SOUTH TEXAS EYE CONSULTANTS, P.L.L.C.

We're so glad that you have chosen us for your eye care needs.

PATIENT INFORMATION **Date:** _____

NAME:_____
FIRST NAME MIDDLE LAST NAME

ADDRESS: _____CITY: _____ STATE: _____ ZIP: _____

MARITAL STATUS: ☐ M ☐ S ☐ D ☐ W SS# _____ SEX: _____

DATE OF BIRTH: _____ AGE: _____ DRIVERS LIC: _____

PRIMARY PHONE #: _____ ☐ Home ☐ Cell ☐ Work

SECONDARY PHONE #: _____ ☐ Home ☐ Cell ☐ Work

EMAIL ADDRESS: _____

PREFERRED CONTACT METHOD: ☐ Home ☐ Cell ☐ Work

EMERGENCY CONTACT:

NAME: _____ RELATIONSHIP: _____

PHONE #: _____ ☐ Home ☐ Cell ☐ Work

RACE: _____ ETHNICITY: _____ PREFERRED LANGUAGE: _____

PRIMARY CARE PHYSICIAN: _____

REFERRING PHYSICIAN: _____

INSURANCE INFORMATION:

PRIMARY INSURANCE: _____

SECONDARY INSURANCE: _____

POLICY HOLDER (if not the patient): _____

RELATIONSHIP: _____ DATE OF BIRTH: _____

OTHER INSURANCE / VISION PLAN: _____

South Texas Eye Consultants, P.L.L.C.

Limited Patient Authorization for Disclosure of Protected Health Information

Form must be signed and dated each year.

Patient Name: _____

Date of Birth: _____

Who will be authorized to receive information - I authorize South Texas Eye Consultants, P.L.L.C to disclose or provide protected health information, about me to the individual(s) listed below**:**

Individual/Entity Name: _____

Phone Number: _____

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or person identified above:

☐ Entire patient record; **or**, check **only** those items of the record to be disclosed:

☐ Office notes

☐ Nursing home, home health, hospice, and other physician records

☐ Lab results, pathology reports

☐ Record of HIV and communicable disease testing

☐ Financial history report (previous 3 years only)

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

☐ Patient Request

☐ Other (please specify): _____

- This authorization will expire at the end of the calendar year of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization.
  Please list the date of expiration if earlier than the end of the calendar year: _____

- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Officer. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.

- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.

- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

_____ _____

Patient or Representative Signature Date

You have the right to receive a copy of the signed authorizations upon request.

Completion of this authorization form is optional.

South Texas Eye Consultants, PLLC
Medical Information

Name: _____

DOB: _____ **Primary Care Physician:** _____

Previous Eye Doctor: _____ **Date of Last Eye Exam:** _____

I. History

What issues do you have with your eyes? _____

Have you had any eye surgeries? _____

Have you had any eye injuries? _____

Any medical allergies? _____

II. Medications

Please list all eye drops you currently take: _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Please list any prescribed medications you take: _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

III. Family History

Do you or any of your blood relatives have/had the following? (Please check all that apply)

Cataracts	_____	Glaucoma	_____	Blindness	_____
Macular Degeneration	_____	Retinal Issues	_____	Hypertension	_____
Thyroid Disease	_____	Cancer	_____	Arthritis	_____
Diabetes	_____	Other	_____		

IV. Social History

	Yes	No
Do you now, or have you every smoked?	_____	_____
Do you currently use alcohol or drugs?	_____	_____
Are you currently pregnant?	_____	_____
Are you currently under HOSPICE Care?	_____	_____
Are you HIV Positive?	_____	_____

V. Review of Systems

Do you have or had any of the following Medical Conditions? (Please check All that apply)

Ears/Nose/Mouth/Throat:	_____	Kidney Problems:	_____
Cardiovascular:	_____	Arthritis/Bone Problems:	_____
Respiratory/Breathing Problems:	_____	Seizure/Neurological Issues:	_____
Stomach Problems:	_____	Chronic Allergies:	_____

Any additional information: _____

_____

_____

_____

_____ _____

Signature of Patient or Guardian Date

South Texas Eye Consultants, P.L.L.C.
Patient Financial Policy

In order to reduce confusion and misunderstanding between our patients and the practice, South Texas Eye Consultants, P.L.L.C., has adopted the following financial policy. We are dedicated to establishing and maintaining a great patient-physician relationship and regard your complete understanding of your financial responsibilities as an essential element of our care and treatment. If you have any questions about the policy, please contact our front desk for assistance.

- **PAYMENT:** Payment is due in full at the time of service including copays, coinsurance and/or deductibles.

- **INSURANCE CARDS:** Please make sure the insurance cards presented are current and accurate. If you have multiple insurance coverages, you must provide all cards at the time of service.

- **INSURANCE:** South Texas Eye Consultants participates with most major insurance plans. While we are happy to submit services rendered to your insurance company, for payment, ultimately you are responsible for any and all financial liabilities.

- **AUTHORIZATIONS:** If you have a plan that requires an authorization to see a specialist, you must obtain a referral in order for your visit in our office to be covered under your medical insurance. If you do not have the valid referral and still wish to be seen, you will be asked to pay for the visit prior to your examination.

- **NON-COVERED SERVICES/DENIED CHARGES**: Certain services may be considered non-covered services or may be denied as investigational, experimental, or not medically necessary by your insurance carrier. If your physician feels these services are needed and they are preformed, you are obligated to pay for these services in full should your insurance carrier deny payment.
    - **Medicare Patients**: South Texas Eye Consultants will inform you ahead of time and will supply you with an Advanced Beneficiary Notice (ABN) to read and sign. The ABN will help you decide whether you want to receive services, knowing you are responsible for payment. You must read the ABN carefully.
    - **Non-Medicare Patients:** Any services not covered by your plan are your responsibility and must be paid in full by the time of service.

- **RETURNED CHECKS & PAST DUE AMOUNTS:** Returned checks will be subject to a $30.00 collection fee. All accounts are considered delinquent if not paid within 90 days of service. Past due accounts may result in collection turnover and/or the refusal of future appointments until old balances have been paid in full. South Texas Eye Consultants does not accept postdated checks.

- **NON-MEDICAL FEES:** Additional fees may apply to completion of disability or other forms, and copying of medical records.

- **REFUNDS:** Refunds are issued when an overpayment has been identified. South Texas Eye Consultants will not issue a refund on any claim that is still processing with insurance carriers and cannot accept patient Explanation of Benefits as proof of payment. If you feel you are due a refund, please contact our billing office at 361-906-3528.

- **SURGERY CHARGES:** South Texas Eye Consultants will make every effort to determine your insurance benefits prior to your scheduled surgery. We will notify you of the amount you will be responsible for paying prior to your scheduled surgery. Please keep in mind that this is just an estimate. You may incur additional charges (in addition to the surgeon's fees) from the surgery facility, anesthesiologist, laboratory and/or radiologist.

South Texas Eye Consultants, P.L.L.C.
Patient Financial Policy

- **MEDICAL RECORDS RELEASE:** After written authorization is received, your medical record may be released. South Texas Eye Consultants follows the Texas guidelines for charges applied for the release of these records.

- **MEDICAL VS. VISION SERVICE:** Insurance plans differentiate between "Medical" and "Vision" problems. Most medical insurance plans do not pay for "Vision" services. Vision plans do not pay for "Medical" problems. If you have a medical eye problem, we can submit a claim with your medical plan. If you simply need an eye exam for glasses, and/or contacts we can submit to your vision plan.
    - We accept EyeMed Vison and Humana Vison.

- **REFRACTIONS:** Many insurances including Medicare, DO NOT cover a refraction. Some insurance plans consider a refraction a "Vision" service and not a "Medical" service, (A refraction is a procedure performed to determine your need for eyeglasses or to evaluate if any visual improvement may be achieved). This is not only a necessary and essential portion of your eye exam, it is in many cases, the sole reason for your appointment. Our fee for this portion of the eye exam is $45.00, due at the time of service.

- **CONTACT LENS EVALUATION AND FEE:** Contact lens evaluations are a specialized service; it is not included in a standard eye exam performed by the ophthalmologist. Patients who wish to be evaluated for contact lenses are responsible for an additional fee. High-complexity evaluations are charged at a higher rate because they will require more in-depth customization and evaluation.

We appreciate you as our patient and we want to provide you with the best care possible. Helping you better manage your medical benefits is another way of saying "**we care**".

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

_____

Printed Name of the Patient

_____ _____

Signature of Patient or Responsible Party if a Minor Date

South Texas Eye Consultants, P.L.L.C.
Authorizations & Acknowledgement

RELEASE OF INFORMATION: I authorize South Texas Eye Consultants, my treating physicians and their respective designees, to use and disclose my health information for all purposes necessary for treatment, payment and healthcare operations, including but not limited to release of information requested by my insurance company (or carrier) and any information necessary for discharge planning purposes.

ASSIGNMENT OF BENEFITS: I hereby authorize my insurance benefits to be paid directly to South Texas Eye Consultants. I understand I am financially responsible for non-covered services. I authorize the release of any medical or other information necessary to process insurance claims on my behalf.

MEDICARE SIGNATURE ON FILE (Medicare Patients Only): I request that payment of authorized Medicare benefits be made either to me or on my behalf to all providers who treat me or any services furnished to me by those providers. I authorize the holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

FINANCIAL LIABILITY: I have been provided a copy of South Texas Eye Consultants' financial policies and agree to the specified terms. I hereby agree to pay all charges due (or to become due) to South Texas Eye Consultants for care and treatment, including co-payments and deductibles as provided under my plan. Benefits, if any, paid by a third party, will be credited on account. I understand that I will be responsible for any charges if any of the following apply:

- My health plan requires prior authorization or referral by a Primary Care Physician (PCP) before receiving services at South Texas Eye Consultants and I have not obtained such an authorization or referral, or I have received services in excess of such authorization or referral
- My health plan determines that the services I receive at South Texas Eye Consultants are not medically necessary and are not covered by my insurance plan
- My health plan coverage has lapsed or expired at the time I receive services at South Texas Eye Consultants

PRIVACY POLICY: I have been provided a copy of South Texas Eye Consultants' privacy policies and agree to the specified terms. The notice provides, in detail, the uses and disclosures of my protected health information that may be made by South Texas Eye Consultants, my individual rights, how I may exercise these rights, and the South Texas Eye Consultants legal duties with respect to my information. I understand that South Texas Eye Consultants reserves the right to change the terms of its Notice of Privacy Policies, and to make changes regarding all protected health information resident at, or controlled by, South Texas Eye Consultants. If changes to the policy occur, South Texas Eye Consultants will provide me a revised Notice of Privacy Practices upon request.

Printed Name of Patient _____

Patient's Signature _____

Medicare Number (if applicable) _____ Date _____