EYE PHYSICIANS OF NORTH HOUSTON

DISEASES & SURGERY OF THE EYE
www.1960eye.com

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www.1960eye.com

845 Cypress Creek Parkway
Suite 101
Houston TX 77090

PHONE
281 893 1760

FAX
281 893 4037

Welcome! Thank you for choosing **Eye Physicians of North Houston** for your eye care.

To help our office serve you better, please bring your current eyeglasses and/or contact lenses with you.

To help expedite your appointment, you may print out our new patient registration form from our website at **www.1960eye.com** and bring them to your appointment.

If you have had any eye conditions requiring surgery or treatment, your records from your previous ophthalmologist would be beneficial to place in your chart in our office. If possible, you may want to bring them with you at your appointment time.

Please be aware that most insurance companies DO NOT pay for "routine" eye exams. Routine exams are those exams performed for the sole purpose of checking your vision for eyeglasses or contact lenses.

Eye exams are normally covered by your *medical* insurance when performed for eye symptoms or diseases such as dry eyes, allergies, cataract, glaucoma, diabetes, etc.

If you are on an insurance plan in which our doctors are contracted with, we will be happy to file with your insurance company. Please be sure our office has the appropriate information so benefits can be verified prior to your exam. **If your insurance plan requires a referral from your primary care physician, it is your responsibility to contact your primary care physician and have it with you at the time of your exam**.

If you have any questions, please feel free to call our office at 281-893-1760 from Monday-Friday from 8am-5pm.

Please refer to our website **www.1960eye.com** for further information regarding our services.

We look forward to seeing you.

Sincerely,

The Doctors and Staff at Eye Physicians of North Houston

Eye Physicians of North Houston, PA
845 Cypress Creek Parkway Suite 101, Houston, Texas 77090
Office: 281 893 1760 Fax: 281 893 4037

Patient Name: _____

Date of Birth: _____

Pharmacy Name: _____

Pharmacy Phone: (_____) _____-_____

Past Medical History (Please check all that apply)

- □ I have no medical conditions
- □ Diabetes (Please circle: type 1 or type 2)
- □ High blood pressure
- □ Cancer (type: _____)
- □ Congestive heart failure /coronary artery disease
- □ Arrhythmia / irregular heart beat / AFIB
- □ Pacemaker or defibrillator **Date**: _____
- □ Heart Attack / Stroke / TIA **Date**: _____
- □ High cholesterol
- □ Asthma/COPD/emphysema/ sleep apnea / home oxygen
- □ Migraine
- □ Lupus / Rheumatoid Arthritis
- □ HIV (If known, last CD4 = _____)
- □ Thyroid disease
- □ Currently pregnant
- □ On dialysis / end stage renal failure
- □ Organ transplant: _____ **Date**: _____
- □ Other: _____

Past Eye History (Please check all that apply)

- □ I have no history of eye diseases or surgeries
- □ Cataract or artificial lens implant _____ eye(s)
- □ Glaucoma or glaucoma suspect
- □ Macular Degeneration
- □ Diabetic Retinopathy
- □ Retinal Tear or Detachment _____ eye(s)
- □ Previous LASIK / PRK / RK
- □ Corneal disease: _____
- □ Lazy or Crossed Eyes / Amblyopia
- □ History of Eye Trauma: _____
- □ Current or past use of contact lenses

Past Surgical History (Please include ALL surgeries)

_____

_____

_____

Family Eye History (Please check if anyone in your family has condition. If so, specify which family member.)

- □ There are no eye problems in my family
- □ Unknown (i.e. if you were adopted)
- □ Glaucoma: who? _____
- □ Retinal Tear or Detachment: who? _____
- □ Macular Degeneration: who? _____
- □ Blindness: who? _____
- □ Lazy or Crossed Eyes / Amblyopia: who? _____

Medications (Oral or injectable) – Please list below:

- □ I take no prescription medications
- □ Check here if you brought your own medication list

Drug Name Dose Frequency

_____

_____

_____

_____

_____

_____

Allergies ☐ No medication allergies

_____

_____

Smoking History (Please check only one)

- □ Current smoker (Year started smoking: _____)
- □ Past smoker (Year started: ____; year stopped ____)
- □ Never smoked

I have read, verified, and updated this sheet
(*Please sign only once per visit*):

_____/____/____ Tech____
Patient Signature Date

_____/____/____ Tech____
Patient Signature Date

_____/____/____ Tech____
Patient Signature Date

Patient Registration Form for Eye Physicians of North Houston, PA

Date: _____ Referred by:_____ Primary Physician_____
(first and last name please)

Patient Name: (Last) _____ (First) _____ (Middle) _____

Gender: _____ Age _____ Birthdate _____ Social Security# _____

Check appropriate box: ☐ Minor/Student ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Preferred language:_____Race/ancestry(i.e.White, Black, Hispanic, Asian):_____

Ethnicity/region of origin(i.e.American, African, Mexican, Korean):_____

Address: _____ City _____ State _____ Zip _____

What is your preferred contact method? ☐ Home ☐ Cell ☐ Work

Home Phone# _____ Cell Phone# _____ Email _____

Patient's Present Employer_____Occupation: _____Phone _____

Business Address:_____

Spouse or Parent's Name_____Phone_____

IN CASE OF EMERGENCY (Friend or Relative Not Living In Same Household)

Name_____Phone_____Relationship_____

PERSON RESPONSIBLE FOR ACCOUNT (If other than the patient named above)

Name_____Address_____Phone_____

INSURANCE INFORMATION*

PRIMARY	SECONDARY (SUPPLEMENTAL)
Insurance Company_____	Insurance Company _____
Insurance Phone#_____	Insurance Phone#_____
Group #_____	Group #_____
ID / Medicare #_____	ID / Medicare #_____
Insured's Name_____	Insured's Name_____
Insured's Birthdate_____	Insured's Birthdate_____
Insured's Social Security #_____	Insured's Social Security #_____
Employer_____	Employer_____

*I authorize payment to be made to Eye Physicians of North Houston, PA. I authorize this office to release any of the patient's medical information or other necessary information about me to my insurance carrier and/or other associated agents to determine the eligibility and benefits allowed for the patient's eye exam and related services.

Signed:_____
(Patient name or authorized account holder)

Medicare #(If Applicable)_____

AUTHORIZATION TO RECEIVE/RELEASE HEALTH INFORMATION

According to the **HIPAA Compliance Privacy Laws of the Federal Government**, it is mandatory that we ask you to review and answer the following questions listed below.

Patient Name: _____

May we leave messages/detailed medical information on voicemail at either of these phone numbers?

□ Yes □ No Home Phone: _____ □ Yes □ No Cell Phone: _____

May we contact you at your place of employment? □ Yes □ No
If so, may we leave a message? □ Yes □ No

If yes: Work Phone: _____ Extension: _____

Do you have any particular person or family member(s) that you authorize to receive and discuss information regarding your personal health information (general information, surgical and billing)?

□ Yes □ No If yes, please provide:

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____

I hereby authorize Eye Physicians of North Houston, P.A. to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, laboratories, radiology facilities or other institutions. **This authorization remains in effect until revoked**.

I have reviewed the aforementioned information and provide my consent regarding any and all the issues as stated above.

I have reviewed Eye Physicians of North Houston, P.A's Notice of HIPAA Privacy Policy. A copy of this policy will be provided to me upon request.

Patient Signature: _____ Date: _____

WITNESSED BY: _____

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EYE EXAMS AND INSURANCE FILING
Acknowledgement of Financial Policy

Please read the following and initial in the space provided to acknowledge your understanding of Eye Physicians of North Houston's financial policy.

- I understand that if my physician is contracted with my insurance plan, a claim for services rendered will be filed to my insurance carrier. I will be responsible for the payment of any co-payment, deductible, co-insurance or non-covered services ***at the time*** services are rendered. I will notify the office in the event of an insurance coverage change.
- I understand that if my physician is not contracted with my insurance plan, or if I am uninsured, I will be considered a self-paying patient and will be responsible for payment ***at the time*** of service.
- I understand that if my insurance carrier requires a **referral** for me to see a specialist, ***it is my responsibility to obtain the referral***. I further understand that if a proper referral is not obtained by the time the services are rendered, I will be responsible for services rendered.
- I understand that during my eye exam, a **"glasses check/refraction"** may be performed to determine whether or not my vision can be improved. This is an essential portion of the eye exam. Most insurance companies do not pay for the refraction fee. Therefore we collect **$50** at the time of service. It will be refunded to you in the event your insurance covers the service.
- I understand that during my eye exam my physician may deem it medically necessary to perform a diagnostic test. Because every patient's insurance coverage varies, this test may be considered a **NON-COVERED** service by your insurance carrier. If this is the case, it will become my responsibility.
- I understand that a service charge will be applied to all returned checks.
- I understand that a **$25** fee may be charged if our office must fill out certain forms on your behalf (i.e. disability forms, flight physicals, FMLA forms, etc.)
- I understand that, at the discretion of Eye Physicians of North Houston, there is a **$50 fee** for appointment cancellations with **less than 24-hour notice and for no-show appointments**.

All efforts are made by this office to confirm your coverage prior to you leaving the office. *Unfortunately, not all benefits quoted by your insurance carrier are correct, and you may receive a bill if your insurance company does not pay according to benefits quoted.*

ACKNOWLEDGEMENT
I, as the authorized account holder, have read and understand the above.

Signed_____ Date_____

Printed Name: _____