Date:_____ Doctor:_____ Chart:_____

Welcome to Houston Eye Associates. So that we can most effectively meet your needs, please complete all the information below.

Name (Last, First, Middle) _____
Address (Street, Apt.) _____
City _____ **State** _____ **Zip Code** _____
Birthday ____/____/____ **Sex**_____ Marital Status _____ Social Security# _____
Employer _____ Drivers License# _____
Primary Care Physician _____**Phone#** _____
Referring Eye Doctor _____**Phone#** _____
Race or Ethnic Group ☐Black/African American ☐White/Caucasian ☐Hispanic/Latino
☐Asian/ Pacific Islander ☐American Indian/Alaskan ☐Other_____

HOW MAY WE CONTACT YOU?

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____
E-Mail_____

EMERGENCY CONTACT

Name: _____ **Phone:** _____ **Relation:** _____

GUARANTOR

Name: _____ Relationship: _____
Birthday: ____/____/____ Sex: ____ Marital Status: _____ Social Security#: _____

PERMISSION TO DISCUSS

I give my permission to the doctors and employees of Houston Eye Associates to discuss my treatment plan, medical records and financial plan with the following person(s).

Name	Relationship	Telephone#

Name	Relationship	Telephone#

Patient's Signature: _____

See page on back

Houston Eye Associates

Notice of Payment Policies and Procedures

PAYMENT POLICY: It is customary to pay for professional services when rendered. For your convenience we accept major credit cards, checks or cash.

INSURANCE: Please read and sign below if you have insurance with: Medicare, Medicaid, and HMO/PPO/POS or State Agency or Worker's Comp, and Physician is contracted with your carrier. Present your insurance card along with any required referrals/authorizations to the Receptionist/Registrar.

MEDICAL/SURGICAL BENEFITS ASSIGNMENT AND RELEASE OF MEDICAL BENEFITS INFORMATION AGREEMENT: I request payment of my authorized insurance benefits be made for charges on my behalf to Houston Eye Associates for any unpaid medical information to my insurance company(ies) or agent, now or in the future, for claim consideration purposes. I understand that payment for services does ultimately remain my responsibility.

NON-COVERED SERVICES: The filing of a claim for any service rendered DOES NOT GUARANTEE PAYMENT from your insurance company. You will be financially responsible for these services. Also, having more than one insurer DOES NOT necessarily mean that our services are covered 100%. Secondary insurers will pay as a function of what your primary carrier pays. We may bill your secondary as a courtesy. You are responsible for any balances after your insurance(s) has cleared.

DIVORCE DECREES: This office is NOT a party to your divorce decree, Adult patients are responsible for their bill at the time of service. The responsibility for minors rests with the accompanying adult.

MINOR PATIENTS: For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved Credit Card, or payment by cash or check at the time of service has been verified.

EYE EXAM: 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 part of the treatment of my condition. I understand that if my pupils are dilated or my eye is patched after the exam, I may not be able to safely operate a motor vehicle and that the staff and doctors of Houston Eye Associates suggest that I evaluate my need for alternative transportation and the decision is solely mine, therefore I will not hold Houston Eye Associates responsible.

The content of this document will remain in effect unless revoked by me in writing.

_____
Name of Patient (Print)

_____
Signature of Patient

_____
Date

_____
Signature of Patient Representative

_____
Relationship of Patient Representative to Patient

_____
Name of Witness

_____
Signature of Witness

_____
Date

HOUSTON EYE ASSOCIATES
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.** The notice is provided in two layers: This layer briefly summarizes how we handle your health information, and the attached bottom layer provides further details of our privacy policies and procedures.

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 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 the 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. The notice will be prominently displayed at all HEA locations and on our website. You can also 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: Houston Eye Associates, Privacy Officer, 2855 Gramercy Street, Houston, Texas 77025. Phone number: (713) 558-8755.

Acknowledgement of receipt of Notice of Privacy Practices: Please sign and print your name and provide the date below to acknowledge that you have received the Notice of Privacy Practices.

Signature: _____

Printed Name: _____ Date: _____

HOUSTON EYE ASSOCIATES

HISTORY FORM

Name: _____ Chart #: _____

Family Physician: _____ Date: _____

REVIEW OF SYSTEMS:

Are you currently experiencing any of the following symptoms? (Circle all that apply)

Constitutional
Fever
Fatigue
Poor Appetite
Night Sweats
Chills

Eye
Blurry
Foggy
Glare
Blindness
Tunnel Vision

Ear, Nose, Throat
Congestions
Sore/Hoarse Throat
Hearing Trouble
Ear Ringing
Nose Bleed

Cardiovascular
Chest pain
Chest Pressure
Racing Heart
Ankle Swelling

Musculoskeletal
Weakness
Aches
Muscle Cramps

Gastrointestinal
Indigestion
Nausea/Vomiting
Diarrhea
Constipation
Tarry/Bloody Stool

Neurological
Dizziness
Severe Headache
Neck Pain
Back Pain
Numbness

Psychiatric
Confusion
Poor Memory
Depressed
Poor Sleep
Nervous/Tense

Skin/Breast
Hives
Rash
Sores
Lump
Pain

Respiratory
Short of Breath
Cough
Wheezing

Genitourinary
Difficulty
Frequent Urination
Burning
Pain

Allergy/Immune
Sinus
Sneezing
Hay Fever
Frequent Infections

Heme/Lymph
Bruising
Nose Bleed
Lymph Nodes

Endocrine
Weight Loss
Weight Gain
Poor Energy

Other
_____
_____
_____

PAST MEDICAL HISTORY:

Circle any of the following conditions that the patient has had:

Cataracts
Glaucoma
Hay Fever
Asthma

Ulcer
Jaundice
Gallstone
Liver Disease

Heart Disease
Kidney Stone
Bladder Trouble
Thyroid Disease

Paralysis
Drug Addiction
Prostate Trouble
Nerve Disease

Cancer (type):
High Blood Pressure
Tuberculosis
Anemia

Diabetes
Hepatitis
Stroke

Other Eye or Medical Problem/Date

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

(Continue on other side)

PREVIOUS SURGERIES/Date:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

FAMILY HISTORY:

Do any of the following illnesses run in the patient's family? (Circle all that apply)

Diabetes	Glaucoma	Seizures	Heart Disease
Stroke	Macular Disease	Arthritis	Asthma
High Blood Pressure	Cancer	Migraine Headaches	Goiter

Other Illness/Relation:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

CURRENT MEDICATIONS:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

DRUG ALLERGIES:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

SOCIAL HISTORY:

Do you currently use tobacco? Y / N Have you used it in the past? Y / N Type: _____

How much each day? _____ How long? _____

Do you use alcohol? Y / N Type: _____ How much? _____

Do you have a history of drug use or addiction? Y / N Type: _____

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HOUSTON EYE ASSOCIATES

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 a necessary and essential portion of your eye exam and in some cases it is the sole reason for the appointment.

The Centers for Medicare and Medicaid Services (CMS) uses a system – The Resource Based Relative Value Scale (RBRVS) – to determine the fees for all Medicare services, including the refraction. Most other insurance companies use this same system to set their payment schedules. However, the refraction is considered a NON-COVERED service by Medicare and some insurance companies.

Please be aware it is the responsibility of the patient to pay for the refraction. Effective January 16, 2012 our office charges $98.00 for this procedure, but provides a prompt pay price of $59.00 to the patient when paid at the time of service. The refraction fee, based on the RBRVS is in addition to the fee for the eye exam and is in addition to the patient's copay.

We appreciate your cooperation in paying this fee at the time services are rendered.

I have read the above information and understand I may be charges a prompt pay price of $59.00 at the time of service. If billing is required, the full charge of $98.00 will be billed.

CONTACT LENS POLICY

The glasses prescription you receive from Houston Eye Associates is NOT a contact lens prescription. A qualified contact lens fitter must fit the contact lenses. Our Optical Department or one of your choice may fit the contact lenses. There is a fee for this service, which varied greatly depending on the type of contact lenses that are right for you, if you have been fitted before, and other individual factors. After your contact lens fitting is completed and services incurred are paid for you will receive a copy of your contact lens specification.

I have read and understand the above refraction and contact lens policy.

_____ _____

Patient or Guardian's Signature Date

HOUSTON EYE ASSOCIATES
Established 1971

Pharmacy Information

Pharmacy Name: _____

Pharmacy Address: _____

City: _____ State: _____ Zip Code: _____

Pharmacy Phone Number: _____

Please fill out as much of the information as possible so the doctor and staff are able to send your prescription if any, electronically to the correct pharmacy.