



(713) 668.6828 PHONE
(713) 668.3823 FAX

NEW PATIENT INFORMATION FORM

Date: _____ Doctor: _____ Chart #: _____

Welcome to Houston Eye Associates.

So that we can most effectively meet your needs, please complete all the information below.

HOW DID YOU LEARN ABOUT HOUSTON EYE ASSOCIATES?

Referral was by: _____ Please provide their name & address so we can thank them:

Physician _____	Name _____		
Optometrist _____	Address _____		
Patient _____	Phone _____		
Other _____	City _____	State _____	Zip _____

PATIENT INFORMATION

Mr. ___ Mrs. ___ Other _____

Name _____
First Middle Last

Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Soc Sec # _____ Date of Birth ____/____/____ Sex Male / Female

Marital Status _____ Single _____ Married _____ Divorced _____ Widowed _____

Employer / Address _____ Phone _____

Family doctor Name/Address _____ Phone _____

E-mail address: _____

In the future may we confidentially communicate with you through this email address? Y ___ N ___

PARENT / GUARDIAN INFORMATION (if patient is a MINOR)

Parent / Guardian's Name _____
First Middle Last

Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Soc Sec # _____ DOB: _____ Relationship to Patient: Child ___ Other ___

Employer _____

Other Parent / Guardian's Name _____
First Middle Last

Home Phone _____ Work Phone _____ Cell Phone _____

Employer _____

RESPONSIBLE PARTY (if different from above)

Contact Person _____
First Middle Last

Address _____
Street City State Zip

Employer/Company/Agency Name _____ Phone _____



(713) 668.6828 PHONE
(713) 668.3823 FAX

NEW PATIENT INFORMATION FORM

2 / 2

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, an HMO/PPO/POS or State Agency or Worker's Comp, and the 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 / surgical procedures performed now or in the future. I also authorize Houston Eye Associate to release 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 your 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 contents of this document will remain in effect unless revoked by me in writing.

Name of Patient (Print)

Name of Witness (Print)

Signature of Patient

Signature of Witness

Date

Date

Signature of Patient Representative

Relationship of Patient Representative to Patient



INSURANCE FORM

1 / 1

INSURANCE INFORMATION

PLEASE COMPLETE THE * LINES ON THIS FORM. UPON COMPLETION, PRESENT TO REGISTRAR WITH INSURANCE CARD FOR COPYING. IF NO CARD AVAILABLE, THEN COMPLETE ENTIRE FORM.

*Patient Name: _____ Chart #: _____
 Completed by Registrar

*Primary Insurance Company Name: _____

Address: _____

Phone #: _____ Type of Insurance: _____

Policy #: _____

Group Name: _____ Group Number: _____

*Insured's (Policy Holder as it appears on card) Name: _____

*Insured's Date of Birth: ___ / ___ / ___ *Insured's Gender: Male / Female

*Patient's Relationship to Insured: Self / Child / Spouse / Other _____

*Secondary Insurance Company Name: _____

Address: _____

Phone #: _____ Type of Insurance: _____

Policy #: _____

Group Name: _____ Group Number: _____

*Insured's (Policy Holder as it appears on card) Name: _____

*Insured's Date of Birth: ___ / ___ / ___ *Insured's Gender: Male / Female

*Patient's Relationship to Insured: Self / Child / Spouse / Other _____

*Vision Insurance Company Name: _____

Address: _____

Phone #: _____ Type of Insurance: _____

Policy #: _____

Group Name: _____ Group Number: _____

*Insured's (Policy Holder as it appears on card) Name: _____

*Insured's Date of Birth: ___ / ___ / ___ *Insured's Gender: Male / Female

*Patient's Relationship to Insured: Self / Child / Spouse / Other _____



(713) 668.6828 PHONE
(713) 668.3823 FAX

HOUSTON EYE ASSOCIATES PATIENT HISTORY RECORD

Name: _____ No.: _____

MEDICAL HISTORY:

Please answer the following questions. DATE: _____

1_ Have you been treated for any medical conditions (e.g. diabetes, high blood pressure, arthritis, etc)?

NO ____ YES ____ IF YES please list:

2_ Have you ever had any eye disease (e.g. glaucoma, cataract, retinal detachment, "lazy" eye, etc)?

NO ____ YES ____ IF YES please list:

3_ Have you ever had any EYE surgery? NO ____ YES ____ IF YES please list:

4_ Have you ever had any OTHER surgery? NO ____ YES ____ IF YES please list:

5_ Have you ever been hospitalized? NO ____ YES ____ IF YES please provide date and reason:

6_ Do you take any EYE medications? NO ____ YES ____ IF YES please list:

7_ Do you take any OTHER medications? NO ____ YES ____ IF YES please list:

8_ Do you have any drug or food allergy? NO ____ YES ____ IF YES please list:

Name: _____ No.: _____

SOCIAL HISTORY:

Do you smoke? NO ___ YES ___. IF YES, how much? _____

Do you drink alcohol? NO ___ YES ___. IF YES, how much? _____

If employed, how many hours per week do you work? _____

FAMILY HISTORY:

Do any medical or eye diseases run in your family (e.g. diabetes, high blood pressure, cancer, glaucoma, macular degeneration, etc.)? NO ___ YES ___. IF YES, please list: _____

REVIEW OF SYSTEMS: _____ Date: _____

Do you currently have any of the following problems:

· Chronic fever, unexpected weight loss/gain, fatigue, night sweats

NO ___ YES ___ PLEASE EXPLAIN: _____

· Ear/nose/throat problems (e.g. hearing loss, sinus problems, sore throat, etc.)

NO ___ YES ___ PLEASE EXPLAIN: _____

· Heart problems (e.g. chest pain, irregular heart beat, etc.)?

NO ___ YES ___ PLEASE EXPLAIN: _____

· Respiratory problems (e.g. shortness of breath, wheezing, coughing, etc.)

NO ___ YES ___ PLEASE EXPLAIN: _____

· Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea, vomiting)

NO ___ YES ___ PLEASE EXPLAIN: _____

· Urinary problems (e.g. pain or discomfort, blood in urine)

NO ___ YES ___ PLEASE EXPLAIN: _____

· Skin problems (e.g. rashes, excessive dryness, etc.)

NO ___ YES ___ PLEASE EXPLAIN: _____

· Musculoskeletal problems (e.g. muscle aches, joint pain, swollen joints, etc)

NO ___ YES ___ PLEASE EXPLAIN: _____

· Neurological problems (e.g. numbness, weakness, headaches, dizziness, etc.)

NO ___ YES ___ PLEASE EXPLAIN: _____

· Psychiatric problems (e.g. depression, anxiety, etc.)

NO ___ YES ___ PLEASE EXPLAIN: _____

· Other: _____ PLEASE LIST: _____

-PATIENT SIGNATURE: _____ **DATE:** _____

PHYSICIAN'S SIGNATURE: _____ M.D. Review date: _____

PHYSICIAN'S SIGNATURE: _____ M.D. Review date: _____

PHYSICIAN'S SIGNATURE: _____ M.D. Review date: _____

PHYSICIAN'S SIGNATURE: _____ M.D. Review date: _____

REFRACTION POLICY

1 / 1

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) use 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. Our office currently charges \$98.00 for this procedure, but provides a prompt pay price of \$44.00 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 co-pay.

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 charged a prompt pay price of \$44.00 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 varies 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



NOTICE OF PRIVACY PRACTICES

1 / 1

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 future 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. 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: _____

PEDIATRIC HISTORY FORM

1 / 2

Patient Name _____ Date: _____ No _____

BIRTH HISTORY: Full Term? _____ If premature, how many weeks? _____

Natural _____ or C-Section _____ Birth Weight _____ Complications or problems during pregnancy, birth, or neonatal period _____

MEDICAL HISTORY:

1. Has your child been treated for any medical conditions (e.g. heart, lung, kidney, liver, brain disorders, cancer, etc.)? NO _____ YES _____ if YES please list: _____

3. Does your child wear glasses or contact lens? NO _____ YES _____ Since _____

4. Has your child ever had any EYE surgery? NO _____ YES _____ If YES please list: _____

5. Has your child ever had any OTHER surgery? NO _____ YES _____ If YES please list: _____

6. Has your child ever been hospitalized? NO _____ YES _____ If YES please provide date and reason

7. Does your child take any EYE medications? NO _____ YES _____ If YES please list: _____

8. Does your child take OTHER medications? NO _____ YES _____ If YES please list: _____

9. Does your child have any drug or food allergy? NO _____ YES _____ If YES please list and give reaction:

SOCIAL HISTORY:

Siblings: Brothers (ages) _____ Sisters (ages) _____ Who does child live with? _____

School Performance: Excellent _____ Good _____ Fair _____ Poor _____ Grade level _____

FAMILY HISTORY:

Do any medical or eye diseases run in your family (e.g. strabismus "crossed eyes", amblyopia "lazy eye", diabetes, high blood pressure, cancer, glaucoma, etc.) NO _____ YES _____ If YES, please list:



(713) 668.6828 PHONE
(713) 668.3823 FAX

PEDIATRIC HISTORY FORM

Patient Name _____ Date: _____ No _____

REVIEW OF SYSTEMS

DATE: _____

Does your child currently have any of the following problems:

Chronic fever, unexpected weight loss/gain, fatigue, night sweats? NO _____ YES _____ If YES please explain: _____

Ear/nose/throat problems (e.g. hearing loss, frequent ear infections, sinus problems, sore throat, etc.)?

NO _____ YES _____ If YES please explain: _____

Heart problems (e.g. heart defect, irregular heart beat, murmur, etc.)? NO _____ YES _____

If YES please explain: _____

Respiratory problems (e.g. reflux, abdominal pain, diarrhea, vomiting, etc)? NO _____ YES _____

If YES please explain: _____

Skin problems (e.g. rashes, excessive dryness, etc.)? NO _____ YES _____ If YES please explain:

Musculoskeletal problems (e.g. rashes, excessive dryness, etc.)? NO _____ YES _____ If YES please

explain: _____

Psychiatric problems (e.g. depression, anxiety, etc.)? NO _____ YES _____ If YES please explain:

Physician's Signature _____ M.D. Review Date _____

Physician's Signature _____ M.D. Review Date _____

Physician's Signature _____ M.D. Review Date _____