** eye.
- I am having trouble with my **near** vision in my **left** eye.
- I am here to explore **surgery** to get rid of my glasses +/- contacts.
- I am experiencing glare/halos/streaks of light at night.
- I am having trouble driving at night.
- Bright sunlight in my eyes makes it harder for me to drive.
- My vision problems interfere with activities I would like to enjoy.
- My eyes feel dry.

Please list Medications (include over-the-counter):

REVIEW OF SYSTEMS

1 Musculoskeletal

- Osteoarthritis
- Osteoporosis
- Muscle weakness
- Other: _____

2 Cardiovascular

- Heart disease
- Chest pain
- Heart attack
- Blood clots
- Blood pressure
- Cholesterol
- Other: _____

3 Respiratory

- Asthma
- COPD
- Pneumonia
- Lung cancer
- Other: _____

4 Gastrointestinal

- GERD
- Peptic ulcer
- Liver/Gall bladder
- Other: _____

5 Neurosensory

- Stroke
- Aneurysm
- Seizures
- Migraines
- Peripheral nerves
- Other: _____

6 Urinary

- Kidney stones
- Renal failure or Dialysis
- Incontinence
- Other: _____

7 Endocrine

- Diabetes type: _____
- How long: _____
- Thyroid
- Menopause
- Other: _____

8 Reproductive

- Prostate
- Breast cancer
- Fibroid
- Other: _____

9 Immune

- Lymphoma
- Leukemia
- Rheumatoid arthritis
- Lupus
- HIV/AIDS
- Autoimmune
- Allergies
- Other: _____

10 Cancer

- Type: _____
- How long: _____

FAMILY HISTORY

(please check all that apply to blood relatives)

- Glaucoma
- Cataracts
- Diabetes
- Blindness
- Macular Degeneration
- Retinal detachment
- Other: _____

SOCIAL HISTORY

- Occupation: _____
- If retired, previous occupation: _____
- Do you smoke? Y/N If Yes, packs per day? _____
- Former smoker? Y/N If Yes, for how long? _____
- Drink alcohol? Y/N If Yes, drinks per week? _____

FOR CONTACT LENS WEARERS ONLY

- Do you currently wear:
- Soft Rigid Gas Permeable or Hard
- How long have you worn contact lenses? _____ years
- Do you use Monovision?
- (One eye for distance and one eye for near)
- Y/N
- If so, which eye is used for far?
- Right/ Left
- Which is your Dominant eye?
- Right/ Left/ Not sure
- Do you sleep in your contact lenses? Y/N
- When was the last time you wore your contact lenses?
- _____

Do you know your prescription?

Please indicate anything else you would like for us to know about you for the purposes of today's examination:
