Austin Pediatric Ophthalmology & Strabismus

Parent first and last name: _____ Date of Birth: _____
Parent first and last name: _____ Date of Birth: _____
PATIENT first and last name: _____ Date of Birth: _____

The following information regards the person responsible for any bills or notification from this office, that person's name is _____.

Address: _____
(Home) Street City State Zip Code

Phone: Cell ( ) _____ Home/Other ( ) _____

Primary Insurance Information: □ HMO □ PPO □ MEDICAID □ OTHER

Company _____

Insured's name _____
First MI Last

Insured's Date of Birth: ___/___/_____

Group #: _____ Plan # _____ Member ID _____

Secondary Insurance Information: □ HMO □ PPO □ MEDICAID □ OTHER

Company _____

Insured's name _____
First MI Last

Insured's Date of Birth: ___/___/_____

Group #: _____ Plan # _____ Member ID _____

Family members that have been previously seen by Dr. Busse: _____
Who is your child's Pediatrician? _____
Who referred you and/or your child? _____

OFFICE POLICY AND PAYMENT AGREEMENT

All office visits are to be paid for at the time of service 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 the paperwork to submit the 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 coverage.

Today's Date: _____; I (Print Name), _____, hereby agree to be financially responsible for fees not covered by insurance. 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. Busse or any other provider employed by this practice. I hereby grant authority to Dr. Busse 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: _____

Medical Information

Family History (Natural ____, Adopted___)

List siblings below:

NAME	AGE	GLASSES?	LIST ANY EYE CONDITIONS

Any family history of serious eye disease or misaligned eyes (strabismus):

Do any other diseases run in the family? □ YES □ NO
If yes, please list: _____

BIRTH HISTORY

Was the baby premature? □ YES □ NO How many weeks? _____ Birth weight _____
Were there any complications with delivery? □ YES □ NO
Was there any breathing or feeding problems in the first week or so? □ YES □NO
Was there any trouble or delayed sitting, walking, talking, or development? □YES □ NO
Are there any outstanding school difficulties? □ YES □ NO

MEDICAL HISTORY

Has the child's regular doctor suspected or diagnosed any serious illness? □ YES □ NO
If yes, please list: _____

Is your child on any medication? □YES □ NO
If yes, please list: _____

Is your child allergic to any medication or environmental factors? □ YES □ NO
If yes, please list: _____

EYE HISTORY

Has your child had previous eye care? □ YES □ NO
By whom? _____ What city? _____ Date of last eye exam_____

Does your child wear glasses? □ YES □ NO
Has he/she ever had an eye injury? □ YES □ NO
Has he/she ever had an eye operation? □ YES □NO

Reason for this visit:

*I grant consent that a photograph, slide, or videotape of myself or my child be used by Dr. Busse for the purpose of medical illustration, teaching, publication, or research without identification of the name of the patient.

Signature: _____ Date: _____ □ Accept □ Decline

Austin Pediatric Ophthalmology & Strabismus

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 in order 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 non-covered benefit.

What do you charge for these exams?

In the event that 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

_____ _____
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

Austin Pediatric Ophthalmology & Strabismus

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.

In the event that 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

Austin Pediatric Ophthalmology & Strabismus

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 ultimately improve patient care and lower health care costs.

The information you provide will be used for reporting purposes only.

Today's Date _____

Patient Name _____ Patient DOB _____

Parent Email _____

Race

□African American

□Asian

□Caucasian

□Hispanic

□Other

□ Refuse to report

Ethnicity

□Hispanic

□Not Hispanic

□Refuse to Report

Primary Language

□ English

□Spanish

□Other

Preferred Pharmacy

Pharmacy Name _____

Pharmacy Address _____

Parent Signature _____

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)

_____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