Patient Account Number: ________________________

Patient Demographic

Personal Information

First Name: _______________________________ **Middle Initial:** _________ **Last Name:** _______________________________

Mailing Address: ____**City:**________________ **State:**______ **Zip Code:**_________

Street Address: ____**City:**________________ **State:**______ **Zip Code:**_________

Date of Birth: _____/_____/________ **Age:** ________ **Gender:** **Male** **Female** **(Circle One)**

Social Security Number: ________ - ________ - ________

Race: _________________________________ **Ethnicity:** Not Hispanic or Latino / Hispanic or Latino **(Circle One)**

Primary Language: _________________________________

Preferred Contact

Home Phone Number: (_____) ________ - _______ **Mobile Phone Number:** (_____) ________ - ________

Appointment Reminder Method: Phone call or Mobile Text (**Circle One**)

Is it okay to leave voicemail messages: **YES or** NO **(Circle One)**

Email: ____

I understand that email is not a secure method of communication and that personal health information, payment receipt, Invoices and billing summary sent via email may not be private.

Status

	Marital		Employment		Student Status		How did you hear about us?
	Single		Full Time		Full Time Student		Friend/Family
	Married		Part Time		Part Time Student		Doctor
	Divorced		Retired				Website
	Widowed		Self Employed				Social Media
	Separated		Not Employed				Other

Guardian/Responsible Party Info

First Name: _______________________________ **Middle Initial:** _________ **Last Name:** _______________________________

Mailing Address: ____**City:**________________ **State:**______ **Zip Code:**_________

Date of Birth: _____/_____/________ **Relation to Patient:** ______________________________

Emergency Contact

First Name: ____________________________ **Last Name:** ____

Relationship: ___________________________ **Phone Number:** ____

Patient Account Number: ______________________

Patient Insurance Information

First Name: ______________________________ **Middle Initial:** _________ **Last Name:** ______________________________

Primary Insurance Information

Insurance Company Name: ______________________________

Name of Insured: ______________________________

Relationship to Patient: ______________________________

Date of Birth: _____/_____/________

Policy Number: ____________________

Group Number: ____________________

Secondary Insurance Information

Insurance Company Name: ______________________________

Name of Insured: ______________________________

Relationship to Patient: ______________________________

Date of Birth: _____/_____/________

Policy Number: ____________________

Group Number: ____________________

Vision Insurance Information

Insurance Company Name: ______________________________

Name of Insured: ______________________________

Relationship to Patient: ______________________________

Date of Birth: _____/_____/________

Policy Number: ____________________

Social Security Number: ______ - ______ - ______

Patient Account Number: ______________________

MEDICAL HISTORY

Preferred Pharmacy: ____

Address: ______________________________ City: ______________________ State: ______________

Zip: ______________ Phone: ______________________ Fax: ______________________

ALLERGIES AND MEDICATIONS

Allergies:

____

____

Please bring a list of all current medications and dosages with you to your appointment.

Patient Account Number: ______________________

Who is your primary care physician? ______________________________

If you have a Rheumatologist, who is it? ______________________________

If you have an Endocrinologist, who is it? ______________________________

Who has referred you to our office today? ______________________________

FAMILY HISTORY:

No significant family history ☐

	FATHER	MOTHER	SISTER	BROTHER
Diabetes	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐
Macular degeneration	☐	☐	☐	☐
Retinal detachment	☐	☐	☐	☐
Blindness	☐	☐	☐	☐

ALCOHOL USAGE:

None ☐

Occasionally/Social ☐

1-2 Drinks/day ☐

3 or more Drinks/day ☐

TOBACCO USAGE:

☐ Never Smoked
☐ Former Smoker
☐ Current Every day Smoker
☐ Current Some Day Smoker

If smoker, smoking history is: ________ packs per day for how long ________________

Patient Account Number: ___________________________

GENERAL MEDICAL HISTORY:

	YES	NOTES
Patient denies any history of medical conditions or diseases	☐	______________________
CARDIOVASCULAR		
Congestive heart failure	☐	______________________
Coronary artery disease	☐	______________________
Elevated cholesterol	☐	______________________
Heart attack	☐	______________________
Heart valve disease	☐	______________________
Hypertension	☐	______________________
Pacemaker	☐	______________________
Other cardiovascular	☐	______________________
DERMATOLOGIC		
Keloid formation	☐	______________________
Shingles	☐	______________________
Skin cancer	☐	______________________
Other dermatologic	☐	______________________
GASTROINTESTINAL		
Colon cancer	☐	______________________
Crohn’s	☐	______________________
GI bleeding	☐	______________________
Ulcerative colitis	☐	______________________
Other gastrointestinal	☐	______________________
GENITOURINARY		
Enlarged prostate	☐	______________________
Kidney disease	☐	______________________
Other genitourinary	☐	______________________
HEMATOLOGIC		
Anemia	☐	______________________
Bleeding disorder	☐	______________________
Blood clots	☐	______________________
Leukemia	☐	______________________
Sickle cell	☐	______________________
Other hematologic	☐	______________________

Patient Account Number: ______________________

	YES	NOTES
INFECTIOUS DISEASE		
Hepatitis C	☐	______
HIV	☐	______
MRSA	☐	______
Tuberculosis	☐	______
Other infectious disease	☐	______
METABOLIC/ENDOCRINE		
Diabetes, Type I	☐	______
Diabetes, Type II	☐	______
Thyroid disease	☐	______
Other metabolic/endocrine	☐	______
MUSCULOSKELETAL		
Gout	☐	______
Osteoarthritis	☐	______
Rheumatoid arthritis	☐	______
Other musculoskeletal	☐	______
NEUROLOGICAL		
Dementia	☐	______
Migraines	☐	______
Multiple sclerosis	☐	______
Seizures	☐	______
Stroke	☐	______
Other neurological	☐	______
PULMONARY		
Asthma	☐	______
COPD	☐	______
Lung cancer	☐	______
Sarcoid	☐	______
Sleep apnea	☐	______
Other lung disease	☐	______
PSYCHIATRIC		
Anxiety	☐	______
Bipolar	☐	______
Depression	☐	______
Schizophrenia	☐	______
Other psychiatric	☐	______

Patient Account Number: ___________________________

	YES	NOTES
WOMEN'S HEALTH		
Breast Cancer	☐	____________________
Ovarian cancer	☐	____________________
Other women's health	☐	____________________

PAST EYE SURGERIES:	YES	NOTES
1. LASIK	☐	____________________
2. PRK	☐	____________________
3. RK	☐	____________________
4. Corneal Transplant	☐	____________________

PAST SURGICAL HISTORY:

	SURGERY DETAILS	DATE
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Plano
West Plano Medical Center
4100 W 15th St., Suite 210
Plano, Texas 75093
Phone: (972) 867-7777
Fax: (972) 519-1679

NORTH TEXAS EYE CENTER

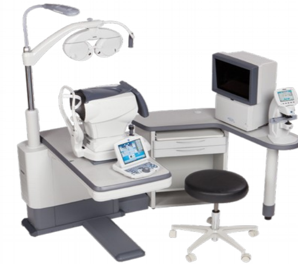
Lewis J. Frazee, M.D. | James A. Passmore, M.D. | Ellen Ngo, M.D.

Lewisville
Hebron Office Plaza
751 Hebron Pkwy., Suite 230
Lewisville, Texas 75057
Phone: (972) 867-7777
Fax: (972) 519-1679

Refraction Services and Fees

These images show the older phoropter on the left and the newest EPIC refracting station on the right. At North Texas Eye Center, we, primarily, use the newest and most sophisticated device, the EPIC.

These devices are used to determine your prescription for glasses and to aid in the determination of the prescription for contact lenses.



What do they do? These instruments determine your need for lenses to correct your refractive error, also referred to as your refraction, or, your eyeglass prescription. This part of your examination is where the doctor, or other staff member flips various lenses inside the devices and asks question such as “which is better, number 1 or number 2” We keep asking these questions until we have resolved an accurate prescription.

Why do I have to pay for it? Most medical insurance plans, including Medicare, do NOT cover refractions or routine eye examination (when no medical eye problem is known or suspected).

If you have a separate vision plan that covers routine or annual eye examinations and/or glasses, please let us know. Your vision plan may assist you with your eye care needs that are not covered by your medical plan.

Our office fee for a refraction is $55.00 and this fee is collected at the time of service in addition to any co-payment your plan may require. Should your plan pay us for the refraction, we will reimburse you accordingly.

Is this new? Refractions (CPT code 92015) has been a “non-covered” service since Medicare was created in 1965. Since about 2007, Medicare has been enforcing the policy of requiring eye doctors to charge separately for refractions.

Patient Acknowledgment:

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service and understand it is due at the time of service. I understand that any co-payment, coinsurance, or deductible I may have are separate from and not included in the refraction fee.

The Refraction acknowledgement is good for one year of signed date. Please understand by signing this form you are authorizing the Provider or Clinician from North Texas Eye Center to complete this test when necessary for once a year.

Print Patient’s Name ____ Patient’s D.O.B ____________________________

Patient Signature (or Parent for a minor) ____ Date _________________________

Thank You
For taking the time to learn about refractions

[OFFICE ONLY]

Patients Account # ____ Refraction Form Expires on __________________

Appointment "No Show" Policy

As of January 1, 2020, North Texas Eye Center has instituted a **$50.00 no show fee** for patients failing to come for a scheduled appointment without prior notification. This fee will apply to every individual for each appointment time that is missed.

At North Texas Eye Center, we greatly value our patients and want to provide the best and most efficient service possible. By instituting this policy, we want to reduce the waiting time for scheduling appointments.

Our policy is to provide multiple reminders to our patients about the appointments that have been scheduled, so that when conflicts arise, we can be noticed in advance and offer those appointments to other patients. At the time an appointment is scheduled the patient has a choice of text or email reminder. We then contact patients again as the appointment approaches. Please confirm with us today that we have your preferred contact information.

North Texas Eye Center understands that circumstances arise that make it difficult to give us advance notice of an appointment that will be missed. At their discretion our staff may excuse a first missed appointment of the year. Otherwise, for each missed appointment without prior notice, the new **$50.00 "no show" fee** will be billed to your account. This fee will be billed to any individual who misses any appointment.

Patients who have not paid their "no show" fee will not be allowed to schedule further appointments with North Texas Eye Center. Patients who repeatedly fail to show up for appointments without advance notice may be dismissed from the practice.

By Signing below, I, the patient acknowledges that I have read the contents of this document and have been offered a copy of this record.

Name: ____ Account Number: ______________

Signature: ____ Date of Birth: ____/____/________

Patient Financial Policy

Patients that require a referral from your Primary Care Provider it is your responsibility to obtain that referral prior to your visit. Our office has attempted to gain information and/or preauthorization from your healthcare and insurance provider. If your insurance requires a referral for full benefits to be paid, please make sure we have that authorization on file to proceed with the requirements to bill your insurance payer for your healthcare services provided at North Texas Eye Center.

You will be responsible today for any co-pays, deductibles, co-insurance, and non-covered expenses. If you do not have insurance payment in full at the time of service, we do provide financial arrangements if needed.

Self-Pay patients will be required to pay all fees at the time of service. If for any reason the full self-pay balance is not collected at time of check out, the Billing Department will bill the patient/legal guardian for the remaining charges for healthcare services provided by North Texas Eye Center.

Our facility will file both primary, secondary, and tertiary insurance claims for medical services rendered. We cannot file claims correctly without accurate information from you. Proof of insurance must be presented at each visit.

I understand that I am responsible for payments of fees for any specialized test requested by my physician for diagnostic purposes if my Medicare or Insurance company denies payment of such diagnostic test for any reason.

North Texas Eye Center (NTEC) is a participating provider for Medicare. This means we must accept Medicare's allowed charge for the services rendered. Medicare will pay 80% of the approved amount. The patient is responsible for the remaining 20%, plus any out-of-pocket deductible. We will write off the difference between what we charge and what Medicare approves. If you have secondary insurance, we will submit the claim for the remaining balance after Medicare has paid. Please remember that although we accept assignment for Medicare, the patient, by federal law, is responsible for any portion of the approved amount not paid by Medicare or a secondary insurance company.

In the unlikely event that your payment is returned to us unpaid, we may elect to re-present your payment, either electronically or by paper draft, to your financial institution up to two more times. We may also collect a return processing charge by the same means, in an amount not to exceed that permitted by state law.

Contact Lens Policy:

1. I understand that in order to get a contact lens prescription, I would need to complete a routine eye examination.
2. I understand that a routine eye exam is needed every 12 months to prescribe contacts.
3. I understand that a contact lens fitting is an additional charge.

Contact Lens Return Policy: North Texas Eye Center (NTEC) requires any contacts that are returned to be in the original container they were delivered in. NTEC cannot return defective lenses without the original packaging, and you would be held financially responsible for the lenses without it. Financial Obligation for ordered lenses is initiated at the time the order is placed

Divorced or Separated Parents: I understand that I'm responsible for payment of all services rendered. Any court ordered judgment must be between the individuals involved, without including our practice (North Texas Eye Center)

I have been provided with the information above and understand that preauthorization by my insurance provider is not a guarantee of payment on my claim. I also understand that all remaining balances are my responsibility and will be paid to North Texas Eye Center.

Unpaid medical bills will be transfer to NTEC business associate collection agency or billing firm by following the HIPPA privacy rules. This Financial Policy Form will be used as your consent and understanding that NTEC will notified the patient about outstanding balances before transferring patient unpaid dept to their collection agency.

My signature on this form will also serve as a "signature on file" for processing insurance claim forms and show that I understand all office billing policies.

Print Patient's Name Date

Signature of Patient's or Legal Guardian Relationship to Patient if Not Self

OFFICE ONLY: Patient Account Number: ___________________________