Patient Information Form

NAME (last, first MI)_____**(Mr., Miss, Mrs., Dr.)**
Address_____
City, State, Zip_____
SSN_____-____-_____ DOB_____/_____/_____ SEX: M_____F_____
Driver's License#_____ Phone (Home)_____ Work_____
Email Address_____
Employer/Occupation_____
Who Referred You? _____
Primary Care Physician:_____
ARE YOU UNDER THE CARE OF A SKILLED NURSING FACILITY? _____
IS THIS VISIT THE RESULT OF AN INJURY ON THE JOB? _____

PRIMARY INSURANCE CARD HOLDER
Subscriber's Name_____ SSN_____-____-_____
Relationship to Patient_____ DOB_____/_____/_____
Insurance Company_____
Secondary Insurance Company_____
Co-payment and deductible payments as determined by your agreement with your insurance carrier are due at the time of service. We will file your insurance claim, but not all insurance plans cover all services. In the event your insurance plan determines a service "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. The following is a partial list of procedures commonly not covered by most medical insurance plans.
REFRACTION: Measurement of the lens power necessary to prescribe or change glasses and/or other corrective lenses. Refractions may also be done for diagnostic purposes. **The charge is $35.00 in addition to copayment for the visit.**
AFTER HOURS/EMERGENCY CARE VISIT: Any office visit occurring when the office is normally closed. **The charge is $65.00 in addition to co-payment for the visit.**
Financial Responsibility Agreement
I hereby authorize this office to apply for benefits on my behalf for services rendered. I thoroughly understand that my insurance is an agreement between the insurance provider and myself, not between the insurance provider and this office. If authorization is required from my primary care physician, I have obtained such documentation prior to the visit. I therefore request payment from my insurance company to be made to Eye Institute of Austin. I also understand that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any medical services rendered.
I certify that the information I have reported with regard to my insurance coverage is correct. I authorize the release of any necessary information, including medical records, to determine insurance benefits to which I may be entitled.
I acknowledge the receipt of notice of privacy practices of EYE INSTITUTE OF AUSTIN.

_____ _____
Patient/Parent or Guardian Signature Date

Date _____/_____/_____ **MEDICAL HISTORY / REVIEW OF SYSTEMS**

PATIENT NAME:_____ DATE OF BIRTH:_____/_____/_____

Do you wear glasses? NO YES (how many years?_____) Do you wear contact lenses? NO YES (how many years?_____)

Ocular history: Please indicate any eye conditions you have by circling or listing:

Blindness Cataract Glaucoma Macular Degeneration Retinal Detachment

Other:_____

Medical history: Please indicate any medical conditions you have by circling or listing:

Diabetes Hypertension Heart Disease Stroke Thyroid Disease Arthritis Cancer (specify type):

Other:_____

List all surgeries: _____

List all medications (prescription and over-the-counter): _____

_____

_____

Family History: Has a member of your family had any of these conditions? Please circle any that apply:

Blindness Cataract Glaucoma Diabetes Hypertension Heart Disease Stroke Cancer

Other:_____

Are you **allergic** to any medications? NO YES (list):_____

Are you allergic to shellfish? NO YES

Social History:

Does your vision limit your daily life (driving, reading, sports, work, hobbies, etc.)? NO YES

Do you drink alcohol? NO YES If yes, how much? _____ per day / week / month (please circle)

Do you smoke or use tobacco products? NO YES

If yes, how much? _____ per day / week / month (please circle) For how many years? _____

DO YOU CURRENTLY HAVE ANY PROBLEMS IN THE FOLLOWING AREAS?	NO	YES	DETAILS
CONSTITUTIONAL (fever, night sweats, weight loss, malaise, etc.)			
EYES (poor vision, pain, tearing, redness, light sensitivity, etc.)			
EARS, NOSE & THROAT (hard of hearing, stuffy/runny nose, sore throat, etc.)			
CARDIOVASCULAR (chest pain, palpitations, high blood pressure, etc.)			
RESPIRATORY (cough, asthma, shortness of breath, etc.)			
GASTROINTESTINAL (upset stomach, nausea, heartburn, ulcers, hernia, etc.)			
GENITOURINARY (kidney or bladder problems)			
MUSCULOSKELETAL (joint pain/arthritis, muscle pain, limited mobility, etc.)			
INTEGUMENT (acne, warts, skin growths, rash, etc.)			
NEUROLOGICAL (numbness, seizures, paralysis, migraines, etc.)			
PSYCHIATRIC (depression, anxiety, insomnia, etc.)			
ENDOCRINE (diabetes, hypo/hyperthyroidism, etc.)			
ALLERGIC/IMMUNOLOGIC (anaphylaxis, enlarged lymph nodes, etc.)			

Physician's Signature_____ Date_____/_____/_____

Due to the **HIPAA Compliance Privacy Laws of the Federal Government**, **IT IS MANDATORY** that we ask you to review and answer the following questions listed below.

Patient Name:_____ Date_____/_____/_____

May we leave messages/detailed medical information on voicemail at either of these phone numbers?

☐**Yes** ☐**No** Home Phone:_____

☐**Yes** ☐**No** Cell Phone:_____

May we contact you at your place of employment? ☐**Yes** ☐**No**

If so, may we leave a message? ☐**Yes** ☐**No**

If yes: Work Phone: _____ Extension: _____

Do you have any person(s) or family member(s) that you authorize to receive and discuss information regarding your personal health information (general information, surgical and billing)?

☐**Yes** ☐**No** If yes, please provide:

Name:_____Relationship:_____

Phone Number: _____

Is this person your Power of Attorney for medical purposes? ☐**Yes** ☐**No**

Name:_____Relationship:_____

Phone Number: _____

Is this person your Power of Attorney for medical purposes? ☐**Yes** ☐**No**

I hereby authorize Eye Institute of Austin, to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, laboratories, radiology facilities or other institutions. **This authorization remains in effect until revoked**.

I have reviewed the aforementioned information and provide my consent regarding any and all the issues as stated above.

Patient Signature: _____ Date_____/_____/_____

WITNESSED BY:_____

REFRACTION POLICY

1. **What is a refraction?**
   Refraction is the process of determining the eye's refractive error, or need for corrective glasses and/or contact lenses.
2. **Why is it necessary?**
   Refraction is sometimes necessary depending on the patient's diagnosis and/or complaints presented that day. For example, if a patient is experiencing blurred vision or a decrease in visual acuity on the eye chart a refraction would be needed to see if this is due to a need for glasses or due to a medical problem. The refraction is an essential part of an eye exam, however, Medicare and most insurances **DO NOT** cover it. These plans consider refraction a "vision" service, not a "medical" service. These plans allow that we charge separately for that portion of the examination since it is not a covered service.
3. **What if I do not want the refraction?**
   You may decline this part of the exam. Please notify the technician **PRIOR** to the beginning of the exam that you want this step skipped. *IMPORTANT:* If you decline we may not be able to determine the cause of your decrease in vision.
4. **How much is it?**
   The charge is **$35.00** for this service. This is in addition to the office visit copay and /or deductible which is set by your insurance carrier. The refraction is due at the time services are rendered. We will bill your insurance according to the individual contracted fee schedules. However, if your insurance pays the fee we will gladly refund you this prepaid $35.00 amount upon receiving notice from your insurance.

ACKNOWLEDGEMENT

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service. The copay and deductible are separate from, and not included in the refraction fee. I understand that I am responsible for this fee if I fail to decline this service before it is performed.

_____ _____/_____/_____

Patient Signature (Parent for minor) Date