Austin Pediatric Ophthalmology & Strabismus
New Patient Paperwork- Adult

Patient Name: First ______________ Last ______________ MI __ Date of Birth: __________ Gender: ____

Address: ______________________________ City: ______________ Zip: ________

Cell Phone:( ) __________ Home: ( ) __________ Work: ( ) __________

Driver's License #: ______________________ Marital Status: ______________

Primary Insurance: ______________________ (Circle One) HMO PPO Indemnity Medicare Other

Identification #: ______________________ Group #: ______________

Guarantor Name: First: ______________ MI: ___ Last: ______________ DOB: ________

Guarantor's Address (If different from above): ______________________ City: __________ Zip: ________

Secondary Insurance: ______________________ (Circle One) HMO PPO Indemnity Medicare Other

Identification #: ______________________ Group #: ______________

Guarantor Name: First: ______________ MI: ___ Last: ______________ DOB: ________

Guarantor's Address (If different from above): ______________________ City: __________ Zip: ________

Tertiary Insurance: ______________________________

Identification #: ______________________ Group #: ______________

Guarantor Name: First: ______________ MI: ___ Last: ______________ DOB: ________

List any member of your family that has previously been seen Dr. Busse or Dr. Thai: ______________

____

Name of Primary Care Physician: ______________________ Phone: ______________

Who can we thank for referring you to our office? (If different from PCP) ______________________

OFFICE POLICY AND PAYMENT AGREEMENT

All office visits are to be paid for at the time of your visit unless prior arrangements have been made. We do not file insurance on office visits unless we have a contract with your insurance company. We can, however, provide you with paperwork to submit an insurance claim yourself. Please feel free to discuss any of the charges or policies with our staff. We are glad to work with you in any way we can. It is your responsibility now and, in the future, to notify our office of any changes in your insurance company, identification number or plan changes.

I, ______________________ hereby agree to be financially responsible for fees incurred. I authorize the release of any medical information necessary to process the claim and request payment of insurance benefits, including Medicaid and other government sponsored programs to Dr. Megyn L. Busse, M.D. I hereby grant authority to Dr. Megyn L. Busse M.D. or any other provider employed by this practice, to perform an eye examination including tests necessary in the diagnosis and treatment of this patient.

Signature: ______________________________ Date: ______________

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MEDICAL HISTORY

Name: ______________________ Date of Birth: ______________________

Name of referring doctor______________________ Referring doctor phone# ( ) ______________

Referring doctor address: ______________________ City: ______________ Zip: __________

Date of last eye exam ______________

REVIEW OF SYSTEMS

Do you currently have any problems in the following areas?

If yes, please put explanation in space provided Below.

SKIN	YES___	NO___	______
EYES			
Loss of Vision	YES___	NO___	______
Double Vision	YES___	NO___	______
Dryness	YES___	NO___	______
Mucous discharge	YES___	NO___	______
Redness	YES___	NO___	______
Sandy or gritty feeling	YES___	NO___	______
Itching	YES___	NO___	______
burning	YES___	NO___	______
Excess tearing/watering	YES___	NO___	______
Occasional tearing	YES___	NO___	______
Glare/Light sensitivity	YES___	NO___	______
Flashes of light	YES___	NO___	______
Floaters	YES___	NO___	______
Eye pain or soreness	YES___	NO___	______
EARS, NOSE, MOUTH, THROAT	YES___	NO___	______
NECK	YES___	NO___	______
RESPIRATORY(LUNGS/BREATHING)	YES___	NO___	______
CARDIOVASCULAR (HEART/BLOOD VESSELS)	YES___	NO___	______
GASTROINTESTINAL (STOMACH/INTESTINES)	YES___	NO___	______
BONES, JOINTS, AND MUSCLES	YES___	NO___	______
NEUROLOGIC SYSTEM	YES___	NO___	______
LYMPHATICS	YES___	NO___	______
HEMATOLOGIC	YES___	NO___	______
ALLERGIC/IMMUNOLOGIC	YES___	NO___	______
PSYCHIATRIC	YES___	NO___	______

OTHER ____

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PAST MEDICAL HISTORY

Please list current medications, hormones, oral contraceptives, vitamins you are presently taking:

1.________________ 2.________________ 3.________________

4.________________ 5.________________ 6.________________

7.________________ 8.________________ 9.________________

10.________________ 11.________________ 12.________________

Have you had crossed eyes, lazy eye, droopy eyelids, or protruding eye?________________

Do you have any allergies to any medication(s)? YES_____ NO_____ If YES, please list medications and reactions:________________

____

____

List all major illnesses and injuries:________________

____

____

List all previous surgeries:

____

____

____

FAMILY HISTORY (Please list personal history/family history)

			RELATIONSHIP TO PATIENT
Blindness	YES	NO	
Cataracts	YES_____	NO_____	________________
Glaucoma	YES	NO	
Macular degeneration	YES_____	NO_____	________________
Retinal detachment	YES	NO	
Strabismus	YES_____	NO_____	________________
Amblyopia	YES	NO	
Arthritis	YES_____	NO_____	________________
Cancer	YES	NO	
Diabetes	YES_____	NO_____	________________
Heart attack	YES	NO	
High blood pressure	YES_____	NO_____	________________
Kidney disease	YES	NO	
Stroke	YES_____	NO_____	________________

OTHER________________

SOCIAL HISTORY

Marital Status Single________ Married________ Separated________ Divorced________ Widowed________ Other________

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Current occupation ______________________________

Do you currently wear glasses? ______________________________

Do you drink alcohol? YES____ NO____ If YES, please indicate how many glasses per day ____________

Do you smoke? YES____ NO____ If YES, how many packs per day ____________

Important Patient Information

REFRACTION POLICY : 92015

What is a refraction exam?

This test is a determination of an eye's refractive error and the best corrective lenses to be prescribed. Doctors agree that this test is a necessary element of most visits, and it is used to create prescriptions for glasses and/or contact lenses, and/or to evaluate possible changes in vision due to medical conditions. This is essential to determine if a decrease in vision is due to only a need for glasses, which is easy to correct, or if another medical reason might be keeping the eye from seeing.

SENSORIMOTOR EXAMINATION: 92060

What is a sensory motor exam?

A sensory motor examination detects, assesses, monitors, and/or manages strabismic conditions. This is an expanded examination which requires additional time, effort, and expertise in measurement of the ocular deviation in various fields of gaze, different distances, and/or with and without optical correction. Doctors agree that information from the sensorimotor examination is used to plan medical, optical, and surgical treatments for these conditions and can have important visual, developmental, and/or systemic implications.

Does my insurance plan pay for this test/exam?

Your insurance may consider these procedures excluded from your benefits and/or a noncovered benefit.

What do you charge for these exams?

If your insurance does not cover the **92015** or **92060** the cost to you will be **$50.00 per test/exam performed.**

I have read and understand the above, and I have had the opportunity to ask questions.

____

Patient Name

Date

______________________________ ______________________________

I agree to have the following test/exam performed.

Date

______________________________ ______________________________

I decline for the following test/exam to be performed and decline a glasses and/or contact prescription.

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Patient Financial Responsibility Agreement

•As a patient, it is in your best interest to know and understand your insurance plan benefits and your responsibility for any deductibles, co-insurance, or co-payment amounts prior to any, visit. Not all services are covered in all insurance contracts. In addition, you should be sure that your physician is listed as a participating provider by your insurance company. If your insurance plan does not cover a service or procedure, you are responsible for payment of these charges.

If your insurance is not valid, or your coverage was terminated at the time the services are rendered, you will be solely responsible for the full: amount of your office visit and/or any procedures rendered.

In addition, if your insurance plan determines a service or product to be "not covered, "you will be responsible for the complete charge of such services.

I agree to be responsible for the payment of ALL unpaid services rendered on my behalf, or my dependents.

_______________________________ _______________________________

Patient/Guardian Signature Date

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Meaningful Use Initiatives

At Austin Pediatric Ophthalmology we are required to implement the Meaningful Use Initiatives. As a result, we are collecting the government-mandated information below. The purpose of Meaningful Use is to improve patient care and lower health care costs. The information you provide will be used for reporting purposes only.

Patient Name____ DOB:________________

Patient/Parent
Email:____

Race:

- ☐ African American
- ☐ Asian
- ☐ Asian Indian
- ☐ Caucasian
- ☐ Other ________________________________
- ☐ Refused to Report

Ethnicity:

- ☐ Hispanic
- ☐ Not Hispanic
- ☐ Refused to Report

Primary Language:

- ☐ English
- ☐ Spanish
- ☐ Other ________________________________

Preferred Pharmacy:
Pharmacy Name: ____

Pharmacy Address: ____

Parent/Patient Signature_________________________________ Date: ________________

For Staff Use Only:
Data entered into ECW by: __________ Date:_________Scanned by: __________ Date:______

AUSTIN PEDIATRIC OPHTHALMOLOGY OFFICE POLICIES

We strongly feel all patients deserve the very best medical care that we can provide. We have prepared this material to acquaint you with our office and financial policies. Please initial all fields below. *All Patients

_______A $27.00 fee may be assessed for NO_SHOW appointments. Please call 24 hours prior to your appointment time if you are unable to make it, to avoid this assessment.

_______A $27.00 charge will be assessed on all returned checks.

_______I understand that if I fail to pay amounts owed the clinic has the right to secure an outside collection agency and/or attorney to collect unpaid debt. I understand that any unpaid debt will be reported to credit-reporting agencies. I further understand that I will be responsible for any additional charges or fees incurred by securing the collection agency or attorney- including reasonable attorney's fees.

______I understand that I am responsible for updating my information (i.e., insurance, address, phone numbers) with the clinic for them to be able to obtain payment through insurance, contact me for future appointments, refunds, etc. I understand I can do this by contacting the office directly or on the patient portal.

______I understand that I have a pending Medicaid application and do not provide a Medicaid ID number within 30 days, I will be considered as a Self-Pay patient and responsible for any incurred charges. If you provide proof of Medicaid coverage after 30 days, your account will be switched back to Medicaid. At that point we will bill Medicaid for all charges. Only after receipt of Medicaid payment, can your payment be returned.

_____I understand that there is a fee for copies of my medical records. I also understand that I may use the online portal to receive copies of my medical record instead.

_____All co-pays are due when you check-in for your appointment. All other payments are expected at the time of service unless prior arrangements have been made.

_____In case of NO insurance coverage. I understand that I am responsible for payment of services rendered to myself or my dependents at the time of service (unless prior arrangements have been made and approved through the office manager)

AUSTIN PEDIATRIC OPHTHALMOLOGY OFFICE POLICIES

_____I authorize any holder of medical or other information about myself to be released to the Social Security Administration and Health Care Financial Administration, and Texas Medicaid Program or its intermediaries or carriers, any information needed for this or any related Medicare/Medicaid claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to either myself or the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withhold this information.) Regulations pertaining to Medicare assignments or benefits also apply.

The undersigned certifies that he/she has read the forgoing, understands it, accepts its terms, has received a copy of it and is the patient or is duly authorized by the patient as their agent execute the above.

____

Signature (Patient or Parent/Legal Guardian if Minor)

____ _______________

Printed Name/Relationship Date