Patient Information Form

Name (First, MI, Last) _____ **(Mr., Miss, Mrs., Ms., Dr.)**
Address_____
City, State, Zip_____
DOB: _____/_____/_____SEX: M_____F_____ Email Address: _____
Phone: (Home)_____ (Cell)_____ (Work) _____
Pharmacy Name: _____ Pharmacy Phone: _____

Primary Care Physician: _____
Who Referred You? _____
Employer/Occupation_____
Are you under the care of a Skilled Nursing Facility? _____

MEDICAL INSURANCE CARD HOLDER (we do NOT accept VISION plans)
Subscriber's Name_____
Relationship to Patient_____ DOB: _____/_____/_____
Primary Insurance Company_____
ID#: _____
Secondary Insurance Company_____
ID#: _____
Drug Insurance Company (if different from above) _____
ID#: _____

Co-payment and deductible payments as determined by your agreement with your medical 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 is necessary to prescribe or change glasses and/or other corrective lenses. Refractions may also be done for diagnostic purposes and may or may not be covered under your insurance plan. **The charge is $45.00 in addition to co-payment for the visit.**

NO SHOW FEE: We ask that you call our office no later than 24 hours before your appointment time if you need to cancel your appointment. **A $25 fee will be charged for late cancellations and no-shows.**

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 before the visit. I, therefore, request payment from my insurance company to be made to the 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 about 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 or 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 Cornea 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 (prescriptions 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**
CONSTUTIONAL (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 (ghost 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.)			

Due to 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, provide:

Name: _____ Relationship: _____

Phone Number: _____

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

Name: _____ Relationship: _____

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

What is a refraction?

Refraction is the process of determining the eye's refractive error, or need for corrective glasses and/or contact lenses.

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.

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 decreased vision.

How much is it?

The charge is **$45.00** 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 **$45.00** 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 copy 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: _____ Date: ____/____/____