



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



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 _____ Address _____

DO YOU HAVE AN OPTOMETRIST? YES NO

Name _____ Address _____

WERE YOU REFERRED TO US BY YOUR OPTOMETRIST? YES NO N/A

IF NOT, HOW DID YOU HEAR ABOUT US?

- Referred by Primary Care Physician Another Patient: _____ Insurance Website
- Modern Luxury Magazine Southlake Style Magazine Living Magazine Society Life Magazine
- Google Search Way FM Radio 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

REASON FOR TODAY'S VISIT _____

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

NO YES _____

ANY PREVIOUS EYE TRAUMA?

NO YES _____

DO YOU WEAR CONTACT LENSES?

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

CURRENT EYE DROPS _____

HISTORY OF EYE SURGERY		DATES		SURGEON
		Right Eye	Left Eye	
Cataract Surgery	<input type="checkbox"/> YES <input type="checkbox"/> NO			
Cornea Surgery	<input type="checkbox"/> YES <input type="checkbox"/> NO			
Glaucoma Surgery	<input type="checkbox"/> YES <input type="checkbox"/> NO			
Refractive Surgery (LASIK, RK, PRK)	<input type="checkbox"/> YES <input type="checkbox"/> NO			
Retinal Surgery	<input type="checkbox"/> YES <input type="checkbox"/> NO			
Strabismus Surgery	<input type="checkbox"/> YES <input type="checkbox"/> NO			
Vitreous Surgery	<input type="checkbox"/> YES <input type="checkbox"/> NO			
Other _____				

MEDICAL DIAGNOSES

RESPIRATORY N/A

- Asthma
- COPD
- Emphysema
- Other _____

PSYCHIATRIC N/A

- Anxiety
- Depression
- Mood Disorder
- Other _____

GASTROINTESTINAL N/A

- Crohn's / IBS
- Diverticulosis
- Other _____

HEMATOLOGIC N/A

- Sickle Cell Disease
- Hemophilia
- Hepatitis
Type _____
- Other _____

NEUROLOGICAL N/A

- Stroke
- Seizures
- Dizziness / Vertigo
- Tremors
- Dementia / Alzheimer's
- Other _____

GENITOURINARY N/A

- Kidney Stones
- Kidney Failure
- Dialysis
- Enlarged Prostate (BPH)
- Other _____



Today's Date: _____

Patient Name: _____

DOB: _____

ENDOCRINE <input type="checkbox"/> N/A <input type="checkbox"/> Diabetes Insulin <input type="checkbox"/> YES <input type="checkbox"/> NO Year Diagnosed _____ A1C _____ Date _____ <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Other _____	OCULAR <input type="checkbox"/> N/A <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"/> N/A <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> High Cholesterol <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 _____
GENERAL/CONSTITUTIONAL <input type="checkbox"/> N/A <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"/> Other _____	EAR/NOSE/THROAT <input type="checkbox"/> N/A <input type="checkbox"/> Hard of Hearing <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Reflux <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Other _____	MUSCLES/BONES/JOINTS <input type="checkbox"/> N/A <input type="checkbox"/> Arthritis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Lupus <input type="checkbox"/> Gout <input type="checkbox"/> Other _____
REPRODUCTIVE <input type="checkbox"/> N/A Are you pregnant? <input type="checkbox"/> YES <input type="checkbox"/> NO Are you nursing? <input type="checkbox"/> YES <input type="checkbox"/> NO		

DO YOU HAVE A HISTORY OF THE FOLLOWING?

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

VACCINATION STATUS

Have you been vaccinated against PNEUMONIA? NO YES, YEAR: _____

Have you received the FLU shot for this year's flu season? YES NO

MAJOR SURGERIES WITHIN THE LAST 10 YEARS _____

CURRENT MEDICATIONS (include all prescription, over the counter, vitamins, and supplements you are taking)		
Medication Name	Dosage and Frequency (e.g. 10mg daily)	Reason for Taking



Today's Date: _____

Patient Name: _____

DOB: _____

HAVE YOU EVER TAKEN ANY OF THE FOLLOWING?

- | | |
|--|--|
| Flomax (tamsulosin)* <input type="checkbox"/> YES <input type="checkbox"/> NO | Rapaflo (silodosin) <input type="checkbox"/> YES <input type="checkbox"/> NO |
| <i>*used to increase urine outflow; not be confused with Flonase</i> | Saw Palmetto <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Cardura (doxazosin) <input type="checkbox"/> YES <input type="checkbox"/> NO | Jaylen <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Uroxatrol (alfuzosin) <input type="checkbox"/> YES <input type="checkbox"/> NO | Accutane <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Hytrin (terazosin) <input type="checkbox"/> YES <input type="checkbox"/> NO | Hormone Therapy <input type="checkbox"/> YES <input type="checkbox"/> NO |

DRUG ALLERGIES <input type="checkbox"/> No Known Drug Allergies			
Allergy	Reaction	Allergy	Reaction

FAMILY MEDICAL HISTORY (include any history of eye disease) <input type="checkbox"/> None	
Paternal Grandparents	
Maternal Grandparents	
Father	
Mother	
Siblings	

SOCIAL HISTORY	
SMOKING	<input type="checkbox"/> Never <input type="checkbox"/> Occasional <input type="checkbox"/> Daily; ___ ppd <input type="checkbox"/> Former Smoker: ___ ppd; Quit: _____ Type: <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigar <input type="checkbox"/> Pipe <input type="checkbox"/> Vape <input type="checkbox"/> Other: _____
ALCOHOL	<input type="checkbox"/> Never <input type="checkbox"/> Occasional <input type="checkbox"/> Daily Type: <input type="checkbox"/> Beer <input type="checkbox"/> Wine <input type="checkbox"/> Liquor <input type="checkbox"/> Other: _____
RECREATIONAL DRUGS	<input type="checkbox"/> Never <input type="checkbox"/> Occasional <input type="checkbox"/> Daily Type: <input type="checkbox"/> Marijuana <input type="checkbox"/> Prescription Pills <input type="checkbox"/> Amphetamines <input type="checkbox"/> Cocaine <input type="checkbox"/> IV Drugs <input type="checkbox"/> Other: _____
HOBBIES	<input type="checkbox"/> Computers <input type="checkbox"/> Music <input type="checkbox"/> Sewing/Crafts <input type="checkbox"/> Sports <input type="checkbox"/> Travel <input type="checkbox"/> Golf <input type="checkbox"/> Hunting <input type="checkbox"/> Reading <input type="checkbox"/> Cards <input type="checkbox"/> Other: _____
OCCUPATION	<input type="checkbox"/> Retired <input type="checkbox"/> Business <input type="checkbox"/> Healthcare <input type="checkbox"/> Office Work <input type="checkbox"/> Manual Labor <input type="checkbox"/> Teacher <input type="checkbox"/> Driver/Pilot <input type="checkbox"/> Engineer <input type="checkbox"/> Other: _____

DO YOU LIVE ALONE? YES NO **ARE YOU AT RISK FOR FALLS?** YES 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 a 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 in time 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 tests 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. However, on some occasions, patients 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 dependent upon the reason for refund and the method of payment. If related to an overpayment by insurance, refunds are typically issued via paper check and mailed to the patient's last known address on file. If related to an overpayment by the patient, refunds are typically issued in the same method that payment was made. Credit card refunds may take up to 3 weeks to post to the patient's account. For CareCredit payments, refunds will be processed through their portal in accordance with CareCredit's guidelines.

I have read and understand the above policies.

Patient Name (Printed)

Patient Signature

Date



SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, & FINANCIAL AGREEMENT

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 Name (Printed)

Patient Signature

Date



PRIVACY NOTICE ACKNOWLEDGMENT

I acknowledge that I have received a copy of ECT’s Notice of Privacy Practice effective April 28, 2020. I hereby consent to the use or disclosure of my protected health information for the following purposes:

- 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).
- 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.
- 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.
- 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):

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Patient Name (Printed)

Patient Signature

Date



SOCIAL MEDIA DISCLOSURE

Authorization For Use Or Disclosure Of Patient Photographic and/or Video Images

Authorization:

I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by Eye Consultants of Texas / LoneStar Ambulatory Surgery Center. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

Purpose:

The photographic/video images, and/or testimonial will be used for: Social Media and/or Advertising.

Revocability:

I understand that I may revoke this authorization at any time, but such revocation must be in writing. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed.

No Treatment Conditions:

I understand that the practice cannot condition treatment on whether or not I sign this authorization.

Patient Name (Printed)

Patient Signature

Date



AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I authorize the following protected health information be released from the medical record of:

Patient Name: _____

DOB: _____ Telephone: _____

Address: _____

RECORDS TO BE RELEASED:

- FROM: EYE CONSULTANTS OF TEXAS
- TO: 2201 Westgate Plaza
Grapevine, Texas 76051
Fax: 817-251-6261
Phone: 817-410-2030

RECORDS TO BE RELEASED:

- FROM: _____
- TO: Name of Practice/Physician

Address

Phone _____ Fax _____

INFORMATION TO BE RELEASED:

- Complete Medical Record
- Examination Notes
- Labs
- Diagnostic Testing
- Surgical Clearance
- Other: _____

DATES OF SERVICE:

From: _____ To: _____

PURPOSE:

- Continuing Care
- Referral to a Specialist
- Change of Doctor/Provider
- Personal
- Insurance
- Workers Comp
- Disability Determination
- Legal
- Other: _____

I understand that:

- I may revoke this authorization at any time by notifying Eye Consultants of Texas in writing. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my health information have acted in reliance upon this authorization.
- THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING.
- according to applicable state and/or federal laws (Texas Medical Practice Act or HIPAA Act), a re-disclosure could be made of records received from another physician or other health care provider involved in my care or treatment.
- the facility, its employees, and contracted healthcare providers are released from legal responsibility or liability for the release of the above information as the extent indicated and authorized herein.
- there may be a charge for providing copies of my medical records as allowed by Federal & State Law.

Patient Signature

Date