Advanced Cataract Surgery • Lens Implants • LASIK Laser Vision Surgery • Glaucoma Surgery • Retina Laser Surgery • Contact Lens • Pediatric Eye Care • Eyelid Surgery

AVERY EYE CLINIC

YOUR VISION IS OUR FOCUS

Board-Certified d Medical and Surgical Ophthalmologists
Fellows of the American Academy of Ophthalmology

Baptiste J. Dejean, III, M.D., F.A.C.S.
Craig C. Kuglen, Jr., M.D.
Linda H. Lin, M.D.
Mark H. Wilkerson, M.D.
Andrew W. Dvorak, M.D.
Jonathan T. Jan, M.D.

Timothy W. Doucet, M.D.
P. Steven Black, O.D.

Notice to Patient: Most health insurance companies will not pay for a Complete Eye Exam with an OPHTHALMOLOGIST unless it is due to a **medical** illness or an injury.

Patient's Name:_____ Age:_____ Date of Birth: _____

Mailing Address:_____ City:_____ State:_____ Zip: _____

Email Address: _____

Home Phone:_____ Cell Phone: _____

IF PATIENT IS A MINOR: List Parent or Guardian Name, Address, and Phone number below:

Name: _____ Phone: _____

Address: _____

Preferred Method of Contact (circle one): Home Phone Text message Email

Patient's Social Security Number:_____ Male_____ Female _____

Spouse's Name:_____ Date of Birth: _____

Primary Care Doctor:_____ Phone: _____

Referring Doctor:_____ Phone: _____

Relative's Name (not living with you):_____ Phone:_____

Local Pharmacy Name:_____ Phone: _____

Address: _____

Mail Order Pharmacy Name: _____ Phone: _____

Address: _____

- ❖ WE REQUIRE A COPY OF YOUR INSURANCE CARD AND PHOTO ID FOR INSURANCE PROOF.
- ❖ WE DO NOT ACCEPT WORKER'S COMP
- ❖ IT IS OUR POLICY THAT PAYMENT BE MADE AT THE TIME SERVICES ARE RENDERED.
- ❖ WE DO NOT LOOK TO A THIRD PARTY TO BILL.
- ❖ A PARENT/GUARDIAN IS RESPONSIBLE FOR ALL CHARGES FOR A MINOR CHILD.
- ❖ BY SIGNING BELOW, I HEREBY AUTHORIZE:

1. My consent for medical treatment by the doctor/Avery Eye Clinic Staff and acknowledge no guarantees have been made regarding the results of treatment/exam.
2. Payment from my insurance company to Avery Eye Clinic for medical treatment.
3. I understand I am responsible for all charges not paid by my insurance.
4. The release of any medical records when necessary to/from another physician, hospital or other medical facility.
5. Release of medical information to/from the insurance for claims processing.
6. I AM RESPONSIBLE IF I DID NOT OBTAIN A REFERRAL OR AUTHORIZATION FROM MY INSURANCE COMPANY OR PRIMARY CARE PHYSICIAN.
7. List the names of people to whom we may give your PRIVATE HEALTH INFORMATION:

_____ _____

_____ _____

8. Permission to leave reminder for appointment on answering machine.

_____ _____

Signature (Patient or Parent/Legal Guardian) *Relationship to Patient*

_____ _____

Printed Name *Date*

Conroe
400 South Loop 336 West
Conroe, TX 77304
(936) 539-4500

Huntsville
3361 Montgomery Road.
Huntsville, TX 77340
(936) 294-0218

Woodlands
129 Vision Park Blvd., Ste 110
The Woodlands, TX 77380
(281) 719-5214

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NOTICE OF PRIVACY PRACTICES

Effective Date: 09/23/2013

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Your medical record may contain personal information about your health. This information may identify you and relate to your past, present, or future physical and/or mental health condition and related health care services and is called Protected Health Information (PHI). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI. We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request, or providing one to you at your next appointment.

How we may use and disclose health care information about you:

For Care or Treatment: Your PHI may be used and disclosed to those who are involved in your care for the purpose of providing, coordinating, or managing your services. This includes consultation with clinical supervisors or other team members. Your authorization is required to disclose PHI to any other care provider not currently involved in your care. *Example: If another physician referred you to us, we may contact that physician to discuss your care. Likewise, if we refer you to another physician, we may contact that physician to discuss your care or they may contact us.*

For Payment: Your PHI may be used and disclosed to any parties that are involved in payment for care of treatment. If you pay for your care or treatment completely out of pocket with no use of any insurance, you may restrict the disclosure of your PHI for payment. *Example: Your payer may require copies of your PHI during the course of a medical record request, chart audit, or review.*

For Business Operations: We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. We may also disclose PHI in the course of providing you with appointment reminders or leaving messages on your phone or at your home about questions you asked or test results. *Example: We may share your PHI with third parties that perform various business activities (e.g. Council on Accreditation or other regulatory or licensing bodies) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI.*

Required by Law: Under the law, we must make disclosures of your PHI available to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigation or determining our compliance with the requirements of the Privacy Rule, if so required.

Without Authorization: Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. Examples of some of the types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

(over)

Verbal Permission: We may use or disclose your information to family members that are directly involved in your receipt of services with your verbal permission.
With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked. Your explicit authorization is required to release psychotherapy notes and PHI for the purposes of marketing, subsidized treatment communication and for the sale of such information.

Your rights regarding your PHI:

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer: Tami Robichau, Avery Eye Clinic, 400 S. Loop 336 West, Conroe, TX 77304 **Right of Access to Inspect and Copy**: You have the right, which may be restricted only in exceptional circumstances or with documents released to us, to inspect and copy PHI that may be used to make decisions about service provided.
Right to Amend: If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
Right to an Accounting of Disclosures: You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
Right to Request Restrictions: You have the right to request a restriction or limitation on the use or disclosure of you PHI for services, payment, or business operations. We are not required to agree to your request.
Right to Request Confidential Communication: You have the right to request that we communicate with you about PHI matters in a specific manner (e.g., telephone, email, postal mail, etc.)
Right to a Copy of this Notice: You have the right to a copy of this notice.

Website Privacy:

Any personal information you provide us with via our website, including your email address, will never be sold or rented to any third party without your express permission. If you provide us with any personal or contact information in order to receive anything from us, we may collect and store that personal data. We do not automatically collect your personal email address simply because you visit our site. In some instances, we may partner with a third party to provide services such as newsletters, surveys to improve our services, health or company updates, and in such case, we may need to provide your contact information to said third parties. This information, however, will only be provided to these third-party partners specifically for these communications, and the third party will NOT use your information of any other reason. While we may track the volume of visitors on specific pages of our website and download information from specific pages, these numbers are only used in aggregate and without any personal information that can identify you or any visitor to our site.

Our site may contain links to other outside websites. We cannot take responsibility for the privacy policies or practices of these sites and we encourage you to check the privacy practices of all internet sites you visit. While we make every effort to ensure that all the information provided on our website is correct and accurate, we make no warranty, express or implied, as to the accuracy, completeness or timeliness, of the information available on our site. We are not liable to anyone for any loss, claim, or damages caused in whole or in part, by any of the information as detailed herein. Any changes to this Privacy Policy will be made public on this site so you will know what information we collect and how we use it.

Breaches:

You will be notified immediately if we receive information that there has been a breach involving your PHI.

Complaints:

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at Avery Eye Clinic. If you have questions and would like additional information, you may contact us by calling 936-539-4500.

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Notice of Privacy Practices Acknowledgement

Notice to Patient:
We are required to provide you with a copy of Avery Eye Clinic's Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice of Privacy Practices. If you wish, you may refuse to sign this acknowledgement.

I acknowledge that I have received a copy of Avery Eye Clinic's Notice of Privacy Practices.

_____
Signature of Patient or Responsible Party if a minor

_____
Printed Patient Name

_____
Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of the receipt of Avery Eye Clinic's Notice of Privacy Practices from the above-named patient, but it could not be obtained because:

_____ _____
Employee Signature Date

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Refraction Advance Notification

Date:_____ Patient's Name:_____

INS/MCR/MCD ID #:_____ MD:_____

The refraction test is an eye examination that measures a person's ability to see an object at a specific distance. The doctors at Avery Eye Clinic can determine if you have nearsightedness, farsightedness, astigmatism (asymmetrical cornea), or presbyopia (inability to focus on objects that are close to you). This test helps confirm the extent of vision difficulty. The information obtained from a refraction test is used to determine if a patient has normal vision. When a person complains of blurred vision, this test can help determine the extent of poor vision. It can also be performed to help follow the progress of treatments for diseases of the eye such as cataracts. The test is also used to allow the prescription for eyeglasses or contact lenses to be correct for each person, if needed.

Medicare, Medicaid, and most commercial insurance plans **do not cover refractions**. If your ophthalmologist determines that you need to have a refraction performed and your insurance is one that does not cover it, you will be held responsible for paying that portion of the exam fee, along with any other fees you are normally responsible for (i.e. copayments/deductibles) at the time of service. Medicare and Medicaid only reimburse for services that they deem medically necessary or are benefits of special preventive and screening programs.

Specific Service(s):

Refraction (CPT 92015) is a non-covered benefit as it is considered "routine" in nature. The fee for this test, when necessary, is $40.00.

"I understand that, in the opinion of my ophthalmologist, the service listed above and provided to me may not be covered under my commercial insurance, Medicare, or Medicaid as reasonable and necessary for my care. I understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be a covered benefit."

_____ _____

Date *Signature of patient or person acting on patient's*

_____ _____

behalf Date *Signature of Witness*

Date of Service:_____ Patient:_____ Witness: _____

Date of Service:_____ Patient:_____ Witness: _____

Date of Service:_____ Patient:_____ Witness: _____

Date of Service:_____ Patient:_____ Witness: _____

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AVERY EYE CLINIC FINANCIAL POLICY

At Avery Eye Clinic, we believe that all patients who come to this office deserve the best medical care and service available. For us to provide you with the highest quality eye care with current technology, we must meet the expenses necessary to operate this facility. To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with the Billing Supervisor.

DEFINITIONS

- *In-Network/Participating Insurance:* These are insurance companies with whom we have a contractual agreement. If we are "in-network", we have agreed to a discounted rate with the insurance company for its members
- *Out of Network/Non-Participating Insurance*: These are insurance companies with whom we do not have a contractual agreement. If we are not "in-network" with your insurance carrier, and you do not have "out of network" benefits on your policy, we will not bill your insurance carrier and you will be considered a "Self-Pay" patient, responsible for all services rendered on your visit. We will be happy to give you an itemized receipt from your visit so that you may file a claim with your insurance company.
- *Accept Assignment:* We agree to accept payment from your insurance company for services rendered. You will still be responsible for any deductible, copay, and/or coinsurance amounts at the time the service is rendered.

SELF-PAY PATIENT: We offer discounted rates for patients without insurance or with "out of network" insurance that have no out of network benefits. We do ask for a credit card, check, or cash deposit of the expected charges payable at check in, to secure your appointment. Any additional charges or reductions will be calculated at check out, and either collected or refunded, as needed.

PAYMENT AT TIME OF SERVICE: As a courtesy, we will bill your insurance for office visits. However, we ask that you pay any portion that we have reason to believe will not be covered by your insurance (i.e. deductible, copay, coinsurance, non-covered services). Full payment is due on the day of service.

REFERRAL: If you did not obtain a required referral or authorization from your insurance company or primary care physician and one is required, you will be responsible for all charges.

MEDICARE PATIENTS: If you have Medicare as your primary insurance, but no secondary/supplemental insurance, then you are responsible for the Medicare deductible and coinsurance at the time of service.

PAYMENT OPTIONS: Avery Eye Clinic accepts cash, check, all major credit cards, and Care Credit. There is a $25 fee for all returned checks.

MEDICAL RECORDS: A copy of your medical records is available to you at your discretion. A medical records release form must be filled out and signed by the patient prior to the release. The fee for medical records preparation and copying is $25.00.

SUBMISSION OF CLAIMS: Avery Eye Clinic will submit your insurance claim on your behalf; however, it is important to understand that your insurance is a contract between you and your insurance company. Although we file insurance claims as a courtesy to you, ***you are still responsible for all charges not paid by your insurance***, such as deductibles, copays, coinsurance, and non-covered services.

Your medical insurance plan will only pay for services that it defines as "reasonable and necessary." If your carrier determines that a particular service does not meet its criteria under program standards, your plan will deny payment for this service. In the event that your insurance carrier determines a service is "not covered," you will be responsible for the complete charge for that service.

BALANCE DUE AFTER INSURANCE PAYS: Patients will receive a statement with any outstanding balance once all applicable insurance companies have responded and payments have been posted. If a balance is due after your insurance carrier pays, payment is due upon receipt of a statement from our office. Payment arrangements may be made for special circumstances by contacting the Billing Supervisor within 30 days of receipt of the invoice. ***It is your responsibility to contact our office to make special arrangements.***

REFRACTIONS: Medicare, Medicaid, and most commercial insurance plans do not cover refractions. Medicare and Medicaid only reimburse for services that they deem ***medically*** necessary, or are benefits of special preventive and screening programs. Refraction (CPT 92015) is a non-covered benefit as it is considered "routine" in nature. The fee for this test, when necessary, is $40.00. If your ophthalmologist determines that you need to have a refraction performed and your insurance is one that does not cover it, you will be responsible for paying that portion of the exam fee, along with any other fees you are normally responsible for (i.e. copayments/deductibles).

"I understand that, in the opinion of my ophthalmologist, the service listed above and provided to me may not be covered under my commercial insurance, Medicare, or Medicaid as reasonable and necessary for my care. I understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be a covered benefit." **X** _____

(Patient/Responsible Signature)

LATE CANCELLATION/NO-SHOW POLICY: Should you need to cancel or rescheduled an appointment, please contact our office as soon as possible, but no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Late cancellation/no-show appointments may result in a $25.00 fee for the first occurrence, increasing to a $50.00 fee for any subsequent occurrences, and may not be rescheduled with that doctor, at the doctor's discretion. A third no-show or late cancellation/reschedule may be reviewed for dismissal as a patient of Avery Eye Clinic. The fee is charged to the patient, not the insurance company, and is **due at the time of the patient's next office visit**. If there are extenuating circumstances for why you are unable to give the minimum 24-hour notice, please contact our Front Office Supervisor to discuss.

I have read and understand the Avery Eye Clinic financial policy and I agree to be bound by its terms. I also understand and agree that Avery Eye Clinic may amend such terms at any time.

_____ _____

Signature of Patient or Responsible Party
(if pt is a Minor)

Date

_____

Printed Patient Name

Conroe
400 South Loop 336 West
Conroe, TX 77304
(936) 539-4500

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3361 Montgomery Road.
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Chart#: _____

Please Fill Out the Front and Back of this Medical History Form.

Name: _____ Date: _____

Family Physician: _____ Referral Source: _____

REVIEW OF SYSTEMS: Height: _____ft _____ in Weight: _____ lbs

Are you currently experiencing any of the following symptoms? (Circle all that apply)

Constitutional
Fever
Fatigue
Poor Appetite
Night Sweats
Chills

Eye
Blurry
Foggy
Glare
Blindness
Tunnel Vision

Ear/Nose/Throat
Congestion
Sore Throat
Hearing Trouble
Ear Ringing
Nose Bleed
Hoarseness

Cardiovascular
Chest Pain/Pressure
Racing Heart
Ankle Swelling

Respiratory
Short of Breath
Cough
Wheezing

Gastrointestinal
Indigestion
Nausea/Vomiting
Diarrhea
Constipation
Tarry/Bloody Stool

Genitourinary
Difficult Urination
Frequent Urination
Burning
Pain

Musculoskeletal
Weakness
Aches
Muscle Cramps

Skin/Breast
Hives
Rash
Sores
Lump
Pain

Neurological
Dizziness
Severe Headache
Neck Pain
Back Pain
Numbness

Psychiatric
Confusion
Poor Memory
Depressed
Poor Sleep
Nervous/Tense

Endocrine
Weight Loss
Weight Gain
Poor Energy

Heme/Lymph
Bruising
Nose Bleed
Lymph Nodes

Allergy/Immune
Sinus
Sneezing
Hay Fever
Frequent Infections

Other: _____

PAST MEDICAL HISTORY: Has the patient had any of the following conditions? *(Circle all that apply)*

Cataracts	Ulcer	Heart Disease	Paralysis	Cancer (type):
Glaucoma	Jaundice	Kidney Stone	Drug Addiction	High Blood Pressure
Hay Fever	Gallstone	Bladder Trouble	Prostate Trouble	Tuberculosis
Asthma	Liver Disease	Thyroid Disease	Nerve Disease	Anemia
Diabetes	Hepatitis	Stroke	Muscle Disease	Bleeding Disorder
Pneumonia	Colitis	Infections	Seizure	High Cholesterol

(over)

OTHER EYE OR MEDICAL PROBLEM:

Eye/Medical Issue	Date	Eye/Medical Issue	Date
1.		4.	
2.		5.	
3.		6.	

PREVIOUS SURGERIES:

Surgery	Date	Surgery	Date
1.		4.	
2.		5.	
3.		6.	

FAMILY HISTORY: Do any of the following illnesses run in the patient's family? *(Circle all that apply)*

Diabetes	Glaucoma	Seizures	Heart Disease
Stroke	Macular Disease	Arthritis	Asthma
High Blood Pressure	Cancer	Migraine Headache	Goiter

Other Illness	Relation	Other Illness	Relation
1.		3.	
2.		4.	

CURRENT MEDICATIONS: *(Prescription, over the counter, herbal/dietary supplements, vitamins)*

1.	5.
2.	6.
3.	7.
4.	8.

DRUG ALLERGIES:

1.	3.
2.	4.

SOCIAL HISTORY:

Do you currently use tobacco? **Y / N** Have you used it in the past? **Y /N** Type_____

How much each day?_____ How long? _ Do you use alcohol? **Y/N**

Type:_____ How much? _____

Do you have a history of drug use or addiction? **Y / N** Type:_____

For office use only: ROS and PFSH Updated

Date:	*Initials:*	*Date:*	*Initials:*
Date:	*Initials:*	*Date:*	*Initials:*