MEDICAL FORM
(please fill in all information)

LAST NAME ______________________ FIRST ______________________ M.I. ______

SPOUSE/PARENT NAME ______________________

HOME PHONE ______________________ BUSINESS PHONE ______________________

HOME ADDRESS ______________________

CITY & STATE ______________________ ZIP CODE ______________________

DATE OF BIRTH ______________________ SEX M ☐ F ☐ SOCIAL SECURITY # ______________________

EMAIL ______________________ DRIVERS LICENSE # ______________________

Who Is Your Current Optometrist? ______________________

Family Physician (PCP) ______________________ Referred By ______________________

EMERGENCY CONTACT PERSON

Name ______________________

Address ______________________

Phone Number ______________________

Relationship To Patient ______________________

PRIMARY INSURANCE INFORMATION

Primary Insured's Name ______________________

Patient's Relationship to Primary Insured ______ Self ______ Spouse ______ Child ______ Parent

Primary Insured's Social Security Number# ______________________ Date of Birth ______________________

Primary Insured's Employer ______________________

Insurance Plan Name ______________________

Insurance ID number ______________________ Group number ______________________

SECONDARY INSURANCE INFORMATION

Primary Insured's Name ______________________

Patient's Relationship to Primary Insured ______ Self ______ Spouse ______ Child ______

Primary Insured's Social Security Number# ______________________ Date of Birth ______________________

Primary Insured's Employer ______________________

Insurance Plan Name ______________________

Insurance ID number ______________________ Group number ______________________

Filling your insurance is not a guarantee of payment, if payment is not received you as a patient will be ultimately responsible for all unpaid services.

BY SIGNING THIS FORM, I ACKNOWLEDGE THE ABOVE AND UNDERSTAND THAT IT IS MY RESPONSIBILITY TO PROVIDE THE PHYSICIAN WITH ALL CORRECT INSURANCE INFORMATION. IF THE CLAIM IS DENIED FOR ANY REASON I WILL BE FINANCIALLY RESPONSIBLE FOR MY OFFICE VISIT.

____

SIGNATURE OF PATIENT DATE

EYE CENTERS OF TEXAS

MEDICAL FORM
Page 2
(please fill in all information)

MEDICAL HISTORY	YES	NO
HEART DISEASE	☐	☐
DIABETES	☐	☐
GLAUCOMA	☐	☐
HIGH BLOOD PRESSURE	☐	☐
SURGERIES	☐	☐
BLEEDING DISORDERS	☐	☐

ALLERGIES TO MEDICINES ______________________________

LIST ANY MEDICATIONS YOU ARE TAKING ______________________________

PATIENT SIGNATURE ON FILE X ______________________________

REVIEW OF SYSTEMS:

Do you currently have any of the following problems:	**YES**	**NO**	IF YES, PLEASE EXPLAIN
Chronic fever, unexpected weight loss/gain, fatigue, night sweats?	☐	☐	
Ear/nose/throat problems (e.g. hearing loss, sinus problems, sore throat)?	☐	☐	
Respiratory problems (e.g. shortness of breath, wheezing, coughing)?	☐	☐	
Heart problems (e.g. chest pressure or discomfort, irregular heartbeat)?	☐	☐	
Gastrointestinal problems (e.g. constipation, heartburn, abdominal pain, diarrhea, vomiting)?	☐	☐	
Urinary problems (e.g. pain or discomfort, blood in urine)?	☐	☐	
Cold intolerance, heat intolerance, polydipsia or polphagia?	☐	☐	
Neurologic problems (e.g. dizziness, numbness, weakness, headaches)?	☐	☐	
Emotional changes?	☐	☐	
Skin problems (e.g. rashes, excessive dryness)?	☐	☐	
Musculoskeletal problems (e.g. muscle aches, joint pains, swollen joints)?	☐	☐	
Bruising and easy bleeding?	☐	☐	
Environmental allergies or food allergies?	☐	☐	

FAMILY AND SOCIAL HISTORY

Do any medical diseases run in your family? (e.g. diabetes, high blood pressure, cancer, heart, strokes, etc.)

YES ☐ NO ☐ If yes, please explain ______________________________

Do you smoke? YES ☐ NO ☐ How much? __________ Do you drink alcohol? YES ☐ NO ☐ How much? __________

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

EYE CENTERS OF TEXAS

REFRACTION POLICY

What is Refraction?

The refraction test, also termed vision test, is an examination that tests an individual's ability to see an object at a specific distance. The test involves looking through a device called a phoropter to read letters or recognize symbols on a wall chart through lenses of differing strength which are contained within the device. (During this process, the eye doctor will ask you "Which is better...one or two?"). This test is performed as part of a normal eye examination to determine the prescription for eyeglasses or contact lenses.

When Does Insurance Not Pay For A Refraction?

Unfortunately, Medicare considers this a *routine* test and therefore does not approve it making it a non-covered service. Since Medicare doesn't cover it, many commercial insurance companies follow suit and also consider it a non-covered service.

OUR POLICY

We are dedicated to providing our patient with the very best medical and surgical eye care in North Texas. Therefore, refraction will be performed when medically necessary (this includes all new patients, those presenting with a decrease in vision and on a yearly basis thereafter). Additionally, we are happy to perform a refraction during any visit upon your request. Please keep in mind that most of the time this service will not be covered and you will be responsible for the charge.

Our fee for the refraction is $47, and is collected at the time of your visit, in addition to any co-payments or deductible amounts due for the medical portion of your examination.

I have been informed, I have read the above and understand the policy regarding refractions.

SIGNATURE OF PATIENT DATE

WITNESS DATE

Thank you for choosing KE Eye Centers for your eye care needs. We are constantly striving to improve the efficiency and quality of your care. Due to numerous changes in the insurance industry we have changed our insurance policies. The new policies are necessary for us to work effectively and will ultimately improve your care.

- ☐ Bring all current active insurance cards to every scheduled appointment.
- ☐ If filing with medical insurance, please contact your insurance carrier to verify your medical and vision benefits.
- ☐ **HMO** Plans will require a referral. **YOU** must contact your primary care physician **PRIOR** to your visit to obtain your referral. Call our office to verify the referral has been received.
- ☐ **ALL** co-payments and fees will be collected at the time of service.

If you do not have ALL of the above listed items at the time of your visit, you will then have the following options:

- Reschedule your appointment
- Pay for services rendered at the time of service

PATIENT CONSENT FORM
(please fill in all information)

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. White binders containing our Notice of Privacy Practices are located in the waiting areas and at the check-in counter for your review. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- ☐ Protected health information may be disclosed or used for treatment, payment or health care operations.
- ☐ The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- ☐ The Practice reserves the right to change the Notice of Privacy Policies.
- ☐ The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- ☐ The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- ☐ The Practice may condition treatment upon the execution of this Consent.
- ☐ The patient grants access to KE Eye Centers of Texas to electronically access their medication history.

This Consent was signed by ______________________________
Printed Name - Patient or Representative

Relationship to Patient (if other than patient) ______________________________

Date ______________________________

Due to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the following information must be filled out by each patient annually.

I authorize KE Eye Centers to release my medical or insurance information as necessary to process my medical claims and coordinate or manage my health care.

In the event a family member or caregiver attends my office visit and is in the exam room at the time of my evaluation and/or treatment, I give the doctors and staff members at KE Eye Centers my permission to discuss freely my condition, treatment or diagnosis with that person. **YES / NO**

HOME PHONE ______________________________ May we leave a message? **YES / NO**

CELL PHONE ______________________________ May we leave a message? **YES / NO**

MAY WE CALL YOUR NAME OUT LOUD IN OUR LOBBY? **YES / NO**

TO WHOM MAY WE DISCUSS FINANCIAL ISSUES RELATING TO TREATMENT & DIAGNOSIS? ______________________________

PHONE: ______________________________ **SIGNATURE:** ______________________________
(PATIENT OR REPRESENTATIVE)