

PATIENT INFORMATION

Name: _____ Date of Birth: _____ Age: _____

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

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

Email: _____ Social Security #: _____

Sex: Male Female Marital Status: Married Single Divorced Widowed

Race: African American Asian Pacific Caucasian Hispanic Native American Other: _____

Occupation: _____ Employer: _____

Employer's Address: _____

Emergency Contact Name: _____ Phone #: _____

Primary Care Physician Name	Address	Phone #	Fax #

Date of Last Eye Exam	Name of Previous Eye Care Provider

REASON FOR TODAY'S VISIT

Cataract Evaluation Routine Eye Exam Surgery to reduce your dependency on glasses/contacts

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

Friend/Family/Acquaintance, Name: _____

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

Address	City, State, Zip	Phone #	Fax#

TV, Channel _____ Radio, Station _____ Magazine _____ Internet Paper

Other: _____

Attention All Patients:

Payment is due at the time of service.

Method of payment: Cash Check Credit Card: MC/Visa/AMEX/Discover Care Credit

PATIENT AUTHORIZATION – ASSIGNMENT OF MEDICARE AND INSURANCE BENEFITS:

I request that payment of authorized Medicare, Medigap or any other insurance be made on my behalf to the Key-Whitman Eye Center, Key-Whitman Surgery Center or Key-Whitman Optical Center for any services furnished to me by a physician of the group. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and other insurers and its agents any information needed to determine these benefits payable for related services. In Medicare assignment cases, or insured contracts, the provider agrees to accept the charge determination of the Medicare carrier or insurance and I am responsible for the deductible (Medicare deductible - \$140), co-insurance (or the 20% Medicare) or insurer does not pay, and for non-covered services (such as the \$45 refraction fee not covered by Medicare and most other insurances). I understand that I am responsible for my bill in the event Medicare or my insurer denies my claim. I authorize release of my medical records to my primary care physician or other physicians associated with the continuity of my care.

My signature below further verifies that I have not joined an HMO or other entity which my designated insurance (Medicare or Insurance card) benefits have been relinquished.

I have been given the opportunity to read the "Patient Information Privacy Notice" for the Key-Whitman Eye Center and the Key-Whitman Surgery Center.

Signature _____ Date _____

Notice concerning complaints:

Complaints about physicians as well as other licensees and registrants of the Texas State Board of Medical Examiners, including physician assistants and acupuncturists, may be reported for investigation at the following address: Texas State Board of Medical Examiners, Attention: Investigations, 1812 Centre Creek Dr., Suite 300, P.O. Box 149134, Austin, TX 78714-9134, 1-800-201-9353.

Complaints regarding Key-Whitman Surgery Center may be registered with the Department of State Health Services Facility Licensing Group, 1100 West 49th St., Austin, TX 78756, 1-888-973-0022.

Thank you for choosing Key-Whitman Eye Center & Key-Whitman Surgery Center today!

Patient Record of Disclosure

The HIPAA privacy rule gives individuals the right to request a restriction on notes and disclosure of their protected health information (PHI). 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: _____

Printed Name: _____

Date of Birth: _____

Name of legal guardian/caretaker: _____



2801 Lemmon Avenue, Dallas, TX 75204
3060 Communications, Suite 205, Plano, TX 75093
910 N. Davis Dr., Suite 400, Arlington, TX 76012
214-220-3937 or 1-800-442-5330

INFORMATION ABOUT REFRACTIONS & WHY THEY ARE TYPICALLY NOT COVERED BY INSURANCE

Federal insurance programs, like Medicare and Medicaid, 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, Medicaid, HMOs, and most private policies will not pay for refraction. Almost all insurance payors 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 the examination. That “best vision” becomes a baseline for checking for any changes that may occur as your eye condition is treated. It is a necessary part of the exam for both medical and legal purposes. In this case, 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 and Medicaid) 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.

What is Our Policy?

We are dedicated to providing our patients with the very best medical and surgical eye care in the region. 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 this matter.

Our fee for the refraction is \$45.00*, 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.

Signature_____

Date_____

Witness_____

Date_____

*Fees are subject to change without notice.

NAME _____ **RACE** _____ **DATE** _____
DOB _____ **AGE** _____ **HT** _____ **WT** _____ lbs stated by patient **SEX** Male Female

MEDICAL HISTORY:

- | | | |
|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> ENT Problems | <input type="checkbox"/> Other Psychiatric Problems |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> GI Problems | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gyn Problems | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Back/Neck Problems | <input type="checkbox"/> HIV | <input type="checkbox"/> Restless Leg Syndrome |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Hard of Hearing | <input type="checkbox"/> Retina Problems |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Hepatitis Type | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> COPD | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Depression | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney/Bladder/Urinary Problems | <input type="checkbox"/> Any other problems of concern: |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Liver Disease | _____ |

SURGICAL HISTORY: (list all prior surgeries to the best recollection)

Complications with anesthesia? Yes No If yes, what is the complication? _____

FAMILY HISTORY OF OCULAR DISEASE:

- Macular Degeneration Whom: _____
 Glaucoma Whom: _____
 Diabetes Whom: _____

DRUG ALLERGIES: No known allergies Latex allergy Sulfa allergy Adhesive tape

Medication allergy _____

PHARMACY NAME _____ **Location** _____ **Phone** _____

MEDICATIONS: (Medications may be listed in the form of a patient's current list.)

Drug Name	Dosage	Times per day

If you need to add more medications, please add to the back of this form.

SOCIAL HISTORY:

Do you drink alcohol? Yes No Drinks per week? _____

Do you smoke? Yes No PPD _____ Years _____

Previous smoker? Yes No When did you quit? _____ PPD _____ Years _____