

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 #: _____

MEDICAL INFORMATION

List all allergies to medication/latex/adhesives: _____

Primary Care Physician Name _____ Address _____ Phone # _____

Date of Last Eye Exam _____ Name of Previous Eye Care Provider _____

Diabetes/Year diagnosed _____ Insulin Oral Medication _____ Diet-Controlled

Glaucoma Lung Problems Bleeding Problems Heart Problems Stomach/Bowel Problems

Kidney Problems Liver Problems HIV Positive Use Plaquenil Prolonged use of Steroids

Use Tobacco Use Alcohol Other Serious Medical Problem _____

Reason for today's visit:

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

Other: _____

HOW WERE YOU REFERRED TO US

Friend/Family/Acquaintance, Name: _____

Were you referred by a doctor? Name: _____

Specialty _____ Address _____ City, State, Zip _____ Phone # _____

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

Other: _____

PLEASE TURN OVER AND COMPLETE THE BACK OF THIS FORM

PRIMARY HEALTH INSURANCE INFORMATION

Insurance Co _____

Address _____

ID _____ Group _____

Subscriber _____ DOB _____

Social Security # _____

Employer _____ Phone _____

Relationship to patient: Self Spouse Parent**SECONDARY HEALTH INSURANCE INFORMATION**

Insurance Co _____

Address _____

ID _____ Group _____

Subscriber _____ DOB _____

Social Security # _____

Employer _____ Phone _____

Relationship to patient: Self Spouse Parent**Attention Medicare Patients:**

Medicare patients are responsible for their deductible and the 20% copayment that Medicare does not pay. If you have met any portion of your yearly \$155 deductible, please bring a copy of your Medicare EOMB which shows how much you have met. You may also be responsible for a \$40 refraction fee that is usually never covered by Medicare or any other insurance.

Attention All Patients:

Payment is due at the time of service.

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

I understand that I am responsible for my bill even in the event my insurance denies my claim. I request payment of authorized insurance benefits be made on my behalf to the Key-Whitman Eye Center and the Key-Whitman Surgery Center for any services furnished to me. I further request that supplemental insurance benefits filed on my behalf be paid as stated above. I authorize direct payments by insurance companies to my physicians, and the ASC facility and I release any information acquired in the course of my examination or treatment to those insurance companies. I authorize any holder of medical information about me to release to any insurance company and its agents any information needed to determine these benefits payable for related services. I authorize release of my medical records to my primary care physician.

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!



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 \$40.00, 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_____

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: _____

