Texas Vision

John Branch, M.D.
Austin Chang, M.D.
Jacob Reynolds, M.D.

PATIENT INFORMATION:

Patient's Name: Last		First		Middle	
Mailing Address: Number	Street	Unit #	City	State	Zip Code
Home Telephone:	**Cell Phone:**		**Social Security Number:**		
Date of Birth:	❑ Male ❑ Female	**Marital Status:** [ ] Married [ ] Single [ ]Divorced		**Spouse Name:**	
Minor Child Guarantor's Name:		**Minor Child Guarantor's Address (if different than above):**			
Emergency Contact Name:		**Work Phone:**	**Cell Phone:**		
Patient's E-mail Address:		**May we use this E-mail address to contact you?** YES NO			

How Did you hear about Texas Vision?

INSURANCE INFORMATION:

Primary Insurance Company:	**Policy/Subscriber ID#**	**Group Number:**	
Who provides Insurance: ❑ Patient ❑ Spouse ❑ Parent ❑ Other	**Name**	**Date of Birth:**	

Secondary Insurance Company:	**Policy/Subscriber ID#**	**Group Number:**	
Who provides Insurance ❑ Patient ❑ Spouse ❑ Parent ❑ Other	**Name**	**Date of Birth:**	

PATIENT CONSENT:

IF INSURED:

The undersigned hereby authorizes the release of any information regarding all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits for services rendered or for services to be rendered without obtaining my signature on each claim to be submitted by myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed that particular claim.

IF *NOT* INSURED:

I understand that Texas Vision is accepting me as a private pay patient. I will be responsible for paying for all services that I receive from this Practice. The doctor's office will not file a claim to any insurance company, including Medicaid for services provided to me.

By signing below, I affirm that I have reviewed a copy of the Office Policies. I have read and understand the policies.

Patient or Legal Guardian Signature:	**Date:**

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Patient Account # *(for office use)*: _____ **Today's Date**: _____

Patient's Name: (Please Print)	**DOB:**

Allergies:

Current & Prior Medical History:	**When Diagnosed:**

Use of Alcohol:	***Use of Tobacco:***
[ ] Never [ ] Rarely [ ] Moderately [ ] Daily _____drinks/day	**[ ] Never [ ] Quit _____ date [ ] Daily_____packs/day**

I have had the Influenza Vaccine:	***I have had the Pneumococcal Vaccine:***	***History of Substance Abuse:***
[ ] Yes [ ] No	**[ ] Yes [ ] No**	**[ ] Yes [ ] No**
Currently Pregnant/Trying to Conceive [ ] **Currently Breast Feeding [ ]** **Recently Gave Birth [ ]**	***Occupation*:_____** **Retired [ ] Student [ ] Not Working [ ]**	***Do you drive?*** **[ ] Yes [ ] No**

Medications	**Dosage**	**How Often**	**Medications**	**Dosage**	**How Often**
1			**9**		
2			**10**		
3			**11**		
4			**12**		
5			**13**		
6			**14**		
7			**15**		
8			**16**		

Pharmacy Name:	**City:**	**State:**	**Telephone:**	**FAX:**

Referring Doctor:	**City:**	**Telephone:**
Primary Care Doctor:	**City:**	**Telephone:**

Have you seen one of our doctors before: [ ] Yes [ ] No	Approximate Date: _____

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PAYMENT POLICY

Thank you for choosing Texas Vision as your care provider. Some of our patients have concerns regarding insurance versus patient responsibility for payment for services rendered. We have developed the following payment policies:

Insurance - We will file claims for all applicable visits and procedures. You are responsible for payment if any copays, deductibles, co-insurance and all non-covered services. The insurance contract is between the patient and the insurance company. The ultimate responsibility for payment rest with the patient.

Referral and Pre-Authorizations – You are required to 1) know whether or not your insurance requires referral for medical and/or surgical treatment and 2) obtain that referral before you are scheduled to see the doctor. Our office will assist you in determining if we are participating or non-participating providers. However, this is not a guarantee of coverage. Referrals typically have an expiration date and a limited number of visits; it is your responsibility to monitor your referral status.

No Insurance – Payment in full is due when service is rendered. We understand that individual situations may vary and we will discuss other payment arrangements as needed.

Returned Checks – You will be charged $30 for each returned check. You will be asked to provide payment by cash or credit card for the total cost of the check and the $30 fee.

Non-Covered Services – We will make every effort to inform you if we believe a service may not be covered by your insurance company. In our professional judgement, these services are needed to render high quality medical care even though they may not be covered by insurance. You will be expected to pay for such services, even if your insurance company denies payment. Texas Vision is not a provider for separate vision plans. We will file to your medical insurance if appropriate.

Appointment Cancellations and No-Shows – If you need to cancel or reschedule your appointment, please give our office at least 24 hour notice.

Patient or Legal Guardian Signature:	**Date:**

REFRACTION FEE POLICY

The refraction fee is $30. Refraction is the process of determining your prescription. The refraction is also necessary in order to rule out certain eye problems. The refraction test occurs when your doctor shows you a variety of corrective lenses and asks you to say which lens makes the images being viewed better or worse. A refraction is an essential part of a complete and comprehensive eye exam but it is NOT a covered service by most medical insurance plans including Medicare. Please be aware that if this service is performed during your examination, a refraction charge of $30 will be collected today in addition to your copayment. ***You have 90 days from the date of prescription to follow up for any rechecks. After 90 days an additional $30 will be require for any rechecks***

By signing below I affirms that I have read and understand that the refraction is a non-covered service. I understand I will only be charged this fee when a refraction process is done during my examination and that this fee is due at the time of service.

Patient or Legal Guardian Signature:	**Date:**

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Authorization for Release of Information

I, the undersigned, hereby authorize the below named doctor to release my medical information.

FROM:

Physician's Name:	**Name of Practice:**
Address: Number Street Unit # City State Zip Code	
Phone Number:	**Fax Number:**

TO: If records are to be sent to Texas Vision, please check this box ❑ and continue to "The Reason"

Physician's Name:	**Name of Practice:**
Address: Number Street Unit # City State Zip Code	
Phone Number:	**Fax Number:**

The Reason For Request:

❑ **Continuity of Care** ❑ **New Doctor** ❑ **Other:** ***(specify)***

I understand that my records are confidential and cannot be disclosed without written authorization, except as otherwise provided by law.
This authorization is valid for six (6) months and may be revoked by the patient, orally or in writing, at any time prior to the six month period.
The information released should include all histories, physical exams, progress notes, lab and Xray reports, mental health records, alcohol/substance abuse records, HIV records, and all correspondence relating to my medical care unless otherwise specified below.
Your prompt reply to my request is greatly appreciated.

According to state and Federal Law, this form must be signed in order to process the release of patient information if such information exists in your chart. Texas Vision charges a fee of $10.00 for transfers to another doctor's office.

Patinet Name: *(Please Print)*	**Date of Birth:**
Patient Signature:	**Date:**

Acknowledgement of Review of Notice of Privacy Practices

My signature above indicates that I have reviewed this office's Notice of Privacy Practice, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document at my request.

PATIENT AUTHORIZATION FORM

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements for HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

☐ **I DO NOT authorize Vision Center of Texas (Texas Vision) to release my records and any information requested to any individuals.**

☐ **I authorize Vision Center of Texas (Texas Vision) to release my records and any information requested to the following individuals.**

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____
3. _____ Relation to Patient: _____

Disclose Medical/Appointment Information:
(Please check all that apply or ALL for all items listed)

- ☐ ALL
- ☐ Appointment Information
- ☐ Surgical Procedure Information
- ☐ External Lab Results & Imaging
- ☐ Medical History
- ☐ Financial & Insurance Information
- ☐ Explanation of diagnosis and/or procedure

_____ _____
Patient Name (PLEASE PRINT) Date of Birth

_____ _____
Patient Signature Date