KEY-WHITMAN EYE CENTER

PLEASE FILL OUT ALL BLANKS COMPLETELY

KEY-WHITMAN SURGERY CENTER

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:_____

PLEASE TURN OVER, READ AND COMPLETE THE BACK OF THIS FORM

ATTENTION ALL PATIENTS:

Payment is due at the time of service.
Method of payment: □ Cash □ Check □ Credit Card: MC/Visa/AMEX/Discover □ Care Credit □ Alphaeon Credit

PATIENT AUTHORIZATION – ASSIGNMENT OF MEDICARE AND INSURANCE BENEFITS AND ACKNOWLEDGEMENT OF OUR NOTICE OF PRIVACY PRACTICES

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 Serves (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. I am responsible for the deductible, co-insurance, or if the insurer does not pay. I am also responsible for all non-covered services such as, but not limited to, the refraction fee and elective OPTOS retinal photography fee. 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 authorize Key-Whitman Eye Center, Key-Whitman Surgery Center and Key-Whitman Optical Center, its assignees, and third party collection agents to utilize all contact information I have provided to communicate with me. This includes, but is not limited to, home telephone, cellular telephone, and employment telephone. I hereby grant permission and consent to Key-Whitman Eye Center, Key-Whitman Surgery Center and Key-Whitman Optical Center, its assignees, and third party collection agents to place calls to my home telephone, cellular telephone, and employment telephone; leave messages (whether voice or text); and utilize pre-recorded/artificial voice messages and/or automatic dialing devices in connection with any communication to me. Additionally, I understand that some procedures/services performed by the physician(s) may not be covered by my insurance plan. If services are not covered, I understand and agree to be financially responsible for payment for such services.

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Key-Whitman Eye Center, Key-Whitman Surgery Center and Key-Whitman Optical Center Notice of Privacy Practices. By signing below I am only giving acknowledgment that I have had the opportunity to receive the Notice of our Privacy Practices.

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.

TDI's Consumer Protection Program helps consumers with insurance questions and problems. The program can be reached toll-free at (800) 252-3439. In addition, the TDI Web Site offers a wealth of information, including a complete listing of licensed agency, agencies and insurers, and records of enforcement and disciplinary actions by TDI as the regulator of the insurance industry.

Consumers with questions and/or complaints about their own insurance claims, agents and/or insurance companies should call the consumer protection line at TDI and can file complaints with TDI. TDI can investigate individual concerns and answers questions. We encourage consumers to also file complaints with the Office of the Attorney General, but please understand that this agency cannot advise you about your specific situation or explain the law. We are prohibited by law from providing these services to private individuals.

The Office of Public Insurance Counsel (OPIC) represents the interests of Texas consumers in matters such as insurance rates and rules. OPIC is required by law to represent all consumers as a group. Individual complaints that suggest a widespread pattern of practices, or which indicate that a large number of consumers are affected, may lead to action by the agency. Therefore, consumers may wish to complain to the OPIC as well.

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 (PHT). 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: _____

KEY-WHITMAN
EYE CENTER

FINANCIAL POLICY

NO SHOW / CANCELLATION POLICY

Key-Whitman Requires notification 24 hours prior to your scheduled office appointment if you are needing to cancel or re-schedule. If less than 24 hours' notice is provided, a $50 fee will be assessed. Out-patient surgeries scheduled in the surgery center will incur a $100 fee and cosmetic oculoplastic procedures scheduled in the surgery center will incur a $500 no show / cancellation fee.

COPAYS / COINSURANCE / DEDUCTIBLES

All current balances, co-payments, coinsurance and deductibles are due and will be collected at the time of service. Any amount collected at the time of service is considered an ESTIMATE only and will be considered partial payment until your insurance company processes the claim and makes final determination of your benefits. In addition to copays, coinsurance, and deductibles, we may collect a refraction fee at the time of your exam outlined separately in our refraction policy.

Please be aware that during the course of your treatment, it may be necessary for the physician to perform testing or minor procedures. In most cases, the exact insurance benefits for these procedures cannot be determined until the insurance company receives the claim. Any amount collected for testing or in office surgical procedures will be considered an ESTIMATED partial payment until your insurance company can process your claim. You may receive a statement indicating that an additional balance is due from what was originally estimated at your appointment. Your insurance is a contract between you and your insurance carrier and it is your responsibility to know and understand your coverage. **Our physicians are not aware of what additional costs may be incurred by you during your course of treatment and do not advise you of additional costs at the time of service.** If you have questions or concerns about the costs of a procedure, please notify the doctor before the procedure is performed.

MEDICAL HEALTH INSURANCE VS. VISION CARE PLANS

The ESTIMATED amount that will be collected at the time of service will be determined based on the purpose of your visit and the type of insurance coverage being billed. **Vision Plans are only accepted at our locations with Optical Shops and DO NOT COVER medical conditions or testing; Vision Plans generally cover exams for only glasses and contacts.** Please reference the separate policy form for more detailed information or notify a receptionist. (Applicable only to those locations that accept vision plans.)

REFERRALS FROM YOUR PRIMARY CARE PHYSICIAN

If you have an HMO, Medicare replacement, or similar plan that requires a referral, you will need a referral from your primary care physician before being seen. Specialists cannot request referrals from your primary care on our own behalf. It is your responsibility to know if your insurance plan requires a referral and obtain that referral before being seen. If you arrive for your appointment without a referral, you will be rescheduled or you will be responsible for the entire bill since your insurer will deny any services performed by Key-Whitman without a referral.

RETURNED CHECK FEE

If your check is returned for any reason, there will be a $35 fee added to your balance.

Signature_____Date_____

KEY-WHITMAN
EYE CENTER

Patients often have both vision care plans and medical health insurance plans; it is important to understand the difference. Vision care plans do not cover the diagnosis of a medical eye condition; just as medical health insurance plans do not cover routine wellness eye exams. We have prepared this form to help you understand how your visit is billed to your medical health insurance plan or your vision care plan.

Vision Care Plan

- Covers eye wellness exams only
- May help pay for glasses or contact lenses

Medical Health Insurance Plan

- Diabetes
- Sudden loss of vision
- Double vision
- Dry eye – itching burning and tearing
- Allergies
- Flashes/or Floaters
- Glaucoma
- Cataracts
- Eye injections
- Macular degeneration
- Referral from outside physicians

The purpose of your visit will determine which plan will be billed. If the doctor determines that your condition falls under the category of a “medical eye examination” instead of “routine wellness eye examination”, you will be responsible for the any co-pays and/or deductibles according to your medical health insurance plan.

_____ _____

Patient Signature Date

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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 $59.00, 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_____

KEY-WHITMAN EYE CENTER **PATIENT HISTORY**

NAME _____**OCCUPATION**_____ **RACE** _____**DATE**_____
DOB_____**AGE** _____ **HEIGHT**_____ **WEIGHT**_____(as stated by pt) **SEX** □ Male □ Female

MEDICAL HISTORY:

□ Anemia	□ ENT Problems	□ Mumps
□ Anxiety	□ GI Problems	□ Psychiatric Problems
□ Arthritis	□ Glaucoma	□ Pacemaker
□ Asthma	□ Gyn Problems	□ Palpitations
□ Back/Neck Problems	□ HIV	□ Prostate Problems
□ Bleeding Disorder	□ Hard of Hearing	□ Restless Leg Syndrome
□ Bronchitis	□ Heart Attack	□ Retina Problems
□ Cancer	□ Heart Disease	□ Shingles
□ Chest pain	□ Heart Murmur	□ Seizures
□ Chicken Pox	□ Hepatitis Type	□ Sinus Problems
□ Congestive Heart Failure	□ High blood pressure	□ Sleep Apnea
□ COPD	□ High Cholesterol	□ Stroke
□ Depression	□ Kidney/Bladder/Urinary Problems	□ Thyroid Problems
□ Diabetes	□ Liver Disease	□ Ulcers
□ Emphysema	□ Measles	□ Other_____

□ **HISTORY OF HEAD OR EYE TRAUMA** (please describe)_____

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_____Reaction_____

PHARMACY NAME_____**Location**_____**Phone**_____

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

Drug Name	Dosage	Times per day

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 _____

KEY-WHITMAN EYE CENTER

Name:_____

Date:_____

Healthcare Provider Form

Primary Care Physician, Internist or Family Doctor

Name	**Phone**
Group or Association	**Fax** or Direct Messaging Address
Address	Condition(s) under management

Endocrinologist

Name	**Phone**
Group or Association	**Fax** or Direct Messaging Address
Address	Condition(s) under management

Rheumatologist

Name	**Phone**
Group or Association	**Fax** or Direct Messaging Address
Address	Condition(s) under management

Other Physician

Name	**Phone**
Group or Association	**Fax** or Direct Messaging Address
Address	Condition(s) under management

Referring Doctor

Name	**Phone**
Group or Association	**Fax** or Direct Messaging Address
Address	Condition(s) under management

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Date:____/____/____

SPEED II Questionnaire

Name:_____, _____
(Last) (First)

Date of Birth:____/____/_____ Sex: M F (circle one)

(Office Use Only)
Total SPEED Score: _____
(Frequency + Severity)

*Report the **FREQUENCY** of any dry eye symptoms you are experiencing using the grid below.*
Please check (✓) one box per line.

SYMPTOMS	Never (0)	Sometimes (1)	Often (2)	Constant (3)
1. Dryness, Grittiness or Scratchiness				
2. Soreness or Irritation				
3. Burning or Watering				
4. Eye Fatigue				

*Report the **SEVERITY** of any dry eye symptoms you are experiencing using the grid below.*
Please check (✓) one box per line.

SYMPTOMS	No Problem (0)	Tolerable (1)	Uncomfortable (2)	Bothersome (3)	Intolerable (4)
5. Dryness, Grittiness or Scratchiness					
6. Soreness or Irritation					
7. Burning or Watering					
8. Eye Fatigue					

9. Please mark if you have experienced any of the above symptoms:
___Today ___Within the past 72 hrs ___Within the past 3 months

10. Do you have fluctuating vision problems that improve if you blink?
___Never ___Sometimes ___Frequently ____A Lot or Always

11. Do your symptoms affect your daily activities? ___Yes ___No

12. Which activities seem to make your symptoms worst?
___Reading _____Computer Use ___Close-Up Work ___Watching TV
___Outdoor Activities_____Other

13. How long can you do the activity before your eyes start bothering you? _____

Eye drops and/or ointments used: Y N Today? Y N Past 4 hrs? Y N How long are they effective?
Name of drops / ointments / gels: _____
Any moisturizers, lotions or facial creams today? Y N
Any make-up today? Y N
Any history of blepharitis or stye? Y N
Are you a CL's Wearer? SCL's RGP's How long have you been suffering with Dry Eye Symptoms?