TEXAS EYE INSTITUTE

*Chart #*_____

Welcome to the TEXAS EYE INSTITUTE. Please complete all the information below.

HOW DID YOU LEARN ABOUT TEXAS EYE INSTITUTE?

Yellow Pages ☐ Ad (Paper, Billboard, Mail) ☐ Patient ☐

Physician ☐ Optometrist ☐ Internet ☐ Other_____

If you were referred by a doctor, please fill in their name and address:

_____

Referring Doctor's Name **Street** **City** **St** **Zip**

PATIENT INFORMATION

Name_____

First **Middle** **Last**

Address_____

Street **City** **State** **Zip**

Apt # _____ Home _____ Work/Cell Phone_____

Social Security #_____Email Address_____

Date of Birth _____ Age_____ Sex: ☐M ☐F Marital Status: ☐ S ☐M ☐W ☐D

Occupation _____ Employer_____

Employer Address_____

In case of Emergency call:_____Phone_____

PARENT/GUARDIAN INFORMATION (if patient is a minor)

Name_____

First **Middle** **Last**

Address_____

Street **City** **State** **Zip**

Home _____Work Phone_____ Social Security #_____

Date of Birth _____ Age_____ Sex: ☐ M ☐ F Marital Status: ☐S ☐M ☐W ☐D

Occupation _____ Employer_____

RESPONSIBLE PERSON (if different from above for NON-MINOR)

Contact Person_____

First **Middle** **Last**

Address_____

Street **City** **State** **Zip**

Employer/Company/Agency Name_____Phone_____

(Form continues on back)

Please give the Registrar your insurance card for copying, then complete the * lines on this form. If no card is available, then complete the entire form:

***Patient Name**: _____ Chart #:_____

Primary Insurance Company Name:_____

Address:_____

Phone#:_____Type of Insurance:_____

Policy #_____ Group Number:_____

*Insured's (Policy Holder as it appears on card) Name: _____

*Insured's Date of Birth: _____/_____/_____ *Insured's Gender: ☐Male / ☐Female

*Patient's Relationship to Insured: ☐Self ☐Child ☐Spouse ☐Other _____

Secondary Insurance Company Name:_____

Addresss:_____

Phone #:_____ Type of Insurance:_____

Policy #:_____ Group Number:_____

*Insured's (Policy Holder as it appears on card) Name: _____

*Insured's Date of Birth: _____/_____/_____ *Insured's Gender: ☐Male / ☐Female

*Patient's Relationship to Insured: ☐Self ☐Child ☐Spouse ☐Other _____

Vision Insurance Company Name: _____

Addresss:_____

Phone #:_____ Type of Insurance:_____

Policy #:_____ Group Number:_____

*Insured's (Policy Holder as it appears on card) Name: _____

*Insured's Date of Birth: _____/_____/_____ *Insured's Gender: ☐Male /☐ Female

*Patient's Relationship to Insured: ☐Self ☐Child ☐Spouse ☐Other _____

NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. You have the right to obtain a paper copy of this Notice upon request.

Patient Health Information
Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We Use Your Patient Health Information
We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment, and Health Care Operations
Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.
Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.
Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses
We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures
We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:

Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
Research: We may use or disclose information for approved medical research.
Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
Judicial and Administrative Proceedings: We may disclose information in response to an appropriate subpoena or court order.
Law Enforcement Purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.
Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
Serious Threat to Health or Safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Military and Special Government Functions: If you are a member of the Armed Forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
Workers' Compensation: We may release information about you for Workers' Compensation or similar programs providing benefits for work-related injuries or illness.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights
You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.
Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.
Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.
Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.
Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.
Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices
We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints
If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person named below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person
If you have any questions, requests, or complaints, please contact:

Privacy Officer
Texas Eye Institute
7710 Beechnut St. Suite 100
Houston, TX 77074
Effective Date: April 14, 2013

I hereby acknowledge receipt of the Notice Of Privacy Practices given to me.

Patient's Name: _____

Guarantor's Name: _____

Signed: _____

Date: _____

If not signed, reason why acknowledgment was not obtained:

_____

Staff witness seeking acknowledgment:

_____ Date: _____

Financial Policy and Exam Authorization

Texas Eye Institute is committed to providing you with excellence in eye health care and a positive experience. Your clear understanding of our Financial Policy / Exam Authorization ***and*** your insurance plan / benefits is important to our professional relationship. If you have any questions about our professional fees or Policies, please contact one of our offices or our billing department at 713-777-7145.

Responsibility of Account

Payment for all services is due at the time services are rendered unless prior arrangements have been made with this office. Please save all itemized statements for completion of your own insurance forms and for tax purposes. Patients of Texas Eye Institute are responsible for payment of fees to the doctor, and any reimbursement by the insurance company is strictly between the patient and their insurance company. Payment in full for an account balance is due prior to your next visit. Our billing staff is available to assist with questions regarding your balance. If your account is past due, we will take all necessary steps to collect on the debt owed, including possible referral to a collection agency which may affect your credit record. You must notify our office of any changes in your insurance coverage, address, telephone number, or other demographic information, prior to your appointment. Failure to do this may result in you being fully responsible for the charges for any services provided.

Insurance

If we are contracted with your insurance company, we will submit your claim. All co-pays, co-insurance and deductibles are due and payable at time of service. Failure to provide necessary referrals or current accurate billing information will result in all charges for services the sole responsibility of the patient/responsible party. You are expected to understand your benefits coverage and financial responsibility. If we do not have a contractual obligation with your insurance company, you are responsible for 100% of the payment at time of service. You will be responsible for any balances not covered by your insurance. Should your account be sent to a third-party collector, you agree to pay an additional 30% of the balance or $50, whichever is greater. A return check fee of $25 will be assessed if your check is returned by your bank. Insurance is a contract between you and your insurance company. Texas Eye Institute are not a party to your contract. We will not become involved in disputes with your insurance company regarding copays, deductibles, co-insurance charges and or, non-covered/covered expenses, other than to supply information as necessary.

Medicare: We are participating providers with Medicare and will file the claim. We will also file with your secondary or supplementary policy as a courtesy to you. Our office does not file tertiary insurance policies. Please make sure that you provide our receptionist with your Medicare and supplementary insurance cards when you sign in for your appointment.

Medicaid: We accept most Medicaid insurances. If you have a Medicaid HMO plan, you are responsible for obtaining the referral from your primary care physician prior to your office visit. Patients must bring their current Medicaid card at every office visit. Failure to do so will result in rescheduling your appointment.

Indemnity/Fee For Service: As a courtesy to our patients, we will file with your insurance, provided you have assigned your benefits to us and have met your annual deductible and pay your co-insurance at the time of service. If you have not met your annual deductible, you must pay at the time of service and a claim will be filed with your insurance upon request.

Contracted Managed Health Care (HMO, POS, etc): It is your responsibility to make sure that your doctor is currently enrolled with your plan. You are obligated by your insurance company to pay any co-pay, deductible, co-insurance at the time of your visit. All necessary referrals must have been obtained prior to each visit. If your referral has not been completed prior to your arrival in the office, it may mean you will be responsible for paying the services received or rescheduling your appointment.

Workers' Compensation: We accept Workers Compensation insurance. However, your insurance information and verification of your injury must be made prior to your arrival in our office. The insurance and injury information must be given to the receptionist prior to your visit. Failure to do so may result in the rescheduling of your appointment. Private insurance will not pay for medical claims resulting from an on-the-job injury. If there are any questions regarding whether or not you have a workers' compensation claim please ask to speak to our Patient Billing Representatives.

Self-Pay / Private Pay: For patients who are not using insurance for their office visit, a $310 deposit will be due at the time of service. This deposit will be applied to the actual charges for the visit. If the visit charges exceed $310, we will make all efforts to inform you of any balance due. In the event the actual charges are less than $310, the difference will be refunded. ($250 medical exam plus $60 refraction fee).

Surgery / Same Day or Scheduled Procedures and/or Treatment

Insurance will be verified at the time of your pre-operative visit. Deductible and co-insurance amounts will be verified at the same time. Payment in full is required in advance if insurance benefits are not assigned or in the event there is no insurance. Prepayment of services that will be assigned to patient deductibles or coinsurance amounts is required at the time of the pre-operative visit or date of service in case of same day procedures and or treatment. We will make every effort to create an accurate estimate of your financial responsibility prior to providing these services. Any overpayment will be refunded to the patient. Any underpayment will be billed to the patient.

Refunds

If Texas Eye Institute owes you a refund due to an overpayment or credit balance, we will issue a refund after our billing team has verified it. Provided that there are no other balances or pending charges, we will then either refund your credit card or mail you a check depending on how you made your initital payment. If you have an email on file you will automatically receive an email receipt. A receipt will also be sent to your patient portal.

Minor Patients

Minor patients must be accompanied by a parent, authorized adult family member, or legal guardian to all appointments. The parent accompanying a child of a divorced family will be responsible for payment of charges incurred for the date of service regardless of insurance or divorce decree status. Unaccompanied minors will not be seen without a written approval of the minor's parent. In addition, for unaccompanied minors, non-emergency treatment will be denied unless charges have been preauthorized to an approved credit card or payment by cash or check at the time of service has been verified.

Well-Care Vision Coverage

Some plans will cover the cost of an annual eye exam whether or not a medical problem exists or is found on exam. This is typically called "well-care" coverage. Others will only pay the claim if a medical disorder is discovered. Find out what your plan says about this. Many plans do not consider the need for eyeglasses for distance or reading a medical disorder, so you may be responsible for the bill if you do not have well-care coverage. Likewise, "routine" or normal eye exams where no problem is found may not be covered without a "well-care" provision.

Routine and Medical Eye Exams

An ophthalmologist is a medical doctor (just like your family doctor or cardiologist) and provides very comprehensive, medical eye exams. However, ophthalmologists can also provide routine vision exams. Texas Eye Institute participates with certain vision plans for "routine eye exams". A routine eye exam is, by definition, a "regular check-up" for someone with no medical eye problems. If the doctor detects any medical condition, (dry eyes, floaters, eye infections, glaucoma, diabetes, etc.) the examination becomes a medical eye examination and will be submitted to your medical insurance. If your insurance plan requires a referral, you will need to obtain one for the medical eye examination. Due to insurance company regulations, routine and medical exams may not be performed on the same day. If you desire only the routine portion of the examination on your visit, the doctor may ask you to return another day for a medical eye examination. Please note that some insurance plans consider a routine eye exam to be a non- covered service. For more information, please request our "Medical Insurance vs Vision Insurance" explanation document.

Refraction

A refraction is a diagnostic test to determine your best corrected vision. This test is performed on your first visit with us, your annual visit, after Cataract Surgery and anytime your vision decreases significantly. A refraction is a vital test to the care of your eyes because it allows for assessment of your current eye health and the detection of eye diseases. We may provide you with a prescription to update your glasses or it may be medically necessary by your insurance to determine if you qualify for certain eye procedures such as, cataract or laser eye surgery. Even though this is a vital test to the care of your eyes, a refraction is a non-covered service through Medicare, and most insurance plans. Unfortunately, they do not differentiate between "medical refractions" and refractions performed solely for the purpose of providing glasses. We are required to charge for this service regardless of whether insurance will pay. **We charge $60 for the Refraction services (92015)**. If you do not desire a refraction, please inform our office staff prior to service.

Glasses and Contact Lens Exams

Examinations for spectacles and contact lenses are SEPARATE exams. If you require both exams on your visit, you will be charged a fee for your contact lens evaluation. The cost of the contact lens exam is payable at the time of service. You may have a vision plan which covers the contact lens exam fee, but it is then deducted from your materials benefit (for glasses or contact lenses). Also, if you decide to use your materials benefit elsewhere, your contact lens exam will NOT be covered. To avoid confusion and future billing issues, it is our office policy to accept payment for the contact lens exam at the time of your visit so you can apply your materials benefit to glasses and/or contact lenses.

Eye Exam Authorization

I hereby authorize Texas Eye Institute to examine and treat me, or the individual for whom I am responsible. I agree to and understand that my eye(s) must be dilated in order for the doctor to thoroughly check the retina of the eye. I agree to and understand that my eye may need to be patched as part of the treatment of my condition. I understand that if my pupils are dilated or my eye is patched after the exam, I may not be able to safely operate a motor vehicle and that the staff and doctors of Texas Eye Institute suggest that I evaluate my need for alternative transportation and the decision is solely mine, therefore, I will not hold Texas Eye Institute responsible.

Assignment of Benefits / Signature on File

I hereby authorize any insurance company to pay the proceeds of any benefits due me directly to Texas Eye Institute. A copy of this can be considered an original for insurance purposes. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. Medicare and insurance guidelines permit us to obtain a one-time signature that is valid for todays and future visits to our office. By signing below, the notation "signature on file" will appear in lieu of your signature on all Medicare and other insurance forms submitted for you by our office.

Authorization for Disclosure

I hereby authorize my employer or any person, company, or entity to release or obtain any information which may be necessary to determine benefits payable under my insurance policy on which I am covered. A copy of this can be considered an original for insurance purposes.

I have read and understand all of the Texas Eye Institute Financial Policies and Exam Authorization stated above and agree to accept Responsibility of Account. Texas Eye Institute reserves the right to change any and all fees at any time. The contents of this document will remain in effect unless revoked by me in writing.

Patient's Name _____ Guarantor's Name _____

Signature _____ Date _____

(Signature of patient or responsible party)

Glasses and Contact Lens Exams

Examinations for spectacles and contact lenses are SEPARATE exams. If you require both exams on your visit, you will be charged a fee for your contact lens evaluation with a contact lens professional. You may have a vision plan which covers the contact lens exam fee, but it is then deducted from your materials benefit (for glasses or contact lenses). Also, if you decide to use your materials benefit elsewhere, your contact lens exam will NOT be covered. To avoid confusion and future billing issues, it is our office policy to accept payment for the contact lens exam at the time of your visit so you can apply your materials benefit to glasses and/or contact lenses.

Contact Lens Policy

The Glasses prescription you receive from Texas Eye Institute is not a contact lens prescription. A qualified optician must fit contact lenses. Texas Optics Institute or an optical shop of your choice may fit the contact lenses for a separate fee. After your contact lens fitting is completed, it is your right to receive a copy of your contact lens specification from the optical shop selected if you desire.

I have read and understand the above contact lens policy.

Patient's Name _____ Guarantor's Name _____

Signature _____ Date _____
(Signature of patient or responsible party)

Appointment Reminder Authorization Form

Texas Eye Institute utilizes an Appointment Reminder System to contact you by telephone, text and email at the phone number and address provided to remind you of future appointments and other matters associated with your overall healthcare component. A message will be left by the Appointment Reminder System on your answering machine and/or voice mail service.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

☐ I CONSENT

☐ DO NOT CONSENT

to being notified by the Appointment Reminder System via phone, text and email.

Home Phone: _____

Cell Phone: _____

Email: _____

Patient's Name _____ Guarantor's Name _____

Signature _____ Date _____
(Signature of patient or responsible party)

Patient Release of Information Authorization Form

Many of our patients allow family members such as their spouse, significant others, parents, or children to call and request the results of tests, procedures, and financial information. Under the federal requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

☐ I **DO NOT** authorize the release of information regarding my medical care, condition, test results, and financial information to anyone other than myself.

I authorize Texas Eye Institute to release my records and any information requested to the following individuals:

Full Name: _____

Date of Birth: _____ Phone Number: _____

Relation to patient: _____

Full Name: _____

Date of Birth: _____ Phone Number: _____

Relation to patient: _____

Full Name: _____

Date of Birth: _____ Phone Number: _____

Relation to patient: _____

Authorization Regarding Messages (please check all that apply)

☐ I authorize Texas Eye Institute to leave a detailed message on my phone number regarding medical treatment, care, test results or financial information.

☐ I authorize you to leave a message with anyone who answers my phone number.

Patient's Name _____ Guarantor's Name _____

Signature _____ Date _____

(Signature of patient or responsible party)

Medicaid Waiver Form for Prism Lens and Refractive Services

For patients 21 years or older with Medicaid or Medicaid Managed Care Plans.

I understand that the servicing provider may be required to perform a **refraction** and or distribute prism lens/s to obtain the most appropriate optical determination. A refraction may be a required part of my exam to determine if other treatments are necessary. A prism lens may be required to correct vision abnormalities and aid in my eyes working together. Or a refraction and or distribute prism lens/s are requested by myself for the prescription required for eyeglasses or contact lenses.

I voluntarily agree and consent to undergo the services and/or handing of lens, as a private paying patient. I agree to waive my Medicaid and or Medicaid Managed Care Plan benefits for refraction services and or prism lens during the period of my care with Texas Eye Institute. I will be responsible for paying the refraction and or Prism lens fee at the time of service or any refraction and or Prism lens balances accrued thereafter.

- Refraction (92015) - (Determination of refractive state) for the prescription required for eyeglasses or contact lenses - $60
- Prism Lens (V2718) – Press-on lens, Fresnel Prism, per lens - $60

I understand that the $60 refraction fee and/or the $60 Prism Lens fee is my responsibility, and I am expected to pay this at the time of service.

I understand that I have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Patient's Name _____ Guarantor's Name _____

Signature _____ Date _____

(Signature of patient or responsible party)

HMO / POS Insurance Referral Waiver Form

I understand that the services provided by the Texas Eye Institute are not eligible for reimbursement by my HMO / (POS) Health plan without a valid referral from my primary care provider.

I voluntarily agree and consent to undergo the services, as a private paying patient. I agree to waive my in network Managed Care Plan benefits for the period of my care with Texas Eye Institute. I will be responsible for paying all services I receive at time of service or any balances accrued thereafter. The provider will only file a claim to my HMO / POS Managed Care plan in the event I am able to obtain a valid required referral in a timely manner with the correct referral information, such as; correct date of service, insurance authorization number, correct billing provider, and number of visit/s.

Patient's Name _____ Guarantor's Name _____

Signature _____ Date _____

(Signature of patient or responsible party)