6560 Fannin St.
Scurlock Tower, Suite 450
Houston, TX 77030
713.441.8843

HOUSTON METHODIST EYE ASSOCIATES

HOUSTON
Methodist®
BLANTON EYE INSTITUTE

General History

Patient Name:______________________ Date:_____________ DOB:___________ Sex: Male/ Female

1. Allergies: ____

2. How did you hear about us? Family/Friend__ Insurance__ Doctor_________________Other__

3. Occupation:____

3. History of following diseases check if YES):

	Self	Family
EYE DISEASE		
1. CATARACTS		
2. GLAUCOMA		
3. MACULAR DEGENERATION		
4. RETINAL DETACHMENT		
Cardiac		
1. Heart disease		
2. High blood pressure		
3. Chest pain		
Neurological		
1. Stroke		
2. Seizures		
Kidney		
1. Renal insufficiency/failure		
2. Dialysis dependence		
Endocrine		
1. Diabetes (Type______)		
2. Thyroid problems		
Musculoskeletal		
1. Walker/wheelchair use		
2. Join pain (Location:________)		

	Self	Family
Respiratory		
1. Asthma		
2. Bronchitis		
3. Emphysema		
4. Oxygen dependence		
Gastrointestinal		
1. GI reflux		
2. Hiatal hernia		
3. Hepatitis (Type:___)		
Ear/Nose/Throat		
1. Chronic cough		
2. Hearing aid use		
Psychiatric		
1. Depression		
2. Anxiety		
Other		
1. Cancer (Type:_____)		
2. HIV		
3. Bleeding disorders		
4.__________________		
5.__________________		

4. Current Medications:____
____

5. Previous Surgeries:____
____

6. Tobacco use: Yes/ No Quantity:__________ If you quit,how long ago?________

7. Alcohol consumption? Yes/ No Quantity:________

8. Drug abuse? Yes/ No Type:___________________

9. If you are female, possibility of pregnancy? Yes/No

10. Do you suffer from any of the following?

Blurry Vision	____	Sinus Problems	____	Dry Eyes	____
Flashes of Light	____	Headaches	____	Halos	____
Watery Eyes	____	Pain in your eyes	____	Floaters	____
Seasonal Allergies	____	Dizziness	____	Other	____

11. Do you wear glasses or contact lenses? Yes/ N Extended Daily Hard Soft

Are you interested in learning more about cosmetic facial rejuvenation? Yes/No

Would you like information on LASIK vision correction? Yes/No

Signature: ____

Physician's signature:___________________________________ Date:___________________________

Subsequent History reviews (check, sign, and date):

__ No changes __ Additions as noted above _________________________ Date:__________________

__ No changes __ Additions as noted above _________________________ Date:__________________

__ No changes __ Additions as noted above _________________________ Date:__________________

Houston Methodist Eye Associates

Signature on File, Assignment of Benefits, Financial Agreement HIPAA Notice

Name:_________________________ Date__________________________

MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to Houston Methodist Eye Associates for services rendered to me by Doctor(s). I authorize any holder of medical information to release to the Centers of Medicare and Medicaid Services and its agents any information needed to determine these benefits or benefits payable for related 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 CMS 1500 form, my signature authorizes releasing the information to the insurer or agency shown. Houston Methodist Eye Associates accepts the charge of determination of the Medicare carrier as the full charge, and I am responsible for the deductible, co-insurance and non-covered services. Co-insurance and deductibles are based upon the charge determination of the Medicare carrier.

MEDIGAP: I understand that if a MediGap policy or other health insurance is indicated in item 9 of the HCFA 1500 form, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Houston Methodist Eye Associates, if possible, or otherwise to me.

OTHER INSURANCE: I authorize payment of my medical and surgical insurance benefits to Houston Methodist Eye Associates. I understand I am financially responsible for any charges whether or not paid by insurance. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Houston Methodist Eye Associates. I authorize Houston Methodist Eye Associates 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.

NON-COVERED SERVICES: I understand that Houston Methodist Eye Associates contract with health care services plans (i.e., HMOs, PPOs) relates only to items and services which are “covered” by the health care service plans. Accordingly, I accept full financial responsibility for all the items or services. Accordingly, I accept full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. I agree to cooperate with Houston Methodist Eye Associates to obtain necessary health care service plan authorizations.

FINANCIAL AGREEMENT: I agree that in return for services provided to me by Houston Methodist Eye Associates, I will pay my bill at the time service is rendered. If my account is sent to an agency for collection, I agree to pay collection expenses. Any benefits of any type under any policy of insurance are hereby assigned to Houston Methodist Eye Associates. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Houston Methodist Eye Associates. However, I understand that I am primarily responsible for the payment of my bill.

HIPAA NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received the Notice of Privacy Practices Issued by Houston Methodist Eye Associates that was effective May 1, 2011. I agree to allow electronic communication as defined in security practices effective April 21st, 2005.

INFORMATION TO BE USED BY OR DISCLOSED TO:

Name of Recipient (Family Member):____

Telephone Number: ______________________ Fax Number: _________________________________

I have read and understand these instructions and have a copy for my review.

Signature: ____

Please direct complaints to: Texas Department of State Health Services 110 West 49th Street, Austin, Texas 78756 Phone: 1-888-973-0022

Houston Methodist Eye Associates

Refraction Policy

During your visit, a refraction test may be necessary to determine your need for glasses or to evaluate if any further visual improvement can be achieved. If performed, it is because it is necessary and essential to your eye exam and in some cases it is the sole reason for the appointment.

It is NOT a covered service by Medicare and many other insurance plans. These plans consider refraction a "vision" service not a "medical" service. Our office fee for refraction is $50 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.

Contact Lens Policy

The glasses prescription you receive from Houston Methodist Eye Associates is NOT a contact lens prescription. A qualified contact lens fitter must fit the contact lenses. There is a fee for this service, which varies greatly depending on the type of contact lenses, whether you have been fitted before, and other individual factors. You will receive a copy of your contact lens prescription only if you have completed the fitting and made payment for the service. WE DO NOT FILE WITH ANY INSURANCE FOR CONTACT LENS SERVICES.

I have read and understand the above refraction and contact lens policy.

______________________________ ____________________

Patient or Guardian Signature Date