northwest eye associates

"Our Mission…Your Vision"

MEDICAL INFORMATION

Date _____ Referred By _____

Name _____ Family Physician _____

Allergies:

Medication Allergies ☐ Yes ☐ No

Medications(s) _____

Other Allergies _____

Past Medical History:

Surgeries _____

_____

_____

Health Problems _____

_____

Current Medications:

_____

_____

_____

Current Medical Problems:

Arthritis	☐ Yes	☐ No
Collagen Vascular Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No

Current Eye Problems:

Cataracts	☐ Yes	☐ No
Eye Disorders	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Retinal Detachment	☐ Yes	☐ No

Family History:

			If yes, who?
Arthritis	☐ Yes	☐ No	_____
Collagen Vascular Disease	☐ Yes	☐ No	_____
Diabetes	☐ Yes	☐ No	_____
Headaches	☐ Yes	☐ No	_____
Heart Disease	☐ Yes	☐ No	_____
High Blood Pressure	☐ Yes	☐ No	_____
Cataracts	☐ Yes	☐ No	_____
Eye Disorders	☐ Yes	☐ No	_____
Retinal Detachment	☐ Yes	☐ No	_____

Review of Systems

Do you have any of the following:

Fever	☐ Yes ☐ No	
Sudden Weight Loss	☐ Yes ☐ No	
Blurred Vision	☐ Yes ☐ No	
Double Vision	☐ Yes ☐ No	
Eye Pain	☐ Yes ☐ No	
Eye Discharge	☐ Yes ☐ No	
Ears, Mouth, Nose, Throat:		*If yes, which?*
Pain	☐ Yes ☐ No	_____
Mass	☐ Yes ☐ No	_____
Discharge	☐ Yes ☐ No	_____
Loss of Senses	☐ Yes ☐ No	_____
Chest Pain	☐ Yes ☐ No	
Shortness of Breath on Exertion	☐ Yes ☐ No	
Irregular Heart Beat	☐ Yes ☐ No	
Cough	☐ Yes ☐ No	
Asthma	☐ Yes ☐ No	
Diarrhea	☐ Yes ☐ No	
Constipation	☐ Yes ☐ No	
Stomach Pain	☐ Yes ☐ No	
Ulcer	☐ Yes ☐ No	
Anemia	☐ Yes ☐ No	
Blood Disease	☐ Yes ☐ No	
Free Bleeder	☐ Yes ☐ No	
Swollen Lymph Nodes	☐ Yes ☐ No	
Muscle Weakness	☐ Yes ☐ No	
Joint Pain	☐ Yes ☐ No	
Decrease Range of Motion	☐ Yes ☐ No	
Breast Masses	☐ Yes ☐ No	
Pigmented Lesions	☐ Yes ☐ No	
Rash	☐ Yes ☐ No	
Extremity Weakness	☐ Yes ☐ No	
Extremity Tingling/Numbness	☐ Yes ☐ No	

FOR OFFICE USE ONLY

Past, family, social history and review of systems updated

Date	Initials
_____	
_____	
_____	
_____	
_____	
_____	

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PATIENT INFORMATION *Información de el Paciente*

First Name _____ MI: _____ Last Name: _____
Primer Nombre *Medio Nombre* *Apellido*

Street Address: _____
Domicilio

City: _____ State: _____ Zip Code: _____
Ciudad *Estado* *Zona Postal*

Date of Birth: _____ Age: _____ Sex: _____ Marital Status: _____
Fetch de Nacimiento *Edad* *Sexo* *Estado Marital*

Social Security: _____ - _____ - _____ Driver's License/ID Number: _____
Seguro Social *Numero de Licencia/ID*

Employer: _____ Work Phone: _____
Compañia *Teléfono de Trabajo*

Email Address: _____ Home Phone: _____
Correo Electrónico *Teléfono de la casa*

Day Time Phone: _____ Cell Phone: _____
Teléfono durante el dia *Teléfono Celular*

I authorize the office to contact me at: ☐ Home ☐ Work ☐ Cell ☐ Text ☐ Email
Autorizer a la officina que se communiqué conmigo al: ☐ *Casa* ☐ *Trabajo* ☐ *Celular* ☐ Texto ☐ *Correo Electrónico*

SPOUSE INFORMATION / INSURANCE CARRIER *Información de Seguro / Esposo, Esposa*

Name: _____ Social Security: _____ - _____ - _____
Nombre *Seguro Social*

Date of Birth: _____ Employer: _____ Work Phone: _____
Fecha de Nacimiento *Compañia* *Teléfono de Trabajo*

EMERGENCY CONTACT (OTHER THAN SPOUSE) *Alguien para notificar en caso de emergencia*

Name: _____ Telephone: _____
Nombre *Teléfono*

Address: _____ City: _____ State: _____ Zip: _____
Domicilio *Ciudad* *Estado* *Zona Postal*

MEDICARE PATIENTS *Pacientes de Medicare*

Medicare Number: _____ Name on Card: _____
Numero de Medicare *Nombre en la Tarjeta*

OTHER INSURANCE CARRIERS Otros seguros medicos

Name of Insurance: _____ Name of Insured: _____
Nombre de Aseguranza *Nombre de Asegurado*

Policy Number: _____ Group Number: _____
Numero de Póliza *Numero De Grupo*

Primary Care Physician (PCP): _____
Doctor Primario

Relationship to Insured *Relacion Asegurado* ☐ Self/*Mismo* ☐ Spouse/*Esposo* ☐ Child/*Hijo* ☐ Other/*Otro*: _____

I authorize the release of any medical information necessary to process this claim and AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE UNDERSIGNED PHYSICIAN FOR SERVICE.
Yo autorizo que les den cualquier información necesaria para procesar este reclame y autorizo pago de Beneficios Medicos al Medico por los servicios.

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE:

_____
Firma de Paciente o Persona Autorizada

Relationship to Patient: _____
Relación al Paciente

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FINANCIAL AGREEMENT

We are committed to providing you with quality medical care. Our main concern is that you recieve the proper and optimal treatment needs for your health.

FINANCIAL AGREEMENT – The undersigned agrees, whether he signs as agent or a patient, that in consideration of the services to be rendered to the patient, hereby is responsible for paying facility co-payments, deductibles, estimated facility coinsurance amounts, and any balance deemed not to be a covered benefit of the insurance policy. I understand fully that I am responsible for all amounts not covered by my insurance. I also understand that in the event my insurance carrier does not pay within 45 days from the day services were billed, I am responsible for payment in full within 60 days of notification. Monthly statements will be sent to guarantors for patient balances.

PAYMENT IS DUE AT TIME OF SERVICE. Acceptable means of payment are cash, money order, cashier's check, credit card, or personal check (Returned checks and stop payments on checks will incur a service charge of $25.00). Cosmetic procedures must be paid in full prior to surgery. This amount is only an estimate and is subject to change due to the charges in your treatment regimen.

ASSIGNMENT OF INSURANCE BENEFITS & AUTHORIZATION TO RELEASE INFORMATION – In consideration of services rendered, I hereby transfer and assign to the facility and/or physicians indicated all rights, title and interest in any payment due me for services described as provided in the stated policy or policies of insurance.

I have presented my insurance card and photo identification and assign all right to payment due me for medical and/or surgical services under said policies to Northwest Eye Associates. I understand I am financially responsible for the physician's services.

MEDICARE PAYMENTS – (Patient's Certification, Authorization to Release Information, and Payment Request) I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

WE MUST EMPHASIZE THAT AS A MEDICAL PROVIDER, OUR RELATIONSHIP IS WITH YOU, NOT YOUR INSURANCE COMPANY.

The undersigned certifies that he/she is the patient or is duly authorized by the patient as the patient's general agent to execute the above and accepts its terms.

_____ _____

Patient, Patient's Agent or Representative Date

_____ _____

Relationship to Patient Witness

northwest eye associates
1740 W. 27th Street, Suite 180
Houston, TX 77008
713-864-8652

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plant and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as qualify assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosure of my health information: I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

northwest eye associates

"Our Mission...Your Vision"
"Nuestra Mision...Su Vision"

Dora E. Cantú M.D.
board certified ophthalmologist
diseases and surgery of the eye

Becky J. Fredrickson M.D., Ph. D.
board certified ophthalmologist
diseases and surgery of the eye

Bao T. Hoang O.D.
therapeutic optometrist
optometric glaucoma specialist

REFRACTION POLICY

A refraction helps us to determine whether your vision may be improved with glasses or if there is another underlying problem from eye disease. A refraction is also necessary to prove to your insurance company the need for cataract surgery.

The refraction is an essential part of the eye exam. However, Medicare as well as other insurances DO NOT cover this test.

Northwest Eye Associates policy is to charge $35.00 for this test in addition to your co-pay and/or deductible. This amount is due at the time of service. We will bill this fee to your insurance for payment and if they do pay, then we will gladly refund this amount back to you.

NOTE: This fee is due at the time of your visit whether or not you receive a written eye glass prescription. This fee covers the doctors or technician's time in this process.

ACKNOWLEDGEMENT

I have read the above information and understand that the refraction is a non-covered service. I accept financial responsibility for this service. I also understand that the co-pay and deducible are separate and are not a part of the refraction fee.

_____ _____

Patient Signature or responsible party Date

1740 West 27th Street, Ste. 180, Houston, TX
Office: 713-864-8652 Fax: 713-864-2865
www.northwesteye.net