PATIENT INFORMATION

Name: Mr. Mrs. Ms_____ Date: _____

Address: _____ City_____ Zip_____

Home Phone: _____ Cell Phone _____ Social Security _____

Date of Birth: _____ Age: _____ Sex: M F

Employer's Name: _____ Business Phone: _____

Employer's Address: _____Zip_____

Spouse's Name: _____ Spouse's Date of Birth _____

Spouse's Employer: _____ Business Phone: _____

MEDICAL INSURANCE INFROMATION

Medicare Number_____ Medicaid Number_____

Insurance Carrier_____ Policy Number: _____

2nd Insurance_____ Policy Number_____

INSURED INFORMATION

Name: _____ Relationship: _____

Date of Birth _____ Social Security # _____

Address: _____ Zip: _____ Phone: _____

Employer's Name: _____Business Phone: _____

Employer's Address: _____Zip: _____

EMERGENCY CONTACT (OTHER THAN SPOUSE)

Name: _____ Relationship: _____

Address: _____Zip_____ Phone: _____

IF INJURY, IS IT WORK RELATED? Yes_____ No_____

If yes give date of injury_____

Name of person to contact for verification_____

Address: _____ Phone: _____

HERITAGE EYE CENTER MEDICAL HISTORY

PATIENT NAME: DATE:

PATIENT'S MEDICAL HISTORY

- ☐ Acid Reflux
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis/Type:
- ☐ Asthma
- ☐ Back/Neck Problems
- ☐ Bleeding Disorder
- ☐ Bronchitis
- ☐ Cancer/Type:
- ☐ Chest Pain
- ☐ Chicken Pox
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Depression
- ☐ Diabetes: Type I / Type II
- ☐ Emphysema
- ☐ ENT Problems
- ☐ G.I. Problems
- ☐ Glaucoma
- ☐ Gynological Problems
- ☐ Hard of Hearing
- ☐ Heart Attack x
- ☐ Heart Disease
- ☐ Hepatitis/Type:
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Irregular Heart Beat
- ☐ Joint Pain
- ☐ Kidney/Urinary Problems
- ☐ Liver Disease
- ☐ Lupus
- ☐ Masses/Tumors
- ☐ Measles
- ☐ Mumps
- ☐ Pain
- ☐ Pacemaker
- ☐ Palpitations
- ☐ Prostate Problems
- ☐ Apsychiatric Problems
- ☐ Respiratory Issues
- ☐ Restless Leg Syndrome
- ☐ Retina Problems
- ☐ Seizures
- ☐ Shingles
- ☐ Shortness of Breath
- ☐ Sinus Problems
- ☐ Skin Disorders
- ☐ Sleep Apnea
- ☐ Stroke/TIA
- ☐ Thyroid Problems
- ☐ Ulcers:
- ☐ Others:

SOCIAL HISTORY:

Do you drink alcohol? YES / NO Drinks per week?

Do you currently smoke? YES / NO Previous smoker? YES / NO

FAMILY HISTORY ONLY:

EX: Glaucoma/Mother

- ☐ CANCER Whom?
- ☐ CATARACT Whom?
- ☐ DIABETES Whom?
- ☐ GLAUCOMA Whom?
- ☐ HEART DISEASE Whom?
- ☐ HIGH BLOOD PRESSURE Whom?
- ☐ HIGH CHOLESTEROL Whom?
- ☐ MACULAR DEGENERATION Whom?
- ☐ RETINAL PROBLEMS Whom?

VACCINES DONE RECENTLY:

Pneumonia in the last 5 years? YES / NO

Flu this season? YES / NO

HERITAGE EYE CENTER MEDICAL INFORMATION Date: _____

Pt Name: _____ Referred by: _____

PCP Dr: _____ Location: _____

Pharmacy: _____ Location: _____

Current Medications:

EX: ATORVASTATIN 10mg **DOSAGE: 2 PILLS ONCE A DAY** **REASON: CHOLESTEROL**

MEDICATION:	DOSAGE:	MEDICAL REASON:

Medication Allergies/Reactions/Severity:

EX: Penicillin/Rash/Mild-Moderate

Medication Allergies:

Past Surgical History:

EX: Appendectomy, Gallbladder, etc.

Surgical History:

HERITAGE EYE CENTER
INSURANCE PAYMENT AUTHORIZATION
SIGNATURE ON FILE

1. MEDICARE

I request that payment of authorized Medicare benefits be made on my behalf to Heritage Eye Center, for services furnished me by Heritage Eye Center. I authorize any holder of medical information about me to release to the Heritage Eye Center Financing Administration and its agents and information needed to determine these benefits of the payable to relate services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on the other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown.

Heritage Eye Center accepts the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Signature Date

2. MEDIGAP

If a Medigap policy or other health insurance is indicated in tIten 9 of HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made either to me or on my behalf to Heritage Eye Center.

_____ _____

Signature Date

3. OTHER INSURANCE

I herby authorize payment of my medical and surgical insurance benefits to Heritage Eye Center. I understand I am financially responsible for any charges whether or not paid by said insurance. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Heritage Eye Center. I authorize Heritage Eye Center to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

_____ _____

Signature Date

HERITAGE EYE CENTER
ALLEN OPHTHALMOLOGY

SANJAY PATEL, M.D. **JAMES NORBURY, JR., M.D.**

JOSEPH CONSTABLE O.D. **GRANT GILLILAND, M.D.**

Heritage Eye Center
1501 N. Redbud Blvd.
McKinney, TX 75069
Phone: 972-548-0771
Fax: 972-562-2300

Allen Ophthalmology
400 N. Allen Dr., # 108
Allen, TX 75013
Phone: 972-727-7477

Welcome to the Heritage Eye Center & Allen Ophthalmology. Please read each of the following policies and initial each paragraph and sign below.

Acknowledgment of Notice of Privacy Practices

_____ I have been given the opportunity to review the Notice of Privacy Practices and Policies for Identity Protection for the Heritage Eye Center/Allen Ophthalmology which explains how my medical information will be used and disclosed and how my personal and financial information will be handled. I understand that I am entitled to receive a copy of these documents upon request.

Patient Bill of Rights

_____I have been given a copy of the Patient Bill of Rights and as a patient; I understand the policies which give me the right to choose my physician, my course of treatment, and my responsibilities as a patient at the Heritage Eye Center/Allen Ophthalmology. I also understand that I have the right to choose a surgical facility in which my physician does or does not have ownership interests. I also understand the center's grievance policy should I not be pleased with any aspect of my service at the center.

Advanced Medical Directives/Medical Power of Attorney

_____I understand that it is my right to execute an advanced medical directive. I understand that upon request, the Center can provide a copy of the official state regulated advanced directive form. I also understand that if I have executed a directive, I must provide a copy of the completed form prior to any procedure performed at the center. I also understand that while a directive may be on file, the Surgery Center will not follow such directives and, if it is necessary, I will receive life saving measures and I will be transferred to a hospital along with the advanced directive.

Refraction Policy & Acknowledgment

Refraction is the process of determining the eye's refractive error, or need for corrective spectacle lenses (glasses). Refraction is part of an eye exam but is NOT a covered service by Medicare or most managed care plans. Our office fee for the results of refraction (glasses prescription) is $40.00. This refraction fee is in addition to the patient's co-pay.

_____I have read the above statement and understand that refraction is a non-covered service. I accept full financial responsibility for the cost of the service. The co-pay is separate from and not included in the refraction fee.

_____ _____

Signature of Patient or Representative Date

_____ _____

Printed Name of Patient or Representative Representative's Relation to Patient

(5/2019)

HERITAGE EYE CENTER

Refraction Policy

One of the most important parts of your eye exam today is the refraction. That is the part of the exam by which the Dr. determines whether you can be helped in any way by a new glasses prescription. It is also how the Dr. determines the best possible visual acuity and function of your eye, which is essential medical information for them to have as they assess your eyes and look for problems. It is **NOT** a covered service by Medicare and many other insurance plans. These plans consider refraction a "vision" service and not a "medical" service. Our office fee for refraction is **$40.00** and unless your plan automatically covers the refraction charge, this fee is collected at the time of service in addition to any co-payment your plan may require. Should your plan pay us for the refraction, we will reimburse you accordingly.

____ I have read the above information and understand the refraction is a non-covered service. I accept full financial responsibility for the cost of this service and understand it is due at time of service. I understand that any co-payment, coinsurance or deductible I may have are separate from and not included in the refraction fee.

____ I decline the refraction service today. I understand that without the refraction, I will not be able to have new lenses made.

_____ _____

Signature Date

***Refraction results are kept on file for up to one year from exam date and will be released if requested. $40.00 fee will be due upon release of those results.

HERITAGE EYE CENTER

AUTHORIZATION TO RELEASE PATIENT INFORMATION

Keeping our patient's information private is important to us and by default we will only disclose information related to the patient's **Billing Account** and **Medical Treatment** to the patient or legal guardian.

If you would like additional contacts (other than the patient or legal guardian) to receive information regarding your medical treatment and/or billing information, please complete the fields below.

Name	Relationship to Patient
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

Signature Date