TEXAS REGIONAL Eye Center

William Riggs, MD ● Kyle Varvel, MD ● Jake Young, MD ● Michael Everson, OD

Patient Information:

Patient's Name: _____

SS#:_____ Birth date: _____ Sex: M / F

Billing Address: _____

City: _____ State: _____ Zip: _____

Home: _____ Work: _____ Cell: _____

Do you consent to be contacted via text messages for appointment reminders? ❑ Yes ❑ No

Email Address: _____ Marital Status: S / M / W / D

Ethnicity: ❒ Hispanic ❒ Non-Hispanic Preferred Language: _____

Race: ❒ American Indian or Alaska Native ❒ Black or African American
❒ Asian ❒ White
❒ Native Hawaiian or Other Pacific Islander

Student Status: ❒ Full-Time ❒ Part-Time Smoker: ❒Yes ❒No Veteran: ❒Yes ❒No

Employer: _____

Address: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Pharmacy: _____ Location: _____

Referred by: □ Doctor: _____ □ Patient _____
□ Television □ Radio □ TREC Website □ Google

Insured (Policy Holder) / Responsible Party Information:

******Fill out if different than the patient's information from above******

Name: _____

SS#:_____ Birth date: _____ Sex: M/F

Address: _____

City: _____ State: _____ Zip: _____

Home: _____ Day: _____ Cell: _____

Relationship to Patient: _____

Emergency Contact Person: _____ Relationship: _____

Address: _____Birth date: _____

City: _____ State: _____ Zip: _____ Phone: _____

_____ _____
SIGNATURE OF PATIENT / GUARDIAN DATE

_____ _____
AUTHORIZED PERSONAL REPRESENTATIVE RELATIONSHIP

TEXAS REGIONAL
Eye Center
3811 Sagebriar Dr. • Bryan, TX 77802
Phone (979) 774-0498 • Fax (979) 774-7673
www.texasregionaleye.com

Insurance Form

Patient: _____ DOB: _____

Is this a **Routine** refractive or **Medical** eye examination?

Routine Vision (Refractive) Coverage: Your "vision" insurance is intended to provide you with a baseline eye evaluation and update your glasses prescription **only**. If the doctor discovers a medical eye problem during a routine exam, the doctor will inform you of the medical problem and will advise you to return at a later date for the medical exam.

Medical Eye Examination Coverage: If you have an eye condition such as but not limited to: cataracts; macular degeneration; glaucoma; dry eyes; cornea problems, this examination will be billed to your medical insurance.

Patient Responsibilities: Many insurance companies do not pay for a routine eye examination. Many private insurance plans **do** pay for annual eye examinations. It is your responsibility to check with your insurance carrier for proper coverage and to let us know before your eye examination. Please understand that each patient's insurance coverage varies and Texas Regional Eye Center is not responsible for determining your coverage prior to your exam.

- I am here for a: (circle one) **Routine Refractive** **Medical Exam**
- Are you experiencing any eye problems or do you have any known eye diseases? _____

_____

_____

INSURANCE INFORMATION: (Please give insurance cards to receptionist to copy)

- Primary Insurance: _____ Insured's Name: _____
- Secondary Insurance: _____ Insured's Name: _____
- Third Insurance: _____ Insured's Name: _____
- **Vision Insurance**: _____ Insured's Name: _____

_____ _____

Patient or Guardian Signature Date

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Financial Policy

All services performed are the financial obligation of the patient or responsible party. **Payment for services provided are expected at the time they are provided.** You are responsible for payment of any "non-covered" services, such as **refractions**, "covered services" that are denied, co-payments, and deductibles. Insurance companies may deny payment for the submitted charges for a variety of reasons. Canceled insurance, services that do not meet the carrier's definition of "medically necessary", or "excluded services" are a few examples. It is your responsibility to know the terms and coverage of your specific insurance plan. Special billing policies will apply to the following patients:

Medicare: We are participating providers with Medicare. You will be expected to pay your deductible and a 20 percent coinsurance if you have Medicare Only. If you have a supplemental insurance, we will file that for you, but you must provide us with your card at the time of service.

***Medicaid*:** We do accept traditional, QMB, and MQMB Medicaid patients.

HMO/PPO/Managed Care: Our physicians have agreed to be specialty providers for many of the HMO/PPO plans. It is the patient's responsibility to make sure that your doctor is currently enrolled with your plan. It is important for you to consult with your insurance company prior to your visit to determine which services are covered.

***Referral Numbers*:** If you belong to a pre-paid plan, HMO, or Point of Service contract, you have an obligation to provide us with a referral number. There rules are stated in your health plan information book. *This referral number must be obtained prior to each visit*. If your referral has not been completed prior to your arrival in the office, it may delay in being seen by the physician and the possible rescheduling of your appointment. You are obligated by your insurance company to pay the copay at the time of your visit.

Self- Pay: All self-pay patients are required to make *payment in full at the time of service*.

Statements: You will receive a statement from our office for any self-pay balance due after your insurance carrier pays.

***Returned Checks*:** There will be a $35.00 service charge for all returned checks.

Refunds: In the event that a credit balance is created on your account and it is determined that the funds belong to you, we will refund you.

***Collection Fee*:** For any account turned over to collections, an additional 33% fee will be added to the existing past due balance to cover the cost charged by the collection agency to collect the balance.

For your convenience, we accept cash, check, VISA, MasterCard, Discover and American Express.

PLEASE PRESENT YOUR INSURANCE CARD ALONG WITH ANY REQUIRED REFERRALS / AUTHORIZATIONS TO THE RECEPTIONIST.

MEDICARE/INSURANCE PATIENT*S: I request that payment of authorized Medicare/Insurance benefits be made to Texas Regional Eye Center for any services furnished by the provider. If Medicare/Insurance denies payment for any services rendered, I agree to be personally and fully responsible for the payment .*

I have read and understand the above terms and conditions and will verify so by giving my signature.

_____ _____

Name of Patient (Print) Date

_____

Signature of Patient or Patient Representative

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1. Refraction Policy:

During your visit, a refraction may be performed to determine your need for glasses, contact lenses, or to evaluate if any further visual improvement can be achieved. This is a necessary and essential portion of your eye exam and in some cases, it is the sole reason for the appointment. However, the refraction is considered a NON-COVERED service by Medicare or most medical insurance plans. These plans consider a refraction a "vision" service not a "medical" service.

Please be aware it is the responsibility of the patient to pay for the refraction at the time of service. Our office currently charges $45.00 for this procedure. The copay is separate from and not included in the refraction fee.

Acknowledgment:

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 co-pay is separate from and not included in the refraction fee.

2. Contact Lens Policy:

ALL contact lens wearers will be charged a fitting/evaluation fee.

There is a fee for this service, which varies greatly depending on the type of contact lenses that are right for you, if you have been fitted before, and other individual factors. This will be collected **in addition** to any copays, deductibles, or non-covered charges at the end of your visit.

☐ I acknowledge the contact lens policy and **DO NOT** want contact lenses.

☐ I acknowledge the contact lens policy and **DO** want contact lenses.

3. Laser Vision Correction Policy:

Laser Vision Correction is a modern surgical procedure that has helped millions of people see better. LASIK permanently changes the shape of the cornea to correct nearsightedness, farsightedness and astigmatism. LASIK does not correct the condition known as presbyopia (loss of auto focus) that occurs around age 40 in most people. To prepare for laser vision correction, a complete eye exam with special testing will be done. The complete eye exam takes 1-2 hours and includes:

*Complete dilated exam *Corneal map *Wavescan measurements
*Corneal thickness measurement *Prescription for glasses if you are not a candidate

I would like information regarding Laser Vision Correction

- ☐ **For myself**
- ☐ **For a friend or family member**

**** I have read and understand ALL the above listed Policies. ****

Patient/Guardian's Signature _____ Date _____

Patient's Name (printed) _____

History Summary

Patient Name: _____

Glasses Wearer ❒Yes ❒No Contact Lens Wearer ❒Yes ❒No

Allergies: ❒ No Known Allergies
❒ **LATEX**

Allergy *Reaction*

_____

_____

_____

_____

_____

_____

_____

ALL Medications: ❒ No Medications at This Time
(including Prescriptions, Vitamins, Herbals, OTC's)

Medication *Dose* ***REASON YOU TAKE THE MEDS***

_____

_____

_____

_____

_____

_____

_____

Past EYE History: ❒ No past eye history noted.

Disease *Eye* *When*

_____

_____

_____

❒ Patient has prosthetic ❒ Right eye ❒ Left eye

Surgical Procedure *Eye* *When*

_____

_____

_____

Past MEDICAL History:

Example: (high blood pressure, diabetic, etc.)

Disease *Year Diagnosed*

_____

_____

_____

_____

_____

Surgical Procedure *Year* *Outcome*

_____

_____

_____

_____

_____

Family History: ❒ No relevant family history
❒ Adopted

Relation *Diagnosis*

_____

_____

_____

_____

Females: *Please check boxes that apply to you*
❒ Pregnant ❒ Breast Feeding

Social History:

Smoke? ❒Yes ❒No ❒Formerly

Amount_____ Years_____

Drinks alcohol? ❒Yes ❒No ❒Formerly

Amount_____ Frequency_____

Caffeine? ❒Yes ❒No Amount Per Day _____

Recreational Drugs? ❒Yes ❒No ❒Formerly

Transmittable Disease: ❒ Negative
❒ Hepatitis type: _____ ❒ HIV ❒ Shingles
❒ MRSA ❒ C-diff ❒Other _____

Review of Systems

Patient Name: _____

Please check box that applies to you:

Constitutional	No	Yes
Fatigue	❒	❒
Fever	❒	❒
Night sweats	❒	❒
Weakness	❒	❒
Weight gain	❒	❒
Weight loss	❒	❒

Other_____

Ears, Nose & Throat	No	Yes
Exopthalmos(bulging eye)	❒	❒
Hearing loss	❒	❒
Hoarseness	❒	❒
Lump in neck	❒	❒
Nasal congestion	❒	❒
Sinus problems	❒	❒
Sore throat	❒	❒
Tinnitus	❒	❒
Vertigo	❒	❒

Other _____

Respiratory	No	Yes
Asthma	❒	❒
Cough	❒	❒
Dyspnea(shortness of breath)	❒	❒
Dyspnea on exertion	❒	❒
Hemoptysis(coughing blood)	❒	❒
Wheezing	❒	❒

Other _____

Cardiovascular	No	Yes
Arrhythmia (irregular heart rate)	❒	❒
Calf pain	❒	❒
Chest pressure	❒	❒
Irregular heartbeat/ palpitations	❒	❒
Leg swelling	❒	❒
Tachycardia(rapid heart rate)	❒	❒

Other_____

Gastrointestinal	No	Yes
Abdominal pain	❒	❒
Black tarry stools	❒	❒
Constipation	❒	❒
Decreased appetite	❒	❒
Diarrhea	❒	❒
Dysphagia (Difficulty Swallowing)	❒	❒
Food intolerance	❒	❒
Heartburn	❒	❒
Increased appetite	❒	❒
Jaundice	❒	❒
Nausea	❒	❒
Vomiting	❒	❒

Other_____

Genitourinary	No	Yes
Dysuria (painful urination)	❒	❒
Genital lesions	❒	❒
Hematuria (blood in urine)	❒	❒
Irregular menstrual cycle	❒	❒
Urethral discharge	❒	❒
Urgency	❒	❒

Other_____

Metabolic/Endocrine	No	Yes
Cold intolerance	❒	❒
Hot intolerance	❒	❒
Polydipsia (excessive thirst)	❒	❒
Polyphagia (excessive hunger)	❒	❒
Polyuria (excessive urine)	❒	❒

Other_____

Neurological	No	Yes
Balance disturbances	❒	❒
Dizziness	❒	❒
Focal weakness	❒	❒
Headache	❒	❒
Memory difficulty	❒	❒
Numbness of extremities	❒	❒

Other_____

Psychiatric	No	Yes
Depressed mood	❒	❒
Emotional changes	❒	❒
Euphoria (emotion)	❒	❒
Frequent nightmares	❒	❒
Hallucinations	❒	❒
Insomnia	❒	❒
Irritability	❒	❒
Nervousness	❒	❒
Stress	❒	❒

Other_____

Integumentary	No	Yes
Abnormal hair distribution	❒	❒
Dry skin	❒	❒
Hives	❒	❒
Itching skin	❒	❒
Nail changes	❒	❒
Rash	❒	❒
Skin changes	❒	❒
Skin lesion	❒	❒
Skin nodules	❒	❒
Skin sores	❒	❒
Ulcer	❒	❒

Other_____

Musculoskeletal	No	Yes
Arthralgias (joint pain)	❒	❒
Back Pain	❒	❒
Fracture	❒	❒
Gait disturbance - (difficultly walking solo)	❒	❒
Joint stiffness	❒	❒
Joint swelling	❒	❒
Muscle cramping	❒	❒
Muscle weakness	❒	❒

Other_____

Hematologic/ Lymphatic	No	Yes
Bleeding	❒	❒
Bruising	❒	❒
Lymphadenopathy - (Swollen lymph nodes)	❒	❒
Tender lymph nodes	❒	❒

Other_____

Immunologic	No	Yes
Environmental allergies	❒	❒
Food allergies	❒	❒
Seasonal allergies	❒	❒

Other_____

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Notice of Privacy Practices

1. **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.**

2. **How we may use and disclose your health information.** We use health information about you for treatment, to get paid for treatment, for administrative purposes, and to evaluate the quality of care that you receive. For example, your health information may be shared with other providers to whom you are referred. Information may be shared by paper, mail, electronic mail, fax, or other methods. We may use or disclose your health information without your authorization for several reasons. If you sign an authorization to disclose information, you can later revoke it to stop any further disclosures.

3. **Your rights.** In most cases, you have the right to look at or get a copy of your health information that we use to make decisions about you. You may request that we limit disclosure to family members, other relatives, caregivers, or close personal friends who may or may not be involved in your care. If you request copies, we may charge you a cost-based fee. You also have the right to request a list of certain types of disclosures of your information that we have made. If you believe that your health information is incorrect or information is missing, you have the right to request that we correct the existing information or add the missing information.

4. **Our legal duty.** We are required by law to protect the privacy of your health information, provide this notice about our privacy practices, follow the privacy practices that are described in this notice, and seek your acknowledgement of receipt of this notice. We may change our privacy policies any time. Before we make a significant change in our policies, we will change our notice. You can request a copy of our notice at any time. For more information about our privacy policies, contact our privacy officer.

5. **Privacy complaints.** If you are concerned that we have violated your privacy rights, our privacy policies, or if you disagree with a decision, we made about access to your health information, you may contact our privacy officer. You may send a written complaint to the U.S. Department of Health and Human Services. Our privacy officer can provide you with the appropriate address upon request.

If you have any questions or complaints, please contact: Texas Regional Eye Center, Privacy Officer, 3811 Sagebriar Drive, Bryan, Texas 77802. Phone number: (979) 774-0498 Fax number: (979) 774-7673

Acknowledgement of receipt of Notice of Privacy Practices: Please sign, print your name and date, and provide anyone authorized to have access to your medical and/or billing records below.

_____ _____

Patient/Guardian's Signature **Date**

_____

Printed Name

_____

Name of Personal Representative & Relationship

_____

Name of Personal Representative & Relationship