

Welcome to the Eye Doctor's Office

Patient Information

Legal Name: _____
First M.I. Last

Nickname: (Please call me): _____

Circle one: I am: Married Single Widowed Domestic Partner
If Student Circle one: Full Time Student Part Time Student

Address: _____ Date of Birth: ____/____/____ Age: _____ Sex: M or F

City: _____ State: _____ Zip: _____ Social Security Number: _____/_____/_____

Home Phone: (____) _____ - _____
 Work Phone: (____) _____ - _____
 Cell Phone: (____) _____ - _____

Circle one of the following that applies to the patient:
I am employed: Full Time Part Time Self Employed Retired
 Homemaker Currently not employed

Home Email: _____
 Alternate Email: _____

Employer: _____
 Occupation: _____

Drivers License # _____ State _____ Exp _____

For New Patients
Whom may we thank for referring you?

Medical/Health Insurance Card Information

This office is a medical facility. Your medical insurance may often times cover advanced testing and treatment of the eyes. Diseases of the body can show up in the eyes. If the doctor determines the need for additional medical testing or treatment, the following information will help us file your claim.

Employee Name: _____ DOB ____/____/____ Sex M or F

Company/Employer Name: _____

Relationship to Patient: Self Spouse Child I am employed F/T P/T Self Employed Retired Not Employed

Insured's ID# _____ Group# _____

SS# _____ Medical Plan Name: _____ Vision Plan Name _____

Acknowledgment of Notice of Privacy Practices

The Federal Law requires that we make every effort to inform you, the patient, of your right related to your personal health information.
Please check only one below

___ **Yes, I have** read or had explained to me by this office the NPP & I wish to continue my care with The Eye Doctor's Office under said terms.

___ **No, I have not** read this office's NPP but, I was given the opportunity to read it upfront and declined. I wish to continue my care with The Eye Doctor's Office under the terms.

___ The NPP **could not be read** due to the emergent nature of the care or other reasons described below.

Comments: _____

Financial Assignment & Release (Signature Required)

- I, the undersigned, assign directly to American Eye Care Centers, Inc. dba: The Eye Doctor's Office and Eye Gallery, Inc. and/or Dr. Robert Consor all insurance benefits, if any, otherwise payable by me or to me for services rendered.
- I understand that I am financially responsible today for all fees. I also agree that I am financially responsible to reimburse any and all fees for services and materials not collected in full at the date of service or should my insurance or vision plan deny payment for services or materials rendered.
- I further understand that after 60 days from the date of service or claim is filed I agree to pay for any unpaid balances on my account as a result of denial in part or whole from my insurance carrier caused by; unmet deductibles, non covered materials or professional services, my negligence in fulfilling any paperwork, providing any required information requested of my by my insurance carrier or uncollected fees on service day.
- If I fail to reimburse said fees in a timely manner with the above stated office and should the need arise, I agree to pay any and all collection fees, court costs and attorney fees.
- If you do not inform us that you have a vision plan or medical insurance before services are rendered, we will assume no coverage exists.
- I agree I am responsible to file my own claim if I discover I have vision or medical benefits after services or products are rendered.
- I agree this office with no exceptions will not back file claims, post authorize claims, or refund fees after services are rendered due to lack of notification of vision or medical benefits.

Signature Agreeing to all above stated entries:

_____/_____/_____
 Patient or Responsible Party Signature Date Signed

 Relationship to Patient

Medical Screening Tests For Early Disease Detection and Prevention of Blindness.

Early Detection of Glaucoma and Optic Nerve Damage Prevents Blindness.

Our new advanced GDX technology detects glaucoma much earlier than ever before. Now we can measure damage and thinning of the optic nerve fibers and detect diseases of the optic nerve and glaucoma sooner preventing loss of sight.

(Our doctors' are Optometric Glaucoma Specialists and highly recommend this test)

Glaucoma and other Diseases of the Optic Nerve are two of the leading causes of blindness.

Glaucoma is a group of conditions resulting in optic nerve damage. It's the second leading cause of blindness and sometimes called the silent thief of sight. It can damage your vision so gradually that you don't notice any loss of vision until the disease is at an advanced stage. There are no noticeable signs or symptoms as the nerves in your eyes painlessly degenerate and your vision is gradually lost.

Early detection is essential in preventing permanent vision loss.

This digital imaging test is quick and painless and takes about a minute to perform.

***Screening with this technology* is accurate and recommended for all our patients over the age of 21**

The nominal fee for this screening is \$24.

I elect to have this screening (please circle one) Yes No

Retinal Photography:

Allows us to take digital pictures of the back of your eyes and view the blood vessels, nerves, retina for more accurate diagnosis today and future comparison to detect eye disease related to genetics, diabetes, high blood pressure and neurological disorders. Many diseases may go undetected without retinal photographs.

Each year we will compare your pictures for more enhanced detection and treatment of eye pathology.

This digital imaging test is quick and painless and takes about a minute to perform

The nominal fee for this screening is \$25.

I elect to have this screening (please circle one) Yes No

X _____
Patient Signature

Date _____

The Contact lens Examination: Do you currently wear contacts? **Yes** **No** (If yes please keep reading)

Texas State Law requires that contact lens wearers have a yearly contact lens examination in order to renew their prescription or buy new lenses. The contact lens exam **is not** part of the comprehensive eye health or refractive vision test examinations. Contact lens patients require additional testing, time, measuring and monitoring to evaluating the design and fit of their current lenses, the health of the eye as it relates to contacts or in the case of a new wearer, their suitability to wear contacts.

The contact lens fee varies with complexity of the lens design and diagnostic fitting time. **Insurance or vision benefit plans may contribute an allowance.**

I understand that there is a separate contact lens examination fee and agree to its terms and conditions.

X _____

Patient

_____/_____/_____