

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:

<u>NAME</u>	<u>AGE</u>	<u>GLASSES?</u>	<u>LIST ANY EYE CONDITIONS</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

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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.

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 _____