Covid-19 Screening Question

Because we are trying to keep our patients and staff as safe as possible we are asking all patients to print out this form, answer each question and sign at bottom. Please bring filled out form to your appointment.

Yes	No	Question
☐	☐	Are you experiencing a new cough (in the last few days)?
☐	☐	Are you experiencing a fever or chills?
☐	☐	Are you experiencing new muscle aches (in the last few days)?
☐	☐	Are you experiencing new shortness of breath (in the last few days)?
☐	☐	Are you experiencing a new sore throat (in the last few days)?
☐	☐	Are you experiencing a loss of smell or taste?
☐	☐	Have you tested positive for Covid-19 and if so, how long ago _____?
☐	☐	Have you been in contact with anyone else who has tested positive for Covid-19 and if so how recent _____?

If you answer yes to any of the above or have been exposed/tested positive in the last 2 weeks, we ask you to reschedule to a later date when symptom free and are past the 2 week window if positive or exposed.

Name: _____ Date: _____

Signature: _____

PATIENT REGISTRATION

Please fully complete all sections.

Referred by:_____ **Family doctor:**_____

Patient Name._____ Today's Date_____
Last First Middle

Home Address_____

City_____State_____ Zip Code_____

Home Phone_____Cell Phone_____

E-mail address_____Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Social Security Number_____ Date of Birth_____ Age _____ Gender ☐ ☐

Employer/Parent's Employer_____Occupation_____

Work Address_____Work Phone_____

City_____State_____Zip Code_____

Spouse name (Parent name if minor)_____Spouse/Parent Work Phone_____

Person to notify in case of emergency (other than spouse)_____

Phone number (s)_____Relationship_____

Primary Insurance Company		
ID#	Group #	Effective Date
Subscriber Name		**Relationship to Patient**
Social Security Number	Date of Birth	Employer

Secondary Insurance Company		
ID#	Group #	Effective Date
Subscriber Name		**Relationship to Patient**
Social Security Number	Date of Birth	Employer

I certify that I (or my dependent) have insurance coverage as stated above and agree to have insurance payments made directly to (Practice Name) to be applied to my account for services rendered. I understand that I am financially responsible for all charges incurred in the event that my insurance denies payment. I am aware there may be additional collection and/or attorney's fees if my account is referred for collection. For patients covered by Medicare the patient will be responsible for 20% of the Medicare allowable charges plus any deductibles, coinsurance and uncovered charges that apply.

_____ _____

Patient's signature **Today's date**

Medical History Questionnaire

(Please print clearly and use the back of this page if you need more space)

Today's date: _____

Name: _____

DOB: _____ Birthplace: _____

Occupation _____

What is the main reason for your visit today?

_____

_____

Do you have any of these eye symptoms?

❑ Blurred distance vision ❑ Glare, halos around lights
❑ Blurred reading vision ❑ Itching or burning eyes
❑ Constant double vision ❑ Eye mattering or tearing
❑ Flashing lights or floaters ❑ Foreign body sensation
❑ Red Eyes ❑ Dry Eye ❑ Eye Pain

Do you have any ALLERGIES to any medications?

❑ None known ❑ Yes, which ones? (list below)

Medication Name	What reaction did you have?
_____	_____
_____	_____
_____	_____
_____	_____

Which *eye medications* do you currently take?

❑ None ❑ Artificial Tears

Medication Name	Amount	How many times/day
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime

Which *other* medications do you currently take?

❑ None ❑ Aspirin/Blood thinner on a daily basis?

Medication Name	Amount	How many times/day
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime

Have you ever had any of these eye problems?

❑ Cataract ❑ Serious eye injury
❑ Glaucoma ❑ Iritis/uveitis
❑ Macular degeneration ❑ Lazy eye
❑ Wore eye patch as a child ❑ Retinal detachment
Other: _____

Have you ever had any of these conditions?

❑ None

❑ Stroke ❑ Dizziness ❑ High blood pressure
❑ Arthritis ❑ Allergies ❑ Heart disease
❑ Diabetes ❑ AIDS, HIV ❑ Lung diseases
❑ Cancer ❑ Anemia ❑ Thyroid disease
❑ Headaches ❑ Other: _____

_____

Have members of your family had any *eye* diseases?

(This would be your father, mother, sister, brother, grandparents)

❑ Glaucoma ❑ Diabetic eye disease or diabetes
❑ Cataract ❑ Crossed eyes ❑ Macular degeneration
❑ Iritis/uveitis ❑ Blindness ❑ Retinal detachment
❑ Poor Vision ❑ Other: _____

Please list any *eye* surgeries you have had:

❑ None

Type of Eye Surgery	Which Eye	Year
_____	Right Left	_____
_____	Right Left	_____
_____	Right Left	_____
_____	Right Left	_____

Please list any *other* surgeries you have had:

❑ None

Type of Surgery	Year
_____	_____
_____	_____
_____	_____
_____	_____

What non-surgery illness have caused a hospital stay?

_____

_____

_____

If you have glaucoma:

In what year was the diagnosis first made? _____

Month and year of your last visual field test? _____

Name of your previous ophthalmologist? _____

Do you use? ❑ Tobacco ❑ Alcohol

Would you like contact lenses or LASIK?

❑ Yes ❑ Not interested at this time.

What was the approximate date of your last eye examination: _____

NEXTGEN EYE SURGEONS
OF TEXAS

HIPAA PRIVACY & CONFIDENTIALITY POLICY

We are committed to providing you with quality, personal healthcare. As a part of our professional relationship, it is important that you understand our Patient Confidentiality Policy. Agreement with these policies is required for all medical services provided through NextGen Eye Surgeons of Texas.

Patient Confidentiality

Last Name:_____ **First Name:**_____ **M.I.:** _____

Please list all family or other personal representatives, and their relationship to you, who may receive information about your medical condition and/or treatment. (i.e. Pick up rx, reports, financial info, appointments, etc.)

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____

Privacy Practice Acknowledgement

I understand that I have certain rights to privacy regarding my confidential health information.

- The right to inspect and receive a copy of your health information
- The right to receive an accounting of disclosures of health information.
- The right to restrict certain uses and disclosures of your health information (i.e. family members, friends, etc.)
- The right to obtain paper copy of this notice from us at any time.

I understand that my health information may be used to:

- Conduct, plan, and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers such as health insurance companies, guarantor, and/or patient.
- Conduct normal healthcare operations such as quality assessment and physical certifications.

I acknowledge that I have received and understood this policy and NextGen Eye Surgeons of Texas has the right to change its Notice of Privacy Policy from time to time and that I may contact NextGen Eye Surgeons of Texas at any time if I have any questions. I understand that I may request in writing that you restrict how my private information is used or disclosed. I also understand that you are not required to agree to my requested restriction, IF MY REQUEST CONFLICTS WITH FEDERAL OR STATE LAW.

_____ _____

Patient Signature Date

FINANCIAL POLICY

The following outlines the financial policies that our office follows. We encourage you to discuss your account and ask any questions. Your understanding of our policy early on in your treatment process will prevent most concerns and issues in the future.

INSURANCE

- All co-payments and/or coinsurances will be collected at time of service.
- We will file claims on all visits and procedures to your **medical** insurance.
- Accounts will be balanced to match the insurance explanation of benefits (EOB) and any remaining balance will be forwarded to you, the patient.
- You are responsible for **ALL** balances **NOT** paid by your insurance.
- **Please remember insurance coverage is a contract between the patient and the insurance company. The ultimate responsibility for understanding your insurance benefits and for payment to your doctor rests with you.**

REFERRALS

- You are required to know whether or not your insurances require a referral and obtain that referral before you are scheduled to visit our office.
- We will require payment in full on day of service if you do not obtain a referral.

NON-COVERED SERVICES

- Insurance companies will only pay for services that they find "reasonable and necessary".
- You are responsible for payment of any services denied by insurance.

REFRACTION SERVICE & FEES

- Refraction is the process of determining if there is a need for eyeglasses and is an **essential** part of an eye exam. It is considered a routine vision service and performed on all comprehensive annual eye exams.
- Most medical insurance plans, including Medicare, **DO NOT** cover routine refractions.
- The fee for refractions is **$50.00** and is collected at the time of service.

PAYMENT

- Payment must be made by: Cash, Check, Credit/Debit Card, and Money Order.
- Cards accepted: **VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER, and CARECREDIT.**
- **A fee in the amount of $75.00 will be charged for all returned checks.**

PAST DUE ACCOUNTS

- Account balances should be handled promptly and will be considered past due after 120 days with an outstanding balance. All past due accounts will be turned over to a collection agency, and a fee of 20% of past due balance will be added to your account.
- We will require full payment before seeing the physician for any future services.

Print Patient Name: _____ Date: _____

Patient Signature: _____

NEXTGEN EYE SURGEONS
OF TEXAS

CREDIT CARD ON FILE – POLICY

NextGen Eye Surgeons of Texas requires keeping your credit/debit card on file as a convenient method of payment for the portion of services your insurance doesn't cover, but for which you are liable.

Your credit card information is kept confidential and secure. Payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

I authorize NextGen Eye Surgeons of Texas to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐ Amex ☐ Visa ☐ MasterCard ☐ Discover

Credit Card Number: _____

Exp. Date: _____

Cardholder Name: _____

Signature: _____

I (we), the undersigned, authorize NextGen Eye Surgeons of Texas and request to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by NextGen Eye Surgeons of Texas.

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to by NextGen Eye Surgeons of Texas in writing and the account must be in good standing.

Patient Name (Print): _____

Patient Signature: _____

Date: _____

NEXTGEN EYE SURGEONS
OF TEXAS

ROUTINE VISION SERVICES

A refraction is the process to determine if there is a need for corrective lenses. This is an essential part of the eye exam and is considered routine service. However, most medical plans, including Medicare, do not cover routine refractions. Our fee is **$50.00** and is collected along with your co-pay. If you buy prescription glasses or contacts from our optical shop, the refraction fee is waived.

Have you noticed a change in your vision lately? ***(Please check one)***

☐ YES ☐ NO

Do you have blurry vision? ***(Please check one)***

☐ YES ☐ NO

Are you interested in getting a glasses prescription? ***(Please check one)***

☐ YES ☐ NO

Do you want a contact lens prescription? ***(Please check one)***

☐ YES ☐ NO

Are you concerned that your cataracts are affecting your vision? ***(Please check one)***

☐ YES ☐ NO

NOTICE: *If you answered "Yes to the last question, the doctor recommends a refraction. This is the process to determine what prescription goes into your glasses. If you need cataracts surgery, your insurance* ***requires*** *a refraction to prove that it is a medical necessity. Without a refraction, your insurance will not pay for your surgery.*

The above information is true to the best of my knowledge. I authorize my medical insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance outstanding. I also authorize NextGen Eye Surgeons of Texas or my insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian Signature **Date**

NEXTGEN EYE SURGEONS
OF TEXAS

INFORMATION REGARDING STANDARD EYE DROPS THAT MAY BE USED AT YOUR VISIT

Topical Aneathetic Drops:

Proparacaine/Fluorescein and Benoxinate is used in the eyes as an anesthetic to numb the pain that may occur during eye procedures (e.g., measurement of intraocular pressure like tonometry). With a single drop, the onset of anesthesia begins within 30 seconds and persists for 20 minutes or longer. Therefore, it is important for you **NOT TO RUB YOUR EYES FOR THE NEXT 20 MINUTES**. Prolonged use of eye anesthetics is not recommended; doing so could cause permanent eye problems (e.g., corneal opacities) or loss of vision.

Side Effects**:** Redness, burning, or stinging of the eye(s) may occur. If these effects persist or worsen, notify your doctor.

Dilating Drops

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the Ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your Ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Dr. Brodbaker and/or such assistants as may be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

_____

Patient Signature (or Person Authorized to Sign for Patient) Date

NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. You have the right to obtain a paper copy of this Notice upon request.

Patient Health Information
Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We Use Your Patient Health Information
We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment, and Health Care Operations
Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.
Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.
Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses
We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures
We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:

Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
Research: We may use or disclose information for approved medical research.
Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
Judicial and Administrative Proceedings: We may disclose information in response to an appropriate subpoena or court order.
Law Enforcement Purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.
Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
Serious Threat to Health or Safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Military and Special Government Functions: If you are a member of the Armed Forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
Workers' Compensation: We may release information about you for Workers' Compensation or similar programs providing benefits for work-related injuries or illness.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights
You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.
Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.
Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.
Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.
Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.
Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices
We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints
If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person named below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person
If you have any questions, requests, or complaints, please contact:

Privacy Officer
NextGen Eye Surgeons of Texas
670 W. Campbell Rd, Suite 100
Dalals, TX 75080
Effective Date: 8/1/2020

I, _____,
hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed: _____

Date: _____

If not signed, reason why acknowledgment was not obtained:

_____