EYE CONSULTANTS
OF TEXAS

Dear Valued Patient,

Your appointment at Eye Consultants of Texas is scheduled on _____, _____at _____am/pm at our **Grapevine location**.

We have enclosed patient information sheets for you to complete prior to your appointment. Hopefully, this will help expedite your time in our office. **Please do not mail these forms back to us.**

Please bring the completed forms plus your insurance card(s) and driver's license with you to your appointment. A copy will be made and kept on file with our office in order to expedite insurance billing.

Please be aware that both of your eyes may be dilated at your visit. The process for testing, diagnosing and treating your eye concerns can take up to 3 hours or more, so please plan accordingly.

Our office policy states that co-payments and or deductibles are due at the time of your visit. If you do not have insurance to cover your visit, payment will be due at the time of your visit. We accept Visa, MasterCard, American Express and Discover.

We look forward to seeing you on your appointment day. If you have any questions, please feel free to contact our office at 817-410-2030 and we would be glad to answer them for you.

Sincerely,

The Eye Consultants of Texas Team

EYE CONSULTANTS
OF TEXAS

Today's Date: _____

PATIENT REGISTRATION FORM

PATIENT INFORMATION:

Last Name _____ First Name _____ MI _____

Date of Birth _____ Age _____ Marital Status _____ SS# _____ ☐ Male ☐ Female

Address _____ Apt # _____

City _____ State _____ Zip _____ Email _____

Home # _____ Cell # _____ Work # _____

Employer Name _____ City _____ State _____ Zip _____

Race _____ Ethnicity _____

Preferred Language _____

EMERGENCY CONTACT:

Name _____ Relationship _____ Phone _____

PRIMARY CARE PHYSICIAN:

Name _____ Address _____

PHARMACY:

Name _____ Location _____

DO YOU HAVE AN OPTOMETRIST? ☐ YES ☐ NO

Name _____ Location _____

HOW DID YOU HEAR ABOUT US?

☐ Referred by Optometrist ☐ Referred by Primary Care Physician ☐ Another Patient ☐ Insurance website
☐ Living Social Magazine ☐ Social Media ☐ Other _____

INSURANCE INFORMATION: (*Please present your insurance cards upon check-in)*

Primary Insurance _____ Policy # _____

Insurance Phone # _____ Group # _____

Subscriber Name and Date of Birth _____

Secondary Insurance _____ Policy # _____

Insurance Phone # _____ Group # _____

Subscriber Name and Date of Birth _____

EYE CONSULTANTS
OF TEXAS

Today's Date: _____

Patient Name: _____

DOB: _____

MEDICAL HISTORY QUESTIONNAIRE

REASON FOR TODAY'S VISIT: _____

_____

HISTORY OF EYE SURGERY		**DATES**	
		Right Eye	Left Eye
Cataract Surgery	☐ **YES** ☐ **NO**		
Cornea Surgery	☐ **YES** ☐ **NO**		
Glaucoma Surgery	☐ **YES** ☐ **NO**		
Refractive Surgery	☐ **YES** ☐ **NO**		
Retinal Surgery	☐ **YES** ☐ **NO**		
Strabismus Surgery	☐ **YES** ☐ **NO**		
Vitreous Surgery	☐ **YES** ☐ **NO**		
Previous Trauma	☐ **YES** ☐ **NO**		
Other _____			

HAVE YOU BEEN DIAGNOSED WITH ANY EYE DISEASES? (glaucoma, macular degeneration, iritis, dry eye syndrome, etc.)

☐ **NO**

☐ **YES** _____

IS THERE A HISTORY OF EYE DISEASE IN YOUR FAMILY?

☐ **NO**

☐ **YES** _____

DO YOU WEAR CONTACT LENSES?

☐ **NO**

☐ **YES:** ☐ **Soft** ☐ **Hard** Are your contacts monovision? ☐ **YES** ☐ **NO**

MAJOR SURGERIES WITHIN THE LAST 10 YEARS _____

_____

SOCIAL HISTORY

Smoking:
- ☐ Current Daily Smoker
- ☐ Current Occ. Smoker
- ☐ Former Smoker
- ☐ Never Smoked

Alcohol:
- ☐ Never
- ☐ Rarely
- ☐ Occasional
- ☐ Daily

Recreational Drugs:
- ☐ Never
- ☐ Rarely
- ☐ Occasional
- ☐ Daily

Occupation:
- ☐ Business
- ☐ Manual Labor
- ☐ Office Work
- ☐ Retired
- ☐ Student
- ☐ Teacher
- ☐ Driver/Pilot
- ☐ Engineer
- ☐ Other:

Hobbies:
- ☐ Computers
- ☐ Music
- ☐ Sewing/Crafts
- ☐ Sports
- ☐ Travel
- ☐ Golf
- ☐ Hunting
- ☐ Reading
- ☐ Cards
- ☐ Other:

Type of Tobacco:
- ☐ Cigarettes
- ☐ Cigar
- ☐ Pipe
- ☐ Electronic Cigarettes
- ☐ Other:

Type of Alcohol:
- ☐ Beer
- ☐ Liquor
- ☐ Wine
- ☐ Other:

Type of Drug:
- ☐ Amphetamines
- ☐ Cocaine
- ☐ IV Drugs
- ☐ LSD
- ☐ Marijuana
- ☐ Other:

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Today's Date: _____

Patient Name: _____

DOB: _____

MEDICATION LIST

DRUG ALLERGIES

☐ No Known Drug Allergies

Allergy	Reaction	Allergy	Reaction

CURRENT MEDICATIONS *(include all prescription, over the counter, vitamins, supplements)*

Medication Name	Dosage and Frequency	Reason for Taking

CURRENT EYE DROPS _____

_____

HAVE YOU EVER TAKEN ANY OF THE FOLLOWING?

Flomax (tamsulosin)	☐ **YES** ☐ **NO**	**Saw Palmetto**	☐ **YES** ☐ **NO**
Cardura (doxazosin)	☐ **YES** ☐ **NO**	**Jaylen**	☐ **YES** ☐ **NO**
Uroxatrol (alfuzosin)	☐ **YES** ☐ **NO**	**Accutane**	☐ **YES** ☐ **NO**
Hytrin (terazosin)	☐ **YES** ☐ **NO**	**Hormone therapy**	☐ **YES** ☐ **NO**
Rapaflo (siladosin)	☐ **YES** ☐ **NO**	**Labetalol**	☐ **YES** ☐ **NO**

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Today's Date: _____

Patient Name: _____

DOB: _____

REVIEW OF SYSTEMS

Do you currently have any problems in the following areas?

GENERAL/CONSTITUTIONAL:
- ☐ Fever
- ☐ Night Sweats
- ☐ Fatigue
- ☐ Weakness
- ☐ Body Aches
- ☐ Decreased Appetite
- ☐ Recent Weight Loss/Gain
- ☐ Cancer, Type: _____
- ☐ Other: _____

EYES:
- ☐ Blurry Vision
- ☐ Double Vision
- ☐ Flashing Lights
- ☐ Floaters
- ☐ Pain
- ☐ Tearing
- ☐ Redness
- ☐ Other: _____

CARDIOVASCULAR:
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ High Cholesterol
- ☐ Chest Pain
- ☐ Irregular Heart Beat
- ☐ Heart Attack
- ☐ Congestive Heart Failure
- ☐ Pacemaker
- ☐ Other: _____

RESPIRATORY:
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Asthma
- ☐ COPD
- ☐ Emphysema
- ☐ Other: _____

EARS/NOSE/THROAT:
- ☐ Hard of Hearing
- ☐ Stuffy Nose
- ☐ Cough
- ☐ Dry Mouth
- ☐ Nosebleeds
- ☐ Ear Pain/Discharge
- ☐ Other: _____

MUSCLES/BONES/JOINTS:
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Joint Pain
- ☐ Gout
- ☐ Stiffness
- ☐ Other: _____

ENDOCRINE:
- ☐ Diabetes, A1C: _____
- ☐ Hypoglycemia
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Other: _____

GENITOURINARY:
- ☐ Painful/Frequent Urination
- ☐ Blood in Urine
- ☐ Bladder Incontinence
- ☐ Kidney Failure
- ☐ Dialysis
- ☐ Other: _____

GASTROINTESTINAL:
- ☐ Hernia
- ☐ Ulcers
- ☐ Abdominal Pain
- ☐ Bloody/Tarry Stools
- ☐ Difficulty Swallowing
- ☐ Constipation/Diarrhea
- ☐ Other: _____

INTEGUMENTARY:
- ☐ Itching
- ☐ Dryness
- ☐ Rash
- ☐ Sores
- ☐ Mole Changes
- ☐ Growths
- ☐ Rash
- ☐ Other: _____

NEUROLOGICAL:
- ☐ Stroke
- ☐ Seizures
- ☐ Numbness
- ☐ Dizziness/Vertigo
- ☐ Tremors
- ☐ Dementia/Alzheimer's
- ☐ Other: _____

PSYCHIATRIC:
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Mood Disorder
- ☐ Suicidal Thoughts
- ☐ Other: _____

HEMATOLOGIC:
- ☐ Hemophilia
- ☐ Sickle Cell Disease
- ☐ Hepatitis, Type: _____
- ☐ HIV/AIDS
- ☐ Other: _____

MALES:
- ☐ Enlarged Prostate
- ☐ Testicular Pain

FEMALES:
- ☐ Pregnant
- ☐ Nursing

**Do you have a history of:

Herpes simplex virus (cold sores)? ☐ **YES** ☐ **NO**

Shingles ☐ **YES** ☐ **NO**

If **YES**, has it affected your eyes or any area around your eyes? ☐ **YES** ☐ **NO**

EYE CONSULTANTS
OF TEXAS

ACKNOWLEDGMENT OF FACILITY POLICIES

PAYMENT

Payment is expected at the time of service. This includes co-pays and/or deductibles if we are filing insurance for you. We accept cash, checks, and major credit cards.

REFERRALS

If your insurance plan requires a referral from your primary care physician, you are responsible for obtaining a referral **PRIOR** to your appointment. **If you do not have a referral, your appointment will need to be rescheduled.**

REFRACTION POLICY

Some insurances do not cover the refraction fee ($50.00); this will be collected at the time of service. If we file insurance other than Medicare and the refraction is not a covered benefit, you will be responsible for the fee (refractions are required annually).

CONTACT LENS FITTING

It is ECT's policy to see patients once a year in order to provide a prescription for contacts. The fee for soft contact lens fitting starts at $100.00. This includes one pair of trial contact lenses. The fee for RGP contact lens fitting starts at $200.00. RGP lenses must be ordered and are an additional cost ($120 single vision per lens, $150 bifocal per lens). **We have a limited contact lens inventory at our clinic. We are happy to refer you to one of our network Optometrists for contact lens fitting.**

WHEELCHAIR PATIENTS

If you are in a wheelchair, please inform our office ahead of time so that we can make sure we have the larger exam room available for your appointment. We also need to know if you are capable of getting out of your chair briefly to allow us to perform the required testing and/or exam.

MEDICAL RECORDS CHARGE

There is a $25.00 fee for copies of medical records.

RETURNED CHECK POLICY

There is a $35.00 fee for returned checks.

NO-SHOW APPOINTMENTS

Eye Consultants of Texas reserves the right to bill you for a missed or "no show" appointment without appropriate notice of cancellation.

REFUNDS

Eye Consultants of Texas strives to collect the accurate amount owed from patients for co-pays, deductibles, co-insurance and advanced technology lenses. However, on some occasions the patient will be due a refund. Refunds are processed for payment within 30 days of notification from the insurance provider, patient, or explanation of benefits that a refund is due to the patient. Refunds will be issued in the form of a paper check and mailed to the patient's last known address on file. If, however, payment was made via CareCredit, refunds will be processed through their portal in accordance with their guidelines.

I have read and understand the above policies.

_____

Patient Name (Printed)

_____

Patient Signature

_____

Date

EYE CONSULTANTS
OF TEXAS

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, & FINANCIAL AGREEMENT

_____ _____ _____

Patient Name (print) **DOB** **Medicare Number or SSN**

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Eye Consultants of Texas, for services furnished me by Eye Consultants of Texas. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Eye Consultants of Texas accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services and/or items. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2. **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Eye Consultants of Texas if possible or otherwise to me.

3. **RELEASE OF INFORMATION:** Eye Consultants of Texas may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Eye Consultants of Texas for reimbursement for services rendered, and (2) any health care provider for continued patient care. Eye Consultants of Texas may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

4. **OTHER INSURANCE:** I understand that Eye Consultants of Texas maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office and that Eye Consultants of Texas has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all items and/or services rendered to me by Eye Consultants of Texas if I belong to a plan that does not appear on the above-mentioned list.

5. **NON-COVERED SERVICES AND ITEMS:** I understand that Eye Consultants of Texas contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Eye Consultants of Texas to obtain necessary health care service plan authorizations.

6. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Eye Consultants of Texas I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Eye Consultants of Texas for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient or any other party liable to the patient, is hereby assigned to Eye Consultants of Texas. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Eye Consultants of Texas. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

_____ I DO NOT HAVE INSURANCE COVERAGE. I UNDERSTAND THAT I AM RESPONSIBLE FOR MY BILL.

_____ _____

Patient Signature **Date**

EYE CONSULTANTS
OF TEXAS

NOTICE OF PRIVACY PRACTICES

CONSENT FOR USE & DISCLOSURE OF MEDICAL INFORMATION

I, _____ (Patient Name), acknowledge that I have received a copy of ECT's Notice of Privacy Practices (above) effective April 28, 2020. I also consent to the use or disclosure of my protected health information for the following purposes:

A. TREATMENT: It will be necessary to share protected health information with all members of the treatment team for treatment purposes. This can include employees in this office, as well as other providers (including any physicians that are currently treating you).

B. PAYMENT: Necessary information will be shared with appropriate payer sources and their representatives for payment purposes, including but not limited to eligibility, benefit determination, and utilization review. It will also be necessary for billing personnel, including but not limited to employees, case managers, claims representatives, third party billing services or clearinghouses to have access to protected health information to carry out their job functions.

C. HEALTHCARE OPERATIONS: Necessary information will be shared for the continuing operations of this office. Some examples include, but are not limited to peer review, accreditation, credentialing processes, and compliance with all federal and state laws. I understand that my treatment may be conditioned upon my consent. This consent is given freely and I understand that I can revoke this consent at any time in writing, which will apply to disclosures and uses made subsequent to the revocation date.

D. DISCLOSURE OF MEDICAL INFORMATION: Please list below the names of any individuals with whom you authorize members of our office staff to discuss your medical information (example: your spouse or a parent):

1. **Name:** _____ **Relationship:** _____
2. **Name:** _____ **Relationship:** _____
3. **Name:** _____ **Relationship:** _____

_____

Patient Signature

_____

Date