## PATIENT INFORMATION

Patient's Name: _____ DOB: _____
Social Security Number: _____ Gender: Male / Female / Other
Address: _____ Apt: _____
City: _____ State: _____ Zip _____
Home number: _____ Cell: _____
Email address_____
**Marital Status** : Married / Single / Divorced / Widowed
**Language:** English / Spanish / Other _____
**Ethnicity**: Hispanic / Not Hispanic / Decline
**Race**: Hispanic or Latino / White / African American / Asian / American Indian Alaskan Native / Native Hawaiian / Decline

**Emergency Contact**: _____ Relationship_____
Phone number: _____
**Preferred Pharmacy**: _____ Phone number: _____
**Pharmacy address:** _____
**PCP Name**: _____ Phone number: _____

**********

**MEDICAL INSURANCE**
**Primary Insurance** _____
Policy Holder Name _____
Member ID _____ Group # _____
Policy Holder DOB_____ Relation to Patient _____

**Secondary Insurance** _____
Policy Holder Name _____
Member ID _____ Group # _____
Policy Holder DOB_____ Relation to Patient _____

**VISION INSURANCE** _____
Policy Holder Name _____
Policy Holder ID/SS# _____
Policy Holder DOB_____ Relation to Patient _____

**I hereby authorize West Texas Eye Associates to perform appropriate examinations and treatments. I understand payment is due at time of services.**

_____ _____
Patient Signature (parent or guardian) Date

# EYE HISTORY

Name: _____

Thank you for choosing our office for your eye care. To better serve you, please answer the following questions:

1. What is the reason for your visit?

   _____

   _____

2. Are you currently experiencing any eye symptoms? Please circle all that apply:

   Eye pain  Blurred Vision  Eyelid Crusting  Flashes of Light  Halos

   Discharge  Light Sensitivity  Double Vision  Decreased Vision  Floaters

   Dry Eyes  Tearing

3. Do you wear glasses? ❒ YES ❒ NO
4. Do you wear Contact Lenses? ❒ YES ❒ NO
5. Do you use a computer? ❒ YES ❒ NO

6. Have you ever had an eye injury or eye diseases?

   _____

   _____

7. Have you ever had eye surgery? Please list type, which eye and approximate dates:

   _____

   _____

8. Are you currently using any eye medications? Please list name and how often used:

   _____

   _____

9. What medications are you currently taking?

   _____

   _____

10. Do you have any family history of eye problems? Please circle and list family relationship:

    Glaucoma  Cataracts  Strabismus  Macular Degeneration  Blindness

    Retinal Disease

11. Please circle any of the following that you would like more information about:

    Contact Lenses  Cataract Surgery  Glaucoma  Diabetic Retinopathy

    Other: _____

12. Are you taking Plavix, Aspirin, Coumadin, Flomax, Hytrin or Cardura?

    _____

WEST TEXAS EYE ASSOCIATES

**Carlos W. Vazquez, M.D.**
AMERICAN BOARD of OPHTHALMOLOGY
Adult and Pediatric Ophthalmology
Neuro Ophthalmology

**Samuel C. Faith, M.D., M.P.H.**
AMERICAN BOARD of OPHTHALMOLOGY
General Ophthalmology
Corneal and External Disease
Refractive Surgery

**Heath Anderson, O.D.**
Therapeutics/Glaucoma
Optometrist

**Daniel Crawford, O.D.**
Therapeutics/Glaucoma
Optometrist

**Cory Grifka, O.D.**
Therapeutics/Glaucoma
Optometrist

Dear Patient/Guardian,

We deal with over 300 Insurance plans, each with their own unique requirements. As a patient it is your responsibility to provide our staff with your current and correct insurance information & Insurance cards at the time of your appointment. If correct information is not provided on the day of service, we will be unable to bill your insurance at a later date.

_____
Patient/Guardian

We are unable to know the particulars of each plan. Be familiar with your Insurance plan requirements. The relationship is between the patient and the Insurance you or your employers have chosen. Any questions about benefits or coverage should be directed to your Insurance agent or employer.

_____
Patient/Guardian

Be certain you know whether your insurance plan requires that you obtain a referral or authorization from your primary physician. It is your responsibility to obtain & bring your referral or authorization on the day of your appointment. If you do not have your referral or authorization, we will be happy to see you on a cash basis. **(FAX WILL NOT BE ACCEPTED).**

_____
Patient/Guardian

Be aware of your plan benefits on payment to your doctor, including co-payments, co-insurance and deductibles. Understand that the benefits we are giving you, are an estimate given to us by your insurance and may change once the claim is filed. Co-payments, Deductibles and Refraction charges will be collected on the day of your appointment. Services not paid by your insurance within 90 days of the office visit, will be your responsibility.

_____
Patient/Guardian

Thank you for helping us to help you.

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I have read and understand this information.

Date:_____

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**AUTHORIZATION FOR RELEASE OF RECORDS:**

I hereby authorize the above named physicians to release any information acquired in the course of my examination or treatment to my insurance.

**AUTHORIZATION FOR RELEASE OF BENEFITS:**

I hereby authorize payment directly to the above named physicians any medical benefits payable under my insurance policy. I understand that I am financially responsible for the charges not covered by my insurance policy.

**HIPPA POLICIES GIVEN**

I have received a copy of the HIPPA policies

**REFRACTION POLICY**

Refraction is the process of determining the eye's error, **(need for glasses and/or contact lenses)**.
It is an essential part of an eye examination, which is **NOT** a covered service by Medicare or most insurances.
Our fee for a refraction is between $25.00 - $45.00 and this fee is collected in addition to the patient's co–payment, if you wish to take your prescription with you. I accept full responsibility for the cost of these service's.

**PLEASE SIGN BELOW SO WE MAY FILE YOUR INSURANCE CLAIM AND TO ACKNOWLEDGE YOUR UNDERSTANDING OF OUR POLICIES.**

Signature of Patient (Parent for Minor) _____ Date _____

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# E-PRESCRIBING CONSENT FORM

ePrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:

- **Formulary and benefit transactions** - Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification** - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that West Texas Eye Associates can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to West Texas Eye Associates to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Print Patient Name:_____ DOB:_____

Signature of Patient or Guardian:_____

Relationship to Patient: _____

Date:_____

# *Medical Information Release Form*

# *(HIPAA Release Form)*

**Name:** _____ **Date of Birth:** ____/____/____

## ***Release of Information***

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

## ***Messages***

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: ____/____/____

Witness:_____ Date: ___/____/_____