Lake Travis Eye and Laser Center, PA

Kyle M. Rhodes, M.D. Tommy Q. Dang, M.D.

Patient Name: _____ Date of Birth: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Ph. # _____ Cell Ph. # _____Work Ph. # _____

Social Security No. _____ Email: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ S ☐ M ☐ D ☐ W Race: _____ Ethnicity: _____

Emergency Contact: _____ Phone # _____

Medical Insurance Information:

Primary Insurance: _____ Secondary Insurance: _____

Member ID: _____Member ID: _____

Policy Holder: _____ Policy Holder: _____

Policy Holder SS # _____ Policy Holder SS # _____

Policy Holder DOB: _____ Policy Holder DOB: _____

Pharmacy Information:

Preferred Pharmacy: _____ Pharmacy Phone # _____

Pharmacy Address: _____

Private Insurance Authorization for Assignment of Benefits/ Information Release:

I, the undersigned, authorize payment of medical benefits to Lake Travis Eye and Laser Center for any services provided to me by the physician. I understand that I am financially responsible for any amount not covered by my medical insurance contract. I also authorize you to release information to my insurance company or their agent concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

_____ _____

Patient, Parent or Guardian Signature (if under 18 yrs old) Date

Lake Travis Eye and Laser Center, PA

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Patient Name: _____ **DOB:** _____

Reason for today's visit: _____

Are you interested in Refractive surgery (LASIK, Kamra Inlay, Clear Lens Exchange) for yourself? ☐ Yes ☐ No

Any known ocular issues you may have? _____

How did you hear about our clinic? _____

Referring Doctor: _____ **Primary Care Doctor:** _____

List all medications and eye drops that you are currently taking, both prescribed and over the counter OR attach list.

Name:	**Dosage:**	**Frequency:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any known drug allergies:	**Reaction (hives, rash, swelling, etc.):**
_____	_____
_____	_____
_____	_____

List all surgeries (including eye surgeries):	**Date:**
_____	_____
_____	_____
_____	_____
_____	_____

Height: _____ **Weight:** _____ **Pneumonia shot:** ☐ Yes ☐ No **Flu shot:** ☐ Yes ☐ No

Are you Pregnant? ☐ Yes ☐ No **Are you nursing?** ☐ Yes ☐ No **Birth Control?** ☐ Yes ☐ No

Do you consume alcohol daily? ☐ None ☐ Less than 1 ☐ 1-2 drinks ☐ 3 or more

Tobacco Use? ☐ Never Smoker ☐ Former Smoker, Quit: _____ ☐ Current Smoker ☐ Cigar Smoker

Use of Recreational and Non- Prescription Drugs? (type & how long) _____

Have you ever been treated for drug or alcohol dependency? _____

Review of Systems: Please indicate if you have ever had the following.

☐ Anxiety	☐ Coronary Artery Disease	☐ HIV/AIDS	☐ Radiation
☐ Arthritis	☐ Depression	☐ Hypercholesterolemia	☐ Seizures
☐ Asthma	☐ Diabetes Type 1/ Type 2	☐ Hyperthyroidism	☐ Stroke
☐ Bone Marrow Transplant	☐ End Stage Renal Disease	☐ Hypothyroidism	☐ Other _____
☐ BPH (Benign prostatic hypertrophy)	☐ GERD	☐ Leukemia	
☐ Breast Cancer	☐ Hearing Loss	☐ Lung Cancer	
☐ Colon Cancer	☐ Hepatitis	☐ Lymphoma	
☐ COPD	☐ Hypertension	☐ Prostate Cancer	

Have you had family history of any of the above diseases? If yes, which family member and which disease?

_____

_____

Any family history of Glaucoma or Macular Degeneration? If yes, which family member and which disease?

_____

_____

Lake Travis Eye and Laser Center Patient Payment Policy

Thank you for choosing our practice. We are committed to the success of your medical treatment and care. Please understand that payment of your bill is necessary for treatment and care. For your convenience, we have answered a variety of commonly asked financial policy questions below. If you need further information about any of these policies, please ask to speak with a Billing Specialist or the Practice Manager.

How may I pay? We accept payment by cash, check, VISA, MasterCard, American Express and Discover.
What is my financial responsibility for services? Your financial responsibility depends on a variety of factors, explained below:

- **Medical Insurance-** Lake Travis Eye and Laser Center will file claims for all office visits and procedures as long as we are considered in network with your plan. You are responsible for payment of all deductible, co-insurance portions and co-payment amounts at the time of your visit. Please keep in mind that coverage for your services is dependent upon your contract with your specific insurance plan. Any non-covered and/ or unpaid services will be billed to the patient.
- **Vision Plans-** We do not accept or file vision plans. We are able to provide you with a detailed receipt from your visit so that you can submit your own claim for reimbursement.
- **Referrals and Pre-Authorizations –** If your plan is considered an HMO, Health Select, or a plan that states a referral/pre-authorization is required from your PCP, then we must receive this before any medical or surgical treatment is provided. If you do not obtain one, then we will not bill your insurance plan and you will be responsible for payment in full.
- **No Insurance-** Patients who do not have insurance will be expected to pay payment in full on the day the services are rendered. If you plan to move forward with a surgical procedure, we will require payment to be paid in full before the treatment is performed.
- **Missed Appointments-** Unless cancelled at least 24 hours in advance, our policy is to charge a $40.00 cancellation fee. We do understand circumstances may arise where 24-hour advance notice is impossible, and we will take that into consideration.
- **Returned checks-** All checks returned by the bank for "Non-Sufficient Funds" will be charged a $50.00 fee, and we do require the check to be replaced by cash or money order within 7 days.

Refraction Policy

During your visit, a refraction may be performed to determine your need for glasses or to evaluate if any further visual improvement can be achieved. This is a necessary and essential portion of your eye exam and in some cases, it is the sole reason for the appointment. Refractions can help distinguish problems caused by poor focus (a need for glasses) versus problems caused by eye disease. However, the refraction is considered a NON-COVERED service by most medical insurance companies including Medicare regardless of why the doctor performs the test. Please be aware it is the responsibility of the patient to pay the refraction fee of $50.00 (if the prescription is needed) in addition to your copay. **If this fee is not paid at the time of your visit, then we will charge a $65.00 fee if the claim is submitted and your insurance plan does not cover the refraction fee.**

I have read the above policies and understand my financial responsibility and that the refraction is a non-covered service. I accept full responsibility for the cost of all services and agree to pay any additional fees that are not covered by my insurance contract.

_____ _____

Patient Signature Date

Retinal Screening

A retinal screening is an integral part of a thorough comprehensive eye examination. This allows early detection of pathology such as optic nerve diseases, retinal diseases, vascular changes, retinal tumors, etc. This is usually done through a dilated pupil. New technology now allows an image of the retina to be captured through an undilated pupil with the Optos camera. It only takes 1-2 minutes to capture the images which will be available for review during your exam and will be included in your electronic health record for permanent comparison. Please note that we still ask patients with specific symptoms or diagnoses to dilate, in order to view the retina beyond the 80% captured with the Optos (ie. Diabetic Eye Exam, Macular Degeneration, Glaucoma, Flashes & Floaters, Cataract Pre-Ops).

Please understand that this service is **not covered under insurance** as a screening examination. Our office charges a $40.00 fee at the time of your visit for the Optos Fundus Photography**. If the doctor request this image due to specific diagnosis, then we will bill insurance and not collect the fee at the time of your visit until we receive notice of coverage from your insurance.**

_____ I elect to have the Optos image of my retina for $40.00.

_____ I decline the Optos image and am choosing to be dilated.

_____ I decline both the Optos and dilation. I elect not to have a thorough comprehensive eye examination today.

_____ _____

Patient Signature Date

Office Policies and Procedures

Below is a list of our office policies. Please take a moment of your time to review our policies, and please do not hesitate to ask any questions. ***After reviewing the policies below, please sign the bottom, indicating that you have read, understand, and will adhere to the written policies.***

Patient Treatment: It is our primary goal to restore and maintain the health of your eyes. We strive to provide you with the highest quality ophthalmology care. If you have any questions regarding your treatment, please feel free to consult with the physician providing your care. It is our responsibility to deliver the best health care possible. We highly value your confidence in our practice and we will make a sincere effort to satisfy all of your ophthalmological needs. Your initials and signature will act as an authorization and consent for treatment.

Release of Records: If you want your records released to another physician or facility you must sign a release of information form. If you wish to receive a copy of your records for personal files, you must send us a written request. Please allow 7-10 business days to process this request.

Verification of Benefits: You as the policyholder are primarily responsible to know your insurance benefits. The insurance DOES NOT guarantee payment of benefits quoted and subsequently you will be responsible for any co-insurance or deductibles for services not covered by your insurance carrier. We must have a copy of your insurance card and photo ID in order to process your claim. Therefore, please give your cards to the receptionist. If you are a first- time patient, or if your insurance information has changed, we must be notified. Failure to notify us of any changes in your insurance coverage constitutes your understanding and acceptance of financial responsibility for charges incurred.

Notice of Privacy Practices

1. **This notice describes how medical information about you may be used and how you can get access to this information. Please read it carefully.** The notice is provided in two layers: This layer briefly summarizes how we handle your health information, and the attached bottom layer provides further details of our privacy and procedures.
2. **How we may use and disclose your health information.** We use health information about you for treatment, to get paid for treatment, for administrative purposes, and to evaluate the quality of care that you receive. For example, your health information may be shared with other providers to whom you are referred. Information may be shared by paper, mail, electronic mail, fax, or other methods. We may use or disclose your health information without your authorization for several reasons. If you sign an authorization to disclose information, you can later revoke it to stop any future disclosures.
3. **Your rights.** In most cases, you have the right to view or receive a copy of your health information that we use to make a decision about you. You may request that we limit disclosure to family members, other relatives, caregivers, or close personal friends who may or may not be involved in your care. If you request copies, we may charge you a cost-based fee. You also have the right to request a list of certain types of disclosures of your information that we have made. If you believe that your health information is incorrect, or information is missing, you have the right to request that we correct the existing information or add the missing information.
4. **Our legal duty.** We are required by law to protect the privacy of your health information, provide this notice about our privacy practices, follow the privacy practices that are described in this notice, and seek your acknowledgement of receipt of this notice. We may change our privacy policies at any time. Before we make significant changes in our policies, we will change our notice. The notice will be prominently displayed at Lake Travis Eye and Laser Center. You can also request a copy of our notice at any time. For more information about our privacy policies, contact our privacy officer or office manager.
5. **Privacy complaints.** If you are concerned that we have violated your privacy rights, our privacy policies, or if you disagree with a decision we made about access to your health information, you may contact our office manager. You may send a written complaint to the U.S. Department of Health and Human Services. Our office manager can provide you with the appropriate address upon request.

If you have any questions or complaints, please contact: Lake Travis Eye and Laser Center, (512) 263-9000.

Acknowledgement

Please sign and print your name and provide the date below to acknowledge that you have reviewed the Office Policies and Procedures and received the Notice of Privacy Practices.

Signature: _____

Printed Name: _____ Date: _____