San Antonio Eye & Face Institute
Patient Registration Form

Date: ____/_____/20____ **E-mail Address:** _____

Circle One: Dr. Mr. Mrs. Ms.

Last Name_____ **First Name**_____ **MI**_____

Address_____ City_____ St_____ Zip_____

Primary Phone: _____ Secondary Phone: _____

Marital Status: S M D W **Sex**: M/F Race:_____ Ethnicity:_____

Language Preference (circle one): English Spanish Other_____

DOB: ____/_____/_____ **Age**_____ **SSN#**_____-_____-_____

Occupation: _____ **Pharmacy Name & Zip**: _____

How did you learn about our office?: Google Facebook Yelp Family/Friend

Primary Care Provider: _____ Phone: _____

Referring Doctor: _____ Phone:_____

Emergency Contact:

Name: _____ Relationship:_____ Phone:_____

Insurance:

Primary Insurance_____ ID#_____ Group#_____

Insured's Name_____ Insured's DOB_____Relationship_____

Secondary Insurance_____ ID#_____Group#_____

Insured's Name_____ Insured's DOB_____ Relationship_____

For Minors: Who will serve as the responsible party?

Full Name_____ Address_____

City_____ State_____Phone_____

DOB_____ Sex: Male Female

Employer (Job Title) & Employer's Address_____

_____

San Antonio Eye & Face Institute Policies

--PLEASE READ CAREFULLY AND SIGN--

Consent to Treat

I hereby consent to the treatment for myself or the above listed patient. I understand, that in case of an emergency, I may have to see the physician on-call in San Antonio, Texas.

_____ _____

Patient Signature (Parent's Signature for minors) Date

Health Insurance Portability and Accountability Act (HIPPA)
Acknowledgement of Receipt of "Notice of Privacy Practices"

I consent to the use or disclosure of my protected health information (PHI) by San Antonio Eye Institute, PLLC for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct healthcare operations.

My PHI means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This PHI relates to my past, present or future physical or mental health or condition and identifies me, or there is a responsible basis to believe the information may identify me.

Identity Theft Prevention and Detection

It is the policy of San Antonio Eye Institute, PLLC to follow all federal and state laws and reporting requirements regarding identity theft. Specifically, this policy outlines how we will (1) identify, (2) detect and (3) respond to "red flags." A "red flag" as defined by this policy includes a pattern, practice, or specific account or record of activity that indicates possible identity theft.

The privacy policy describes the types of uses and disclosures of PHI that will occur in treatment, payment of bills or in the performance of healthcare operations. It also describes your rights and our duties with respect to my PHI. **I understand I have a right to review the Company's Privacy Policy and I.D. Theft Prevention and Detection Policy prior to signing this document.** The Privacy Policy and I.D. Theft Prevention Policy for the company are available at the practice and on our website at www.saeyeinstitute.com. We reserve the right to change the practices that are described in the Privacy Policy and I.D. Theft Prevention Policy. You may obtain revised policy documents by assessing the our website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of your appointment.

By signing this form, you acknowledge that this Medical Practice has made available to you its Privacy Policy (required by Federal HIPPA laws) and I.D. Theft Prevention Policy (no longer required by Federal Trade Commission). I have received a copy of the policies (if requested). The Practice has given me the opportunity to ask any questions about these policies and all my questions have been answered.

_____ _____

Patient Signature (Parent's Signature for minors) Date

Insurance

First and foremost, we are here to provide you with the best care possible. In order to remain a viable business and be here when you need us, it is critically important that we receive payment for services rendered. Having medical insurance is no guarantee of payment for your medical care. **Co-Payments, Co-Insurance, Deductibles and Non-Covered Services are the responsibility of the patient and must be paid at the time service is rendered**. We will attempt to determine if you are responsible for paying for any part of the service you will receive. However, there are times when we may receive incorrect, inaccurate, or incomplete information from your insurance company. If we learn that you are responsible for a charge that we did not collect during your visit, we will send you an invoice for the amount due. The invoice is **DUE UPON RECEIPT**. If we do not receive payment in a timely fashion, we may contact you by phone to collect payment. Failure to pay an outstanding invoice after 90 days will result in the account being turned over to a collection agency, which could have an adverse effect on your credit record. If you have billing related questions, please do not hesitate contacting us. In most cases, your questions can be answered by first reviewing your insurance company's "Explanation of Benefits" or by contacting your insurance company's Member Services Department (the phone number is on your insurance card). In situations pertaining to minors (regardless of custody arrangements or divorce decrees), the person bringing a dependent in for services is financially responsible and is expected to pay at the time service is rendered.

Referrals

If your insurance is a HMO plan (or another plan that requires a referral), you are responsible for obtaining this referral from your primary care physician. It will typically be faxed to us by your primary physician's office. As a courtesy to our patients, we will file your claim for your office visit or surgery with your insurance and allow 45 days for payment in full (if we are participating providers with your insurance). Should payment NOT be received within 45 days, the balance due will become the obligation of the patient (or parent/guardian in the case of minors) and must be paid within 30 days. If you do NOT have insurance, or we are NOT a participating provider with your insurance carrier, payment is expected the day services are provided.

Agreement to Pay

The undersigned responsible party does hereby agree to pay for all services provided. The undersigned excepts the fee charged as a lawful debt and promises to pay the fee, including all cost of collection, attorney fees, and court costs, if necessary, waving now and forever the right to claim exemption under the Constitution and laws of the state of Texas or any other state. **FULL PAYMENT IS DUE AT THE TIME OF SERVICE. Payment can be made in cash or with a major credit card (Discover, Master Card, VISA, or American Express) – we do NOT accept personal checks.** All unpaid balances may be charged a 1.5% re-billing fee monthly.

_____ _____

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Green Policy & E-mail Communication

The San Antonio Eye Institute, PLLC uses electronic medical record and practice management systems to reduce the use of paper products. This is good for patient care and the environment. To make efficient use of these technologies, we ask patients to **provide a valid e-mail address**. We may periodically send communication by e-mail. By providing us with your e-mail address, you consent to being contacted by e-mail if the need arises. Individuals may opt out of mass mailings at any time. Patients periodically contact us via our online contact form or by e-mail. Please note that we **CANNOT** discuss topics of a medical nature, including your protected health information, or provide medical advice by email. E-mail is used **SOLELY** for scheduling purposes. If you have a medical question or concern, you understand that these issues must be handled over the phone or in person.

_____ _____

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Cancellation & "No Show" Policy

Due to patient demand for appointments, you must provide us **more than 24-hours** notice to cancel an appointment. If you cancel an appointment with less than 24-hours notice or do not show up for a scheduled appointment, you will be **charged $35.00** for the missed appointment. You are responsible for this charge; your insurance company will not pay this LATE CANCELLATION/NO SHOW FEE.

NOTE: You are responsible for keeping track of your appointments. We will make an attempt to notify you by text message or by phone one day prior to your appointment. We **CANNOT** *guarantee that you will always receive a reminder for various reasons* (i.e. some phone plans do not accept text messages from our electronic record system) and therefore you are ultimately responsible for keeping track of your appointments.

***If you would like to receive text reminders**, please list which phone number can receive text messages: **Cell Phone Number:** _____.

We reserve the right to dismiss patients who repeatedly miss scheduled appointments from the practice. Patients who miss their appointments may put their general or ocular health at risk. **I understand that I am responsible for keeping my appointments to prevent poor medical outcomes. I hereby hold the San Antonio Eye Institute and its doctors/staff faultless for poor outcomes that result from me missing scheduled appointments.**

_____ _____

Patient Signature (Parent's Signature for minors) Date

Refraction Fees

What is a refraction?

Refraction is the process of determining the eye's refractive error, or need for corrective glasses and/or contact lenses. "What's better, one or two?"

Why is it sometimes necessary?

A refraction is sometimes necessary depending on the patient's diagnosis and/or complaints. For example, if a patient is experiencing blurred vision or a decrease in visual acuity on the eye chart a refraction would be needed to see if this is due to a need for glasses or due to a medical problem. A refraction is necessary to prove the need for cataract surgery. We must document that your vision cannot be improved with a glass's prescription. As you can see a refraction is an essential part of an eye exam, however, Medicare and most insurances **DO NOT** cover it.

Will I be notified in advance if I need it?

Yes, a technician or doctor is qualified to tell you if this procedure is necessary.
They will let you know if this procedure is necessary. You will be given the option to accept or decline this service. If you decline we may NOT be able to accurately determine the cause for your decrease in vision.

How much is it?

We charge **$40** for this procedure in addition to any other out-of-pocket charges. This is due at the time services are rendered. We will bill your insurance according to the individual contracted fee schedules. If your insurance pays the fee we will refund the $40 back to your account. A glasses presciption will NOT be provided until the fee is paid.

Refraction Fee Acknowledgement

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service. The copay and deductible are separate from, and not included in, the refraction fee.

_____ _____

Patient Signature (Parent's Signature for minors) Date

Medical History Questionnaire

(Please print clearly and use the back of this page if you need more space)

Today's date: _____

Name: _____

Your age: _____ Your birthplace: _____

Who is your medical doctor? _____

What is the main reason for your visit today?

_____

_____

Do you have any of these eye symptoms?

❑ Blurred distance vision ❑ Glare, halos around lights
❑ Blurred reading vision ❑ Itching or burning eyes
❑ Constant double vision ❑ Eye mattering or tearing
❑ Flashing lights or floaters ❑ Foreign body sensation
❑ Red Eyes ❑ Dry Eye ❑ Eye Pain

Do you have any allergies to any medications?

❑ None known ❑ Yes, which ones? (list below)

Medication Name	What reaction did you have?
_____	_____
_____	_____
_____	_____
_____	_____

Which *eye medications* do you currently take?

❑ None ❑ Artificial Tears

Medication Name	Amount	How many times/day
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime

Which *other* medications do you currently take?

❑ None ❑ Aspirin on a daily basis?

Medication Name	Amount	How many times/day
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime

Have you ever had any of these eye problems?

❑ Cataract ❑ Serious eye injury
❑ Glaucoma ❑ Iritis/uveitis
❑ Macular degeneration ❑ Lazy eye
❑ Wore eye patch as a child ❑ Retinal detachment
Other: _____

Have you ever had any of these conditions?

❑ None

❑ Stroke ❑ Dizziness ❑ High blood pressure
❑ Arthritis ❑ Allergies ❑ Heart disease
❑ Diabetes ❑ AIDS, HIV ❑ Lung diseases
❑ Cancer ❑ Anemia ❑ Thyroid disease
❑ Headaches ❑ Other: _____

_____

Have members of your family had any *eye* diseases?

(This would be your father, mother, sister, brother, grandparents)

❑ Glaucoma ❑ Diabetic eye disease or diabetes
❑ Cataract ❑ Crossed eyes ❑ Macular degeneration
❑ Iritis/uveitis ❑ Blindness ❑ Retinal detachment
❑ Poor Vision ❑ Other: _____

Please list any *eye* surgeries you have had:

❑ None

Type of Eye Surgery	Which Eye	Year
_____	Right Left	_____
_____	Right Left	_____
_____	Right Left	_____
_____	Right Left	_____

Please list any *other* surgeries you have had:

❑ None

Type of Surgery	Year
_____	_____
_____	_____
_____	_____
_____	_____

What non-surgery illness have caused a hospital stay?

_____

_____

_____

If you have glaucoma:

In what year was the diagnosis first made? _____

Month and year of your last visual field test? _____

Name of your previous ophthalmologist? _____

Do you use? ❑ Tobacco ❑ Alcohol

Would you like to wear contact lenses?

❑ Yes ❑ Not interested at this time.

What was the approximate date of your last eye examination: _____