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

2201 Westgate Plaza, Grapevine, Texas 76051

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 ____ 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 ____

EYE CONSULTANTS
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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	☐ **YES** ☐ **NO**			
Cornea Surgery	☐ **YES** ☐ **NO**			
Glaucoma Surgery	☐ **YES** ☐ **NO**			
Refractive Surgery (LASIK, RK, PRK)	☐ **YES** ☐ **NO**			
Retinal Surgery	☐ **YES** ☐ **NO**			
Strabismus Surgery	☐ **YES** ☐ **NO**			
Vitreous Surgery	☐ **YES** ☐ **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 ____________

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ENDOCRINE ☐ N/A	**OCULAR** ☐ N/A	**CARDIOVASCULAR** ☐ N/A
☐ Diabetes Insulin ☐ **YES** ☐ **NO** Year Diagnosed ___________ A1C _____ Date ___________ ☐ Hypoglycemia ☐ Hypothyroidism ☐ Hyperthyroidism ☐ Other ___________________	☐ Blurry Vision ☐ Double Vision ☐ Flashing Lights ☐ Floaters ☐ Pain ☐ Tearing ☐ Redness ☐ Other ___________________	☐ Coronary Artery Disease ☐ High Blood Pressure ☐ Low Blood Pressure ☐ High Cholesterol ☐ Irregular Heart Beat ☐ Heart Attack ☐ Congestive Heart Failure ☐ Pacemaker ☐ Other ___________________
GENERAL/CONSTITUTIONAL ☐ N/A	**EAR/NOSE/THROAT** ☐ N/A	**MUSCLES/BONES/JOINTS** ☐ N/A
☐ Fever ☐ Night Sweats ☐ Fatigue ☐ Weakness ☐ Body Aches ☐ Decreased Appetite ☐ Other ___________________	☐ Hard of Hearing ☐ Sleep Apnea ☐ Reflux ☐ Sinus Problems ☐ Nosebleeds ☐ Other ___________________	☐ Arthritis ☐ Osteoporosis ☐ Fibromyalgia ☐ Lupus ☐ Gout ☐ Other ___________________
REPRODUCTIVE ☐ N/A Are you pregnant? ☐ **YES** ☐ **NO** Are you nursing? ☐ **YES** ☐ **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

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Patient Name: ____________________
DOB: ____________________

HAVE YOU EVER TAKEN ANY OF THE FOLLOWING?

Flomax (tamsulosin)*	☐ **YES** ☐ **NO**	Rapaflo (siladosin)	☐ **YES** ☐ **NO**
**used to increase urine outflow; not be confused with Flonase*		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**

DRUG ALLERGIES ☐ No Known Drug Allergies

Allergy	Reaction	Allergy	Reaction

FAMILY MEDICAL HISTORY *(include any history of eye disease)* ☐ None

Paternal Grandparents	
Maternal Grandparents	
Father	
Mother	
Siblings	

SOCIAL HISTORY

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

DO YOU LIVE ALONE? ☐ **YES** ☐ **NO** **ARE YOU AT RISK FOR FALLS?** ☐ **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 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:

1. **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).
2. **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.
3. **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.
4. **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**

EYE CONSULTANTS
OF TEXAS

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**