

**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 49<sup>th</sup> 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.

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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: \_\_\_\_\_



Name \_\_\_\_\_

DOB \_\_\_\_\_

Date \_\_\_\_\_

PLEASE CIRCLE THE STATEMENT THAT MOST APPLIES TO YOUR EXPECTATIONS AFTER SURGERY:

1. I would love to **not** have to always **depend on glasses** for functional **near, intermediate** or **distance** vision.
2. I wouldn't mind **wearing glasses for reading and intermediate vision** if I **didn't** always **need** them to see at a **distance**.
3. I really don't care if I need to wear glasses for everything. I just want to get rid of these cataracts.

**Functional Near**

Books  
Magazines  
Newspapers  
Crossword Puzzles

**Functional Intermediate**

Price Tags  
Grocery Shelves  
Cell Phones  
Computer

**Functional Distance**

Driving  
Movies  
Podium Speakers  
Across the Room

## VISUAL ACUITY QUESTIONNAIRE

Pt. Name \_\_\_\_\_

Pt. # \_\_\_\_\_

Date \_\_\_\_\_

Activity of Daily Living Complaint: \_\_\_\_\_

### **VISUAL FUNCTIONAL STATUS (circle responses)**

1. Do you have difficulty seeing street signs or to drive? (curbs, freeway exits, traffic lights, halos/glare around lights)	YES	NO	N/A
2. Do you have difficulty seeing TV or movies? (faces, numbers, or printing)	YES	NO	N/A
3. Do you have difficulty reading small print with good light, blinking and proper glasses? (books, newspaper, telephone book, medicine labels, instructions)	YES	NO	N/A
4. Do you have difficulty performing handiwork? (sewing, knitting, crocheting, embroidery or other fine tasks)	YES	NO	N/A
5. Do you have difficulty with personal correspondences? (writing checks, reading bills, filling out forms)	YES	NO	N/A
6. Do you have difficulty with leisure activities? (playing card games, bingo, dominoes, or sport activities such as bowling, golf, tennis, other _____)	YES	NO	N/A
7. Do you have visual difficulty with navigation around the house? (cooking, ironing, general household upkeep, climbing steps or curbs, dialing the telephone, telling time on watch, using public transportation)	YES	NO	N/A
8. Are you able to see and recognize faces of people? (In church, grocery stores, clubs, and other daily activities)	YES	NO	N/A
9. Are you able to care for yourself with your present vision?	YES	NO	N/A
10. Do you live alone and wish to remain independent?	YES	NO	N/A

### **DO YOU HAVE ANY OF THE FOLLOWING VISUAL SYMPTOMS?**

1. Double or distorted vision?	YES	NO
2. Glare, halos, rings around lights?	YES	NO
3. Difficulty with color perception?	YES	NO
4. Difficulty with depth perception?	YES	NO
5. Worsening vision – blurred vision?	YES	NO



#### PATIENT RIGHTS

1. Patients undergoing surgical procedures in the Key-Whitman Surgery Center have the right to be treated with all due respect, consideration, and dignity. Patients shall be provided appropriate privacy.
2. The patient has the right to be free from all forms of abuse or harassment.
3. Patients have the right to confidentiality. Confidentiality of records of all treatment/procedures performed in the Key-Whitman Surgery Center is the right of each patient. Except as required by law, no patient's medical information will be disclosed to any source without prior legal authorization for approval or refusal from the patient or the patient's legal guardian.
4. Patients have the right to expect proper information. To the best of the knowledge of the Key-Whitman Surgery Center medical staff, all information concerning the patient's diagnosis, treatment, and prognosis will be provided to the patient. When concern for a patient's health makes it inadvisable to give such information to the patient, such information is made available to an individual designated by the patient or to a legally authorized individual.
5. Key-Whitman Surgery Center patients are given the opportunity and are encouraged to participate actively in the decision-making process concerning their need for medical and surgical care. Language barriers are dealt with on case by case basis through interpreters provided for the patient, language line, and resources available.
6. Patients have the right to expect all procedures and treatments be explained, and the informed consent provided for each surgical procedure be explained prior to being signed by the patient, or patient's legal guardian, and witnessed. Patients are given ample time for discussion and/or questions of the medical staff regarding their treatment. Postoperative instructions are provided, and complication and/or consequences if pre-op and post-op instructions are not followed completely, are discussed with each patient and/or his legal guardian.
7. Patients have a right to request information regarding advanced directives or present their own advanced directive. The patient has a right to the Key-Whitman Surgery Center policy regarding advanced directives. It is our policy that the advanced directive will be taken to the Medical Director and after discussion; the Medical Director will explain that we do not follow advanced directives in our surgery center. A copy of the directive will be placed in the patient's chart, but it will be ignored. A patient receiving treatment here will always be given emergency, life saving measures if necessary and/or transferred to a hospital with the advanced directive.
8. All patients of the Key-Whitman Surgery Center have the right to address their physician and/or Key-Whitman Surgery Center administrator should any problems or questions arise relating to the medical-nursing care provided and/or subsequent billing for services rendered, without compromise to the patient's future access to care. Each concern so expressed will receive a response and consideration will be given to appropriate corrective action channeled through the Quality Management Committee, Patient Safety Committee, and/or the Board of Directors as needed. Grievances will be addressed within 30 days.
9. Patients have a right to be treated regardless of race, color, creed, gender or national origin. Requirements for patients' use of the Key-Whitman Surgery Center are based solely on the medical needs of the patient without regard to race, color, creed, or national origin. All persons having occasion either to refer patients for admission or recommend the Key-Whitman Surgery Center must do so without regard to the patient's race, color, creed, gender or national origin.
10. Patients have a right to file any complaints with the Department of State Health Services Facility Licensing Group, 1100 West 49<sup>th</sup> Street, Austin, Texas 78756 1-800-973-0022. They also file complaints with Medicare by using the website for the Ombudsman: <http://www.medicare.gov/Ombudsman/resources.asp> or they may simply call 1-800-Medicare for help. In addition, our patients may also contact AAAHC to report any grievances, as we are accredited through this agency: AAAHC, 5250 Old Orchard Road, Suite 200, Skokie, IL 60077, 1-847-853-6060

#### ADVANCED DIRECTIVES

When a patient of the facility provides a staff member an advanced directive, the document will be shown to the Medical Director so that an appropriate discussion may take place. (If the Medical Director is unavailable, then the Director of Nurses or the physician caring for the patient may hold the discussion). When the discussion has concluded to the satisfaction of both the Medical Director and the patient, the document will be copied and become part of the patient's medical record. The patient will be informed by the Medical Director that it is the policy of our facility to provide immediate emergent care to all patients and that while a copy of the advanced directive will remain in the patient's chart, it will be ignored. The patient will be provided emergency, life saving measures if necessary while under the care of any practitioner of the facility. Key-Whitman Surgery Center will transfer care of any patient in acute distress via 911 emergency medical assistance to a nearby hospital. The patient record, including the advanced directive documentation, will be transferred with the patient for continuity of care. If a patient requests information regarding the formulation of advance directives, staff members will provide them with information from the Texas Medical Association. Copies can be obtained if the patient desires while they are present in the surgery center. In addition, the patient can contact the Texas Medical Association, Attn: Living Will, 401 W. 15<sup>th</sup> St., Austin, TX 78701-1680. If the patient is Internet savvy, they may also contact the Texas Medical Association Knowledge Center at [knowledge@texmed.org](mailto:knowledge@texmed.org).

#### DISCLOSURE OF OWNERSHIP

A physician performing the procedure may have an ownership interest in this facility. A schedule of typical fees for services provided by this facility may be made available upon request. These procedures are performed at hospitals and other outpatient facilities in this community. The patient has a choice where to receive services, including a facility where their physician does or does not have ownership interest.

The patient and/or his family members have the following responsibilities to the Key-Whitman Surgery Center in order to assure the best possible results of surgical intervention:

1. A patient has the responsibility to provide accurate and complete information about present complaints, past illnesses, hospitalizations, medications and dosages, and other matters relating to their health. This includes presenting advanced directives to staff prior to surgery or treatment.
2. The patient has the responsibility to report unexpected changes in condition to the responsible practitioner.
3. A patient is responsible for reporting clear comprehension of a contemplated course of action and what is expected of him/her.
4. A patient is responsible for following the treatment plan that is developed with the health care provider.
5. The patient should express concern regarding inability to comply with a planned course of treatment, and every effort should be made to adapt the treatment plan to the patient's specific needs and limitations.
6. The patient is responsible for keeping appointments and, when unable to do so for any reason, notifying us at 214-754-0000 or 800-442-5330 or 214-220-EYES.
7. The patient is responsible for their own actions if refusing treatment or not following the practitioner's instructions. Noncompliance with the proposed course of treatment may lead to further complications or illness.
8. The patient is responsible for following the all preoperative instructions and leaving valuables at home.
9. The patient is responsible for being considerate of the rights of other patients and Key-Whitman Surgery Center personnel and for assisting in the control of noise and distractions.
10. The patient is responsible for adhering to and assisting in the enforcement of the no smoking policy throughout the building.
11. The patient is responsible for being respectful of the property of other persons and of the Key-Whitman Surgery Center.
12. Patients can access all services available using our website, [www.keywhitman.com](http://www.keywhitman.com) or merely by asking for the information. It is the patient's responsibility to ask any questions on information they need clarified.
13. Fees for services will be addressed with each patient before surgery. It the patient's responsibility to make payment prior to surgery for what is owed out of pocket. The patient is responsible for all expenses not covered by the insurance company, which will be completely assessed after insurance is billed.
14. Patients have the responsibility to inquire about any questions they have after hours at our emergency number located on all post-op instructions and also accessible by the regular phone number.