North Texas Center for Sight

PLEASE FILL OUT ALL BLANKS COMPLETELY

PATIENT INFORMATION

Name:_____ Date of Birth:_____ Age:_____

Address:_____ City:_____ State:_____ Zip_____

Home Phone #:_____ Cell Phone #:_____ Work Phone #:_____

Email:_____ Social Security #: _____

Sex: □ Male □ Female Marital Status: □ Single □ Married □ Divorced □ Widowed

Race: □ African American □ Asian Pacific □ Caucasian □ Hispanic □ Native American □ Other_____

Occupation:_____ Employer: _____

Emergency Contact Name:_____ Phone #: _____

Primary Care Physician Name:_____ Phone #: _____

Date of Last Eye Exam:_____ Name of previous eye Dr.: _____

REASON FOR TODAY'S VISIT

□ Routine Eye Exam □ Cataract Evaluation □ Glaucoma Evaluation □ Retinal Evaluation
Other: _____

Please let us know about your history and family history of eye related problems and indicate whom below:

□ Diabetes: _____

□ Glaucoma: _____

□ Age Related Macular Degeneration: _____

HOW WERE YOU REFERRED TO US

Were you referred by a doctor? Name: _____ Specialty: _____

Were you referred by a friend/ family? Name: _____

Insurance Information

Attention All Patients

Payment is due at the time of service.

Method of payment: DCash □ Check □ Credit Card: MC/Visa/Discover **Insurance**

Information - Please present current insurance card

Name of Insurance Company: _____

Secondary Insurance Company: _____

Please complete if patient is not the primary insurance policy holder

Primary Policyholder Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security #: _____ Race: _____

We must emphasize that as a medical provider our relationship is with you, the patient, and not your insurance company. Your insurance is a contract between you, your insurance company and possibly your employer. **It is your responsibility to know and understand your insurance benefits covered by your insurance company.**

Co-payments, coinsurance and/ or deductibles are due at time of service. We will estimate the amount you owe based on information we receive from your insurance company.
However, you are responsible for paying the full amount determined by your insurance company once they have paid your claim, regardless of our estimation.

Before receiving services, you must verify that we are participating providers for your insurance company. In the event we are not participating providers with your insurance company, you are responsible for payment due at time of service.

It is your responsibility to provide us with your most current insurance information including copy of your current insurance card and a current referral if needed from your Primary Care Physician. We need to have the referral before you are seen. If not, your appointment will be rescheduled.

Assignment of Insurance Benefits

Medicare/ Other Insurance

I hereby assign benefits to be paid, on my behalf, to North Texas Center for Sight for any services furnished to me. I authorize any holder of medical information about me to be released to the Centers for Medicare and other insurers and its agents any information needed to determine these benefits payable for related services. I understand that I am responsible for my bill in the event Medicare or my insurer denies my claim. I understand and agree to be financially responsible for charges not paid within a reasonable time by insurance or other third party payer. I certify the information given with regard to insurance coverage is correct.

Date:_____ Signature: your common name here _____

North Texas Center for Sight
Acknowledgment of Review of the Notice
Of Privacy Practices
Patient Record of Disclosure

I have been given a copy or offered a copy of the Patient Rights and Patient Responsibilities of North Texas Center for Sight's, which explains how my medical information will be used and disclosed.

The HIPAA privacy rule gives individuals the right to request a restriction on notes and disclosure of their protected health information. The individual is also granted the right to request confidential communications, or that a communication be made by alternative means.

I wish to be contacted in the following manner: (Check all that apply)

☐ By my home telephone, my number is: _____
☐ It is ok to leave me a message with detailed information
☐ It is NOT ok to leave me a message with detailed information
☐ It is ok to contact me at work and my number is: _____
☐ It is ok to leave me a message at work with detailed information
☐ It is NOT ok to leave me a message at work with detailed information
☐ It is ok to leave a call back number only at my work number

I authorize you to discuss my medical history and release any and all medical information to the following individuals: (Fill in all that apply)

☐ My spouse, whose name is:_____phone _____

☐ My parent, whose name is:_____phone _____

☐ No one other than myself

☐ Fill in any other name you desire:_____

Patient Signature: here _____

Printed Name: _____

Date of Birth: _____

Name of legal guardian/ caretaker:

North Texas Center for Sight
Information about Refractions & Contact Lens
Fitting/ Modification
Why they are typically not covered by insurance

Federal insurance programs, like Medicare, and even private insurance contracts cover most medical and surgical eye exams, but they typically do not cover the eye service called "refraction".

What is Refraction?
Refraction is a testing procedure that measures how much optical (focusing) error an eye has. Certain eye measurements are taken using a variety of instruments. Based on these measurements, a series of trial lenses are placed in front of your eyes, and you are asked to compare one lens with another to determine which lens combination offers you better vision. This leads to a determination of how well you see.

When does insurance NOT pay for a Refraction?
Most health insurance was not designed to pay for non-emergency or routine procedures. Thus, Medicare, HMO's, and most private policies will not pay for refraction. Almost all insurance payers consider a refraction merely to obtain a prescription to improve vision as a routine procedure and will not reimburse it.

When DOES private insurance pay for Refraction?
Most health insurance will pay for medical examinations. If you have a sudden eye problem or visually threatening medical or surgical eye condition, refraction will be performed as part of your eye evaluation. Refraction in this instance is necessary to learn your eye's best vision capability at the time of examination. That "best vision" becomes a baseline for checking for any changes that may occur as your eye condition is treated. It is necessary part of the exam for both medical and legal purposes. In this care, it is possible that the refraction may be covered by your insurance. However, Medicare will not cover refraction under any circumstances.

Who has made this distinction for Insurance Coverage?
It is our government (for Medicare) or your own insurance company that determines exactly which clinical services are covered by their policies, and not your individual physician. Therefore if you have any questions or concerns regarding your coverage, you will need to address these with your specific insurance carrier.

Contact Lens Fitting/ Modification

Contact lens fitting/ modification is NOT a covered service by Medicare or most managed care Plans.

What is our policy?

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

Our fee for the refraction is $77.00, 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 I understand the above policy regarding refractions.

your common name here

Signature:_____Date:_____

North Texas Center for Sight **Patient History**

Name Occupation Race Date

DOB Age Height Weight Sex ☐ Male ☐ Female

Medical History:

☐ Anemia
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Back/ Neck Problems
☐ Bleeding Disorder
☐ Bronchitis
☐ Cancer
☐ Chest Pain
☐ Chicken Pox
☐ Congestive Heart Failure
☐ COPD
☐ Depression
☐ Diabetes Type
☐ Emphysema
☐ ENT Problems
☐ GI Problems
☐ Glaucoma
☐ GYN Problems
☐ HIV
☐ Hard of Hearing
☐ Heart Attack
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis Type
☐ High Blood Pressure
☐ High Cholesterol
☐ Kidney/ Bladder/ Urinary
☐ Liver Disease
☐ Measles
☐ Mumps
☐ Psychiatric Problems
☐ Pacemaker
☐ Palpitations
☐ Prostate Problems
☐ Restless Leg Syndrome
☐ Retina Problems
☐ Shingles
☐ Seizures
☐ Sinus Problems
☐ Sleep Apnea
☐ Stroke
☐ Thyroid Problems
☐ Ulcers
☐ Other
☐ History of Head or Eye Trauma **Surgical History:**

Family History:

☐ Asthma
☐ COPD
☐ High Blood Pressure
☐ Macular Degeneration
☐ Other
☐ Emphysema
☐ Diabetes
☐ Neurological
☐ Cataract
☐ Cancer
☐ Heart Disease
☐ Thyroid
☐ Glaucoma

Drug Allergies: ☐ No known allergies ☐ ☐ Latex allergy ☐ Sulfa allergy ☐ Adhesive tape

Medication allergy Reaction

Pharmacy Name: Location/ Number

Medications: If you need to add more medications, please add to the back of this form. Please document Drug name, Dosage and Times per day

Social History: Do you drink alcohol? Yes/ No Drinks per week? ☐

Do you smoke? Yes/ No PPD ☐ Years ☐ Previous smoker? Yes/ No Year quit? ☐

Other ☐

Family Doctor:

Other Drs.

Please check the following if you are currently experiencing

- ☐ Blurry Vision
- ☐ Burning Eyes
- ☐ Decreased Vision
- ☐ Dizzy Spells
- ☐ Double Vision
- ☐ Droopy Eyelid
- ☐ Eye Injury
- ☐ Eye Pain
- ☐ Eye Strain
- ☐ Flashing of Lights
- ☐ Floaters
- ☐ Foreign Body
- ☐ Glare
- ☐ Headaches
- ☐ Itchy Eyes
- ☐ Light Sensitive
- ☐ Red Eyes
- ☐ Seeing Halos
- ☐ Tearing
- ☐ Twitching
- ☐ Temporary Vision Loss
- ☐ Other _

Do You Wear Glasses? Yes/ No

Are Your Glasses: Single Vision Distance only/ Reading only Line Bifocals

Progressive Line Bifocals (No-Line)

Do You Wear Contact Lens? Yes/ No Days

Are Your Contact Lens: Soft/ RGP/ Hard **Wearing time:** Hours.

Single Vision

Monovision

Bifocal

Other ☐

Current Eye Medications -- Please List