Patient Account Number: _____

NTEC
North Texas Eye Center

Patient Demographics

Personal Information

First Name: _____ Middle Initial: _____ Last Name: _____

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

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

Date of Birth: ___/___/_____ Age: _____ Birth gender: Male Female (circle one)

Social Security Number: _____-_____-_____

Race: _____ Ethnicity: Not Hispanic/Latino Hispanic/Latino (circle one)

Primary Language: _____

Home telephone number: _____ Mobile telephone number: _____

Email address: _____

I understand that email is not a secure method of communication and that personal health information, payment issues, invoices and billing information is not secure and is not private.

Appointment reminder Method: Telephone call Text message Email (circle all that apply)

Is it okay to leave a voice mail message? Yes No (circle one)

Marital	Single	Married	Divorced	Widowed	Separated	(circle one)
Employment	Full time	Part time	Retired	Self-employed	Not-employed	(circle one)
Student	Full time	Part time				(circle one)

How did you hear about us? Friend/family Doctor Website Social media Other (circle one)

Guardian/Responsible party Information

Relationship to patient: _____

First Name: _____ Middle Initial: _____ Last Name: _____

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

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

Date of Birth: ___/___/_____ Age: _____

Emergency contact

Relationship to patient: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Home telephone number: _____ Mobile telephone number: _____

Patient Account Number: _____

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North Texas Eye Center

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: _____

Group number: _____

Patient Account Number: _____

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Patient Medical Information

Preferred pharmacy: _____

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

Phone: _____ Fax: _____

Medication allergies: _____

_____

Medications (including strength)	Quantity	Times per day/week/month

Patient Account Number: _____

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Patient Medical Information

Note: THIS INFORMATION IS VITAL FOR CONTINUITY OF CARE

Primary Care Physician: _____

Rheumatologist: _____

Endocrinologist: _____

Other Specialist: _____

Other Specialist: _____

Family History:

No significant family history: ☐

	Father	Mother	Sister	Brother
Diabetes	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐
Macular degeneration	☐	☐	☐	☐
Retinal detachment	☐	☐	☐	☐
Blindness	☐	☐	☐	☐

Alcohol Usage: None ☐ Social ☐ 1-2 drinks per day ☐ 3 or more drinks per day ☐

Tobacco Usage: Never ☐ Former smoker ☐ Occasional smoker ☐ Daily smoker ☐

If smoker: Packs per day _____ For how long: _____

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GENERAL MEDICAL HISTORY:

	Yes	Notes if "yes"
No medical conditions or diseases	☐	
Cardiovascular		
Congestive Heart Failure	☐	
Coronary Heart Disease	☐	
Elevated Cholesterol	☐	
Heart Attack	☐	
Heart Valve Disease	☐	
Hypertension	☐	
Pacemaker	☐	
Other	☐	
Dermatologic		
Keloid Formation	☐	
Shingles (Herpes)	☐	
Skin Cancer	☐	
Other	☐	
Gastrointestinal		
Colon Cancer	☐	
Crohn's Disease	☐	
GI Bleeding	☐	
Ulcerative Colitis	☐	
Other	☐	
Genitourinary		
Enlarged Prostate	☐	
Kidney disease	☐	
Other	☐	
Hematologic		
Anemia	☐	
Bleeding Disorder	☐	
Blood Clots	☐	
Leukemia	☐	
Sickle Cell Disease	☐	
Other	☐	

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Patient Account Number: _____

	Yes	Notes if "yes"
Infectious Disease		
Hepatitis C	☐	
HIV	☐	
MSRA	☐	
Tuberculosis	☐	
Other	☐	
Metabolic / Endocrine		
Diabetes Type I	☐	
Diabetes Type II	☐	
Thyroid Disease	☐	
Other	☐	
Musculoskeletal		
Gout	☐	
Osteoarthritis	☐	
Rheumatoid arthritis	☐	
Other	☐	
Neurologic		
Dementia	☐	
Migraines	☐	
Multiple Sclerosis	☐	
Seizures	☐	
Stroke	☐	
Other	☐	
Pulmonary		
Asthma	☐	
COPD	☐	
Lung Cancer	☐	
Sarcoidosis	☐	
Sleep Apnea	☐	
Other	☐	

Patient Account Number: _____

	Yes	Notes if "yes"
Psychiatric		
Anxiety	☐	_____
Bipolar Disorder	☐	_____
Depression	☐	_____
Schizophrenia	☐	_____
Other	☐	_____
Women's Health		
Breast Cancer	☐	_____
Ovarian Cancer	☐	_____
Other	☐	_____
Past Eye Surgery		
LASIK	☐	_____
PRK	☐	_____
Radial Keratotomy	☐	_____
Corneal Transplant	☐	_____
Cataract	☐	_____
Other	☐	_____

PAST SURGERY HISTORY:

	Date	Surgery Details
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

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Billing / Insurance Information

You will be responsible for any co-pays, deductibles, co-insurance and non-covered expenses.

Pre-Authorization: Our billing staff will assist in obtaining any required pre-authorization and benefits detailing your financial obligations prior to your procedure or surgery. If your insurance requires a referral for full benefits to be paid, please make sure that we have that authorization on file to proceed with the requirements to bill your insurance payer for you healthcare services.

Self-Pay Patients: Payment is expected at the time of service. Payments may be made by cash, check, money order or credit card. If, for any reason, the full self-pay balance is not collected at the time of check-out, the billing department will see the patient/legal guardian for the remaining charges for healthcare services provided.

Refractions: Routine eye examinations for glasses prescription are usually not covered by medical insurance plans and are never covered by Medicare. The $55 fee must be paid at the time of service.

Appointment "No Show" policy: Patients failing to come for a scheduled appointment without prior notification will be charged a $50.00 no-show fee. The fee will apply to every individual for each appointment time that is missed. Patients who have not paid their no-show fee will not be allowed to schedule further appointments.

Contact Lens Policy:

- An eye examination is needed every 12 months in order to prescribe contacts.
- Contact lens fittings are an additional charge.
- Any contacts that are returned need to be in the original container in which they were delivered.

I have been provided with the information above and understand that pre-authorization by my insurance provider is not a guarantee of payment on my claim. I understand that all remaining balances are my responsibility and will be paid to North Texas Eye Center (NTEC). Unpaid medical bills will be transferred 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 notify the patient about outstanding balances before transferring patient unpaid dept to this 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 and insurance policies.

Print patient's name: _____ Date: _____

Signature of Patient or Legal Guardian: _____

Relationship to Patient if the Legal Guardian: _____

Patient Account Number: _____

NTEC
North Texas Eye Center

Refraction Services

What is a refraction?
A refraction, also known as a vision test, is a typical part of an eye examination. This examination helps your eye doctor to determine your precise prescription for glasses and/or contact lenses.

A value of 20/20 is typically considered to be normal vision. People with 20/20 vision can read letters that are 3/8 of an inch tall from a distance of 20 feet. If you don't have 20/20 vision, this might mean that you have a refractive error. A refractive error occurs when light does not bend properly as it passes through the lens of your eye. The refraction test will help your doctor determine what prescription lenses you need to achieve your best vision.

Why is this test important?
This test helps your doctor to determine if you need prescription lenses and the precise prescription needed for optimal vision. The results of this test are used to diagnose refractive errors such as astigmatism, farsightedness or nearsightedness. Furthermore, the results can help diagnose more severe eye problems, like macular degeneration or cataracts.

The cost of a refraction
While a refraction is essential for a comprehensive eye examination, the charge for a refraction is only covered by some insurance companies, but, not all. Medicare does not cover refractions because the test is considered to be a part of a routine examination and not medically necessary. Medicare does not cover most routine procedures, but rather, health related vision expenses. If you have a separate vision coverage, let us know. You vision plan might cover your refraction.

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

I acknowledge and authorize the provider or clinician to complete this test. I, furthermore, understand that the doctor cannot write a glasses prescription without this test. And, the doctor cannot discuss the need for new glasses without this test.

Patient signature: _____ Date: _____

I decline the refraction

I decline the refraction test and understand that I will not be getting a new prescription for glasses or contact lenses at the end of my appointment. In addition, I understand that neither the staff nor the doctor can answer any questions about my prescription as a consequence of declining this test.

Patient's printed name: _____

Patient's signature: _____

Date: _____

NORTH TEXAS EYE CENTER

NOTICE OF PRIVACY PRACTICE
ACKNOWLEDGMENT & HIPPA RELEASE FORM

By signing this form, you will consent to our use and disclosure of your protected health information (PHI) for the following purposes:

- To conduct and plan treatment, including multiple healthcare providers who may be involved in your treatment directly or indirectly
- To obtain payment for services provided to you through third-party payers
- To conduct normal healthcare operations such as quality assessments, etc.

I have received/been offered a copy of the above-named office's HIPPA Notice of Privacy Practice (NOPP) containing a detailed description of the use and disclosure of my PHI.

I understand that I have the right to revoke this consent at any time by giving my written notice of this revocation, submitted to our office. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation.

I have had full opportunity to read and consider the contents of this consent form and this office's NOPP. I understand that, by signing this consent, I am giving my consent to your use and disclosure of my PHI to carry out treatment, payment activities and health care operations.

Designated Individual Release Information

I, _____ (Patient or Guardian's full name) hereby acknowledge that I am giving consent to North Texas Eye Center for use and disclosure of my protected health information to carry out treatment, payment activities, appointment reminders and other health care operations. I have the right to revoke this consent at any time by submitting a written declination letter.

You may also elect to have your PHI shared with your spouse, children or other party outside the normal practice of North Texas Eye Center's healthcare operations. Please disclose below with whom you may want to share your PHI.

Name of person to whom your medical records are to be released:

_____ Phone number: _____

_____ Phone number: _____

_____ Phone number: _____

Patient Account Number: _____