HOUSTON LASIK & EYE

Last Name: _____

First Name: _____

Date of Birth: _____

Welcome! You cannot be seen until every question has been answered.

Do you have or have had any medical and/or eye diseases?

- ❒ wear glasses/contacts
- ❒ cataracts
- ❒ glaucoma
- ❒ macular degeneration
- ❒ dryness of eyes
- ❒ lazy or crossed eyes
- ❒ retinopathy (any type)
- ❒ retinal tear/detachment
- ❒ diabetes mellitus
- ❒ high blood pressure
- ❒ high cholesterol
- ❒ COPD/emphysema
- ❒ heart attack
- ❒ stroke
- ❒ hypothyroidism
- ❒ hay fever
- ❒ uveitis/iritis
- ❒ lupus or RA
- ❒ multiple sclerosis
- ❒ herpes
- ❒ AIDS/HIV
- ❒ sickle cell disease
- ❒ pseudotumor cerebri
- ❒ cancer (any)

Any other conditions we should know about? _____

Have you had any surgeries?

- ❒ cataract-lens implants
- ❒ pterygium removal
- ❒ LASIK or PRK/ASA
- ❒ corneal transplant
- ❒ blepheroplasty/eyelids
- ❒ detached retina repair
- ❒ glaucoma laser
- ❒ strabismus repair
- ❒ retinal laser

Any other surgeries we should know about? _____

Do eye diseases such as glaucoma, macular degeneration, or lazy eye run in the family?

Mother	❒ glaucoma	❒ macular degeneration	❒ lazy eye	❒ none
Father	❒ glaucoma	❒ macular degeneration	❒ lazy eye	❒ none
Sibling(s)	❒ glaucoma	❒ macular degeneration	❒ lazy eye	❒ none

Are you feeling any of the symptoms below TODAY?

General/Constitutional
- ❒ Fatigue
- ❒ Fever
- ❒ Weight change

Allergy/Immunology
- ❒ Sneezing
- ❒ Itchy eyes

Ophthalmologic
- ❒ Blurred vision
- ❒ Discharge
- ❒ Dry eye
- ❒ Pain
- ❒ Flashes of light
- ❒ See floaters
- ❒ Red eye

ENT
- ❒ Dry mouth
- ❒ Congestion
- ❒ Post-nasal drip
- ❒ Sinus pain
- ❒ Hearing loss
- ❒ Runny Nose

Endocrine
- ❒ Thyroid
- ❒ Diabetes

Respiratory
- ❒ Cough
- ❒ Breathing problems

Cardiovascular
- ❒ Chest pain
- ❒ Irregular Heart

Gastrointestinal
- ❒ Diarrhea
- ❒ Nausea/vomit
- ❒ Constipation

Hematology
- ❒ Anemia
- ❒ Bleeding problems

Genitourinary
- ❒ Blood in urine
- ❒ Painful urination

Musculoskeletal
- ❒ Joint pain
- ❒ Muscle pain

Skin
- ❒ Rash

Neurologic
- ❒ Headache
- ❒ Seizures
- ❒ Weakness

Psychiatric
- ❒ Anxiety
- ❒ Depression
- ❒ Stressors

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Within the last 10 years, have you had any of the habits below?

❒ tobacco/smoking ❒ alcohol ❒ illegal drugs

What medications are you currently taking?

Are you allergic to any medications you know of?

What is the reason(s) you are visiting us for today? Please include as much information as possible.

HOUSTON LASIK & EYE

PRESCRIPTIONS FOR EYEGLASSES (YOU MUST CHOOSE ONE)

Refraction is determining the need for and measuring of eyeglasses. **We cannot tell if you need glasses without a refraction.** A medical eye exam evaluates the medical and surgical health of your eyes to address any problems you are having such as dry eyes, diabetes, high blood pressure, cataract, family history of glaucoma, etc. **Refraction is NOT part of a medical eye exam as defined by your health insurance policy.** A routine vision exam only checks for and provides an eyeglasses prescription and confirms the health of normal eyes **but any medical and/or surgical issues have to be addressed at a separate visit. There is a fee for rechecking of glasses prescription after 60 days. Rechecking after 6 months requires a new examination with associated fees.**

Please check what type of exam you are having today.

- ❑ I am having a medical eye and will pay $50 out-of-pocket to cover my refraction.
- ❑ I am having a medical eye exam and will come in for a separate visit for a refraction. Please note, children under 6 years of age will have to be dilated again if this option is chosen.
- ❑ I am having a routine vision exam which includes refraction but does not address any symptoms I am having from medical or surgical issues.

Office Use

PRESCRIPTIONS FOR CONTACT LENSES (YOU MUST CHOOSE ONE)

There is a fee for an **annual** contact lens fitting to obtain a contact lens prescription which is different from a glasses prescription. It cannot be finalized until the eyes are evaluated while wearing a pair of trial lenses which may need to be ordered. Several visits may be necessary. Insurance does NOT fully cover your contact lens fitting, related shipping & handling charges, and your supply of contact lenses. Some plans require for you to purchase contact lenses from the same provider that performed the contact lens fitting, otherwise you may be fully responsible for all contact lens fitting fees. Additional fees will apply for contact lens checks more than 30 days after dispensing of trials and for fitting more than one type of contact lens.

Office Use

- ❑ I would like a contact lens fitting today. Please consult the front desk for our current fees.
- ❑ I am not interested in a contact lens prescription.

DILATION (YOU MUST CHOOSE ONE)

Dilation involves placing drops in your eye to enlarge your pupil allowing your doctor to evaluate the internal health of your eyes. It can precipitate angle closure glaucoma in an estimated 1 in 50,000 individuals. The risk of not detecting a serious eye condition by failing to dilate the eyes is much greater than that of precipitating glaucoma. Houston Lasik & Eye has procedures in place in the event that angle closure glaucoma does occur. Thirty minutes after drops are instilled, things will be brighter and vision will be somewhat blurry mostly for near vision for usually about 4-6 hours. Most individuals are able to drive home slowly in good driving conditions along familiar paths. **If your vision is significantly disturbed following dilation, driving a car and/or a motorbike should be avoided.**

If you are here for a routine vision exam, dilation is often not necessary for the determining the need and measuring of eyeglasses except in children under 6 years of age and may NOT covered by your benefit plan.

Office Use

- ❑ I would like my eyes to be dilated.
- ❑ I do not want my eyes to be dilated and understand the risk of not doing so.

I understand these policies for this and future visits. Furthermore, all information on this form is true.

Signature: _____ Date: _____

HOUSTON LASIK & EYE

PLEASE FILL OUT THIS FORM COMPLETELY. VERIFY ANY PREFILLED INFORMATION FOR CORRECTNESS

PERSONAL INFORMATION

Last Name: _____ First Name: _____ MI: _____ Sex: ❑M ❑F

❑Dr. ❑Mr ❑Mrs. ❑Ms. ❑Miss Date of Birth: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____ Occupation: _____

Race: ❑American Indian ❑Asian ❑African-Amer. ❑White ❑Hispanic ❑Other ❑Do not report

Email address: _____

This will be used to give you web-access to your account on our secure Patient Portal, available at www. Houston-Lasik.com. The Patient Portal facilitates better communication with your physician's office by providing convenient 24 x 7 access from the comfort and privacy of your home. Using your secure portal, you will be able to view your personal health record, view your appointment history, manage your personal information, etc.:

Who is you family physician (PCP)?

Name:	Phone:

Office Use

How did you hear about us? (PLEASE CHOOSE ONE BELOW)

❑ From my family physician/PCP listed above.

❑ From another doctor (who is not your family physician/PCP or regular eye doctor).

Name:	Phone:
Please check here if this is another eye doctor: ❑	

Office Use

❑ From another patient.

Name:

❑ Other

Please explain:

I certify the information above is true to the best of my knowledge.

Signature: _____ Date:_____

HOUSTON LASIK & EYE

PLEASE FILL OUT THIS FORM COMPLETELY. VERIFY ANY PREFILLED INFORMATION FOR CORRECTNESS

EMERGENCY CONTACT

Last Name: _____ First Name: _____

Relationship: _____ Phone: _____

CONFIDENTIALITY In compliance with the Health Insurance Portability and Accountability Act (HIPAA), we are required to make every effort to inform you of your rights related to your personal health information. By signing this form, you acknowledge that you have read or declined to read our Notice of Privacy Practices, a copy of which is available in the office.

FINANCIAL REPONSIBLE PARTY (If patient is under the age of 18 this section MUST be completed)

❑ Patient is the financial responsible party.

Last Name: _____ First Name: _____ MI: _____

Relationship: _____ Phone: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

PHARMACY

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Office Use

❑ Check here if we may view your prescription history from external sources)

INSURANCE AND BENEFIT PLANS

Please provide your insurance cards to the front desk

I certify the information above is true to the best of my knowledge.

Signature: _____ Date: _____

HOUSTON LASIK & EYE

PRACTICE POLICY

Financial Policy: Insurance coverage is an arrangement between the insurance carrier and the patient. As a courtesy to you, we may obtain eligibility and/or benefit information from your insurance company and communicate this to you as well as file a claim for any services rendered. Ultimately, you and only you are responsible for understanding the specifics of your insurance plan. You bear full financial responsibility for the services rendered and products provided by Houston Lasik & Eye and agree to pay at the time of service. Additionally, you authorize and request that insurance payments be made directly to Houston Lasik & Eye and/or its doctors should they elect to receive such payments.

Payments that you are responsible for include but are not limited to any and all copayments, coinsurances, and deductibles. You have agreed with your insurance company to pay these at each doctor's office visit. Please note that copayments for office visits are usually higher for specialists (like ophthalmologists) versus primary-care physicians. So check with your insurance carrier to determine if you have a higher copayment for specialists. Additional diagnostic and therapeutic procedures may be subject to separate copayments, coninsurances, and deductibles than your office visit. Again, check with your insurance carrier to determine how your benefits apply.

Though Houston Lasik & Eye will attempt to determine and collect your payment responsibility at the time of service, you understand that you are responsible for any additional payment responsibilities determined after any claims are processed by your insurance company within 30 days of being notified by either your insurance company or Houston Lasik & Eye. Our charges may be estimated based on each insurance company's fee schedule. After your insurance processes the claim and if a balance is due you will receive a statement. If a refund is due, we will be happy to mail it to you.

Authorization for Treatment / Referrals (HMO & POS Plans): You are responsible for obtaining an authorization for examinations & treatments if required by your insurance company. Often separate referrals will be required for examinations, diagnostic tests, and procedures. Though we may attempt to assist you in obtaining a referral as a courtesy, it is your responsibility to have authorization on file with us before your visit. Otherwise, the insurance company will not pay for your visit. Without a referral, you have the option to receive services on a fee for service basis.

Keeping Your Account Up-To-Date: It is your responsibility to inform us of any changes in your insurance, telephone numbers, and address. Please have your insurance card available at all office visits. Insurance companies gives us 90 days to file a claim. Therefore, if we bill the wrong insurance carrier because you failed to provide the correct information, the visit will be your responsibility.

Delinquent Accounts: Accounts turned over to a collections agency will be assessed a $25.00 fee. You may also be given notice legally dismissing you from our practice and be asked to find another physician. You agree to pay all reasonable attorney fees and collection costs in the event of default of payment. We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate such problems to us so that your account can be properly managed.

Return Checks: There will be a $25.00 charge for all returned or cancelled checks.

Release of Medical Records: There will be a $25 charge for copies up to 20 pages. Each additional page is $0.50. If you need any insurance forms completed by our office, there will be a $50.00 charge. You authorize us to release of all medical records to the referring and family physicians and to your insurance company, if applicable. You allow fax transmittal of your medical records, if necessary.

Late or Missed Appointments: If you are unable to keep your appointment, please call to reschedule at least 24 hours prior to your visit to allow someone else to take your place. If you arrive too late to be accommodated, you may be rescheduled or worked in depending upon our schedule. If you simply do not show up for your appointment, we will need to bill you a $25.00 missed appointment fee.

All copayments, coinsurances, deductibles, fees, and outstanding balances must be settled before seeing the physician.

We reserve the right to immediately cancel your care for conduct, non-cooperation or non-payment.

Your signature represents your consent to treatment necessary for the patient named, your acknowledgement of full financial responsibility, and your understanding and acceptance of our policies detailed above. Furthermore, you certify that all information on this form is true to the best of your knowledge.

Signature: _____ Date:_____

HOUSTON LASIK & EYE

Authorization to Disclose Health Information to Family Members and Friends

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Houston Lasik & Eye to release my medical and/or billing information to the following individual(s):

1._____ Relation to Patient:_____

2._____ Relation to Patient:_____

3._____ Relation to Patient:_____

Information I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed. I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

You have the right to revoke this consent in writing.

Signature:_____Date:_____

HOUSTON LASIK & EYE

Patient Portal

Log in to your patient portal with the user name and password provide from our office.

Go to www.houston-lasik.com and click on Patient Portal under the Contact menu.

Using your Patient Portal you will be able to:

 Check your medical history and summary of all your visits.

 Make new appointments and see your future appointments.

 Request for refills and prescription for glasses and contacts.

 Send a message to doctor or staff member.

HOUSTON LASIK & EYE

Houston Lasik & Eye

SPECIALS

Free Single Vision Poly Lenses!

With the purchase of a Bebe Frame

Not combinable with insurance or other specials. Bebe brand frames only. See optical for more details and restrictions

20% OFF Gucci Designer Sunglasses

Not combinable with insurance or other specials. See optical for more details and restrictions.

$1000 Off Blade-Free Custom LASIK

See clearly without glasses.

Not combinable with insurance or other specials. See a lasik counselor for more details and restrictions.

These offers expire soon! Call for details.