



EYE CONSULTANTS
OF TEXAS

Dear New Patient,

Thank you for choosing Eye Consultants of Texas. We strongly believe in a **TEAM** approach to patient care and our team is committed to providing a smooth patient experience. Our holistic approach working with cooperating doctors enables us to collect unbiased information in order to track our results and for better our outcomes.

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 improve our billing process.

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



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 _____



Today's Date: _____

Patient Name: _____

DOB: _____

MEDICAL HISTORY QUESTIONNAIRE

REASON FOR TODAY'S VISIT: _____

Table with columns: HISTORY OF EYE SURGERY, DATES (Right Eye, Left Eye). Rows include: Cataract Surgery, Cornea Surgery, Glaucoma Surgery, Refractive Surgery, Retinal Surgery, Strabismus Surgery, Vitreous Surgery, Previous Trauma, 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:



Today's Date: _____

Patient Name: _____

DOB: _____

REVIEW OF SYSTEMS

Do you currently have any problems in the following areas?

GENERAL/CONSTITUTIONAL: <input type="checkbox"/> Fever <input type="checkbox"/> Night Sweats <input type="checkbox"/> Fatigue <input type="checkbox"/> Weakness <input type="checkbox"/> Body Aches <input type="checkbox"/> Decreased Appetite <input type="checkbox"/> Recent Weight Loss/Gain <input type="checkbox"/> Cancer, Type: _____ <input type="checkbox"/> Other: _____	EYES: <input type="checkbox"/> Blurry Vision <input type="checkbox"/> Double Vision <input type="checkbox"/> Flashing Lights <input type="checkbox"/> Floaters <input type="checkbox"/> Pain <input type="checkbox"/> Tearing <input type="checkbox"/> Redness <input type="checkbox"/> Other: _____	CARDIOVASCULAR: <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Chest Pain <input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> Heart Attack <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Pacemaker <input type="checkbox"/> Other: _____
RESPIRATORY: <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Asthma <input type="checkbox"/> COPD <input type="checkbox"/> Emphysema <input type="checkbox"/> Other: _____	EARS/NOSE/THROAT: <input type="checkbox"/> Hard of Hearing <input type="checkbox"/> Stuffy Nose <input type="checkbox"/> Cough <input type="checkbox"/> Dry Mouth <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Ear Pain/Discharge <input type="checkbox"/> Other: _____	MUSCLES/BONES/JOINTS: <input type="checkbox"/> Arthritis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Joint Pain <input type="checkbox"/> Gout <input type="checkbox"/> Stiffness <input type="checkbox"/> Other: _____
ENDOCRINE: <input type="checkbox"/> Diabetes, A1C: _____ <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Other: _____	GENITOURINARY: <input type="checkbox"/> Painful/Frequent Urination <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Bladder Incontinence <input type="checkbox"/> Kidney Failure <input type="checkbox"/> Dialysis <input type="checkbox"/> Other: _____	GASTROINTESTINAL: <input type="checkbox"/> Hernia <input type="checkbox"/> Ulcers <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Bloody/Tarry Stools <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Constipation/Diarrhea <input type="checkbox"/> Other: _____
INTEGUMENTARY: <input type="checkbox"/> Itching <input type="checkbox"/> Dryness <input type="checkbox"/> Rash <input type="checkbox"/> Sores <input type="checkbox"/> Mole Changes <input type="checkbox"/> Growths <input type="checkbox"/> Rash <input type="checkbox"/> Other: _____	NEUROLOGICAL: <input type="checkbox"/> Stroke <input type="checkbox"/> Seizures <input type="checkbox"/> Numbness <input type="checkbox"/> Dizziness/Vertigo <input type="checkbox"/> Tremors <input type="checkbox"/> Dementia/Alzheimer's <input type="checkbox"/> Other: _____	PSYCHIATRIC: <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Insomnia <input type="checkbox"/> Mood Disorder <input type="checkbox"/> Suicidal Thoughts <input type="checkbox"/> Other: _____
HEMATOLOGIC: <input type="checkbox"/> Hemophilia <input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> Hepatitis, Type: _____ <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Other: _____	MALES: <input type="checkbox"/> Enlarged Prostate <input type="checkbox"/> Testicular Pain **Do you have a history of: Herpes simplex virus (cold sores)? <input type="checkbox"/> YES <input type="checkbox"/> NO Shingles <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, has it affected your eyes or any area around your eyes? <input type="checkbox"/> YES <input type="checkbox"/> NO	



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



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



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