LAKE AUSTIN EYE

Your Vision, Your Life

3944 RR620 S, Bldg 8, Suite 222, Austin, TX 78738
Phone 512-263-1113 Fax 512-263-1119

PERSONAL PATIENT INFORMATION

Patient Name: Ms./Mrs./Mr./Dr. (First)_____(M.I.)_____(Last)_____

Date of Birth: ____/____/____ Age: ____ Sex: M / F Marital Status: □ Single □ Married □ Widowed □ Divorced

Home Address_____ City: _____State: _____ Zip:_____

Best contact Ph#: (_____)_____ Alternative Ph#: (_____)_____

Email: _____ SSN#: _____-_____-_____ Language Preference: _____

Ethnicity (circle one): Hispanic/Latino Caucasian African-American Asian/Pacific Islander Native American Other

Emergency Contact: _____ Emergency Phone#: (_____)_____

I was referred by: Dr. _____ □ Website □ Friend/family □ Advertisement □ Other _____

Reason for your visit: □ Cataract □ Dry Eye □ Corneal Issue □ General eye exam □ LASIK/PRK □ Emergency
□ Other _____

MEDICAL INSURANCE INFORMATION: *If you would like us to file a claim with your insurance, please continue below.*

Primary Insurance: _____ □ HMO □ PPO □ Other:_____

Subscriber Name: _____ Relationship to Patient: _____

Subscriber DOB: _____/_____/_____ Subscriber SSN#: _____-_____-_____

Subscriber's Employer: _____ Member/Subscriber ID#: _____ Group #: _____

Secondary Insurance: _____ □ HMO □ PPO □ Other:_____

Subscriber Name: _____ Relationship to Patient: _____

Subscriber DOB: _____/_____/_____ Subscriber SSN#: _____-_____-_____

PHARMACY INFORMATION

Preferred Pharmacy: _____ Pharmacy Phone#: (_____)_____

Pharmacy Address: _____

Acknowledgement of Review of Notice of Privacy Practices:
I have been given the opportunity to review the Notice of Privacy Practices (HIPAA), which describes how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document if I ask for one.

Signature (Patient, Guardian, Parent if child is under 18): _____ Date: _____

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Private Insurance Authorization for Assignment of Benefits/ Information Release:
I, the undersigned, authorize payment of medical benefits to Lake Austin Eye, PLLC for any services furnished me by the physician. I hereby assign all medical and surgical benefits to Lake Austin Eye, including major medical benefits, to which I am entitled. I authorize and direct my insurance carrier(s) to issue payment checks to Lake Austin Eye for medical and surgical services rendered to me or my minor children.

I authorize Lake Austin Eye, PLLC to release to my insurance company or their agent information concerning health care, advice, treatment, or supplies provided to me; to process insurance claims generated in the course of the examination; and to allow a photocopy of my signature to be used to process insurance claims for the period of my lifetime. This information will only be used for evaluating and administering claims of benefits. I also authorize Lake Austin Eye to disclose protected health information, including lab results and diagnoses, in messages left on my voicemail at the following number:

(____)_____, and to the following person _____.

Signature (Patient, Parent or Guardian if child is under 18):_____ Date: _____

Information Regarding Dilating Eyedrops:
Dilating drops are used to enlarge the pupil of the eye to allow the ophthalmologist to better view the inside of your eye. These drops may blur your vision for up to several hours depending on the person and may make bright lights bothersome. Your ophthalmologist cannot predict how much your vision will be affected.
I hereby authorize the physicians of Lake Austin Eye and/or their assistants to administer dilating eye drops in my/my child's eyes for the doctor to thoroughly check the nerve and retina and acknowledge that these drops are necessary to diagnose my condition, if any exists. I understand that pupil dilation may affect my ability to safely operate a motor vehicle and the staff and doctors at Lake Austin Eye recommend I find alternative transportation if necessary.

Signature (Patient, Guardian, or Parent if child is under 18): _____ Date: _____

MEDICAL HISTORY

Primary Care Physician: _____ Office Phone #: (_____)_____

Height: _____ Weight: _____

Female Patients: Are you currently Pregnant? □ Yes □ No Nursing? □ Yes □ No Taking birth control? □ Yes □ No

MEDICATIONS: □ None □ See list I have provided

Please list your prescription medications and eye drops you are currently taking (name, dose, and frequency required):

Medication Name:	Dose:	Frequency:

Please list over-the-counter medications, vitamins, or herbal supplements you are taking:

Name/Dose:	Name/Dose:

DRUG ALLERGIES: □ None

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Please list all drugs and adverse reactions:

Name:	Reaction:
_____	_____
_____	_____
_____	_____
_____	_____

Surgeries: □ None

Please list all surgeries (including eye surgeries, procedures such as LASIK, lasers or other):

Name:	Date of surgery:
_____	_____
_____	_____
_____	_____
_____	_____

Tobacco, Alcohol, Drug Use:

Use of Tobacco: □ Never smoker □ Former smoker, quit: _____ □ Current smoker: # Packs/day _____
Use of Alcohol: □ None □ Less than 1 drink/day □ 1-2 drinks/day □ 3+ drinks/day
Use of recreational and Non-Prescription drugs: _____ Have you ever been treated for drug or alcohol or dependency? □ Yes □ No

MEDICAL HISTORY:

Please indicate if you have or ever had the following

Vision or Eye History: □ None

□ Cataracts
□ Dry Eyes
□ Glaucoma
□ Diabetic retinopathy
□ Retinal Tear/Detachment
□ Keratoconus
□ Strabismus/Amblyopia ("Lazy eye")
□ Herpes simplex/zoster
□ Trauma/Foreign Body/Scar
□ Recurrent Erosion
□ Macular degeneration
□ Contact lens wear: # of years Used: _____ □ Soft: daily wear/ Overnight / Toric □ Rigid gas permeable
□ Other: _____

Eye Surgeries or Procedures: □ None

□ Cataract
□ Corneal Transplant
□ Eye muscle surgery
□ LASIK/PRK
□ Retinal laser
□ Glaucoma laser
□ Other: _____

General Medical Issues: □ None

□ High blood pressure
□ Kidney problems (renal failure, transplant, other)
□ Asthma/ COPD / Emphysema
□ Healing problems/ Keloid
□ Prostate problems
□ Heart disease (murmur, heart attack, pacemaker)
□ Autoimmune or other Connective Tissue Disease (Sjogren's, lupus, other)
□ Diabetes
□ Arthritis
□ High cholesterol
□ HIV
□ Claustrophobia
□ Tuberculosis

Family History: □ None □ Unknown

□ Cataracts
□ Cancer: Specify type: _____

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□ Blindness
□ Glaucoma
□ Diabetic retinopathy
□ Retinal Tear/Detachment
□ Keratoconus
□ Strabismus/Amblyopia ("Lazy eye")
□ Other: _____

□ Macular Degeneration
□ High blood pressure
□ Stroke
□ Diabetes
□ Heart Disease
□ Arthritis

REVIEW OF SYSTEMS:
Please circle any of the symptoms or issues that are ***currently*** affecting you and require medical attention.

Constitutional: □ Negative	**Eyes:** □ Negative	**Cardiovascular:** □ Negative	**Endocrine:** □ Negative
Chills	Blurry vision	Chest pain	Cold intolerance
Fatigue	Discharge	Heart murmur	High blood sugar
Fever	Double vision	High blood pressure	Excessive hunger
Loss of appetite	Droopy eyelids	Irregular heart beats	Excessive thirst
Night sweats	Dryness	Palpitations	Excessive urination
Respiratory: □ Negative	Flashes/floaters	Shortness of breath at night	Heat intolerance
Asthma	Foreign body sensation	Slow heart rate	Low blood sugar
Bronchitis	Fluctuating vision	Feet swelling	Thyroid problems
Chronic cough	Glare	**Gastrointestinal**: □ Negative	**Allergies/Immunologic:** □ Negative
Emphysema	Itching	Abdominal pain	Asthma
Pneumonia	Loss of vision	Black tarry stools	Hives
Shortness of breath	Pain	Change in bowel movements	Rashes
Spitting up blood	Light sensitivity	Constipation	Hay fever
Excessive sputum	Redness	Diarrhea	**Hematologic/Lymphatic:** □ Negative
Wheezing	Side vision loss	Gastritis / Heartburn/GERD	Anemia
Musculoskeletal: □ Negative	Tearing	Hemorrhoids	Easy bleeding
Arthritis	**Genitourinary**: □ Negative	Hepatitis	Easy bruising
Decreased range of motion	Blood in urine	Jaundice	Swollen glands
Gout	Discharge		Blood clots
Joint pain /swelling	Frequent urination	Nausea	**Skin (integumentary):** □ Negative
Low back pain	Hesitancy	Rectal bleeding	Breast issues (cancer, etc)
Muscle aches / cramps	Impotence	Trouble swallowing	Dermatitis
Stiffness	Incontinence	Stomach ulcer	Dry skin
Neurologic: □ Negative	Urinary infection	Vomiting/vomiting blood	Eczema
Weakness	Kidney stones	**Psychiatric:** □ Negative	Hives
Headache	Painful urination	Anxiety	Itching / Rashes
Memory loss	Excessive urination	Depression	Hair loss
numbness	Sexual difficulties	Hallucinations	Skin cancers/tumors
Paralysis	Sexually transmitted disease	Nervousness	Pigmented lesions
Seizures			
Tingling			

FINANCIAL POLICY, PROCEDURE, AND RESPONSIBILITIES

LAKE AUSTIN EYE

Lake Austin Eye is committed to meeting your healthcare needs. Our goal is to keep your insurance or other financial arrangements as simple and transparent as possible. Therefore, we would like to inform you of the following:

1. **INSURANCE**: *Insurance coverage is a contract between you (the patient) and the insurance company. Lake Austin Eye will verify your benefits and coverage prior to your visit. We cannot guarantee that your insurance company will pay for all services rendered by our facility.*
   a. Your Responsibility: Provide a current address, current phone number, email address and insurance information at each visit. All co-payments, deductibles, and coinsurance as determined by your agreement with your insurance carrier are due at time of service. We will provide as accurate an estimate of the charges at time of service and a statement for any outstanding balance.
   b. We submit claims for payments to your insurance company as a courtesy to you. This process may take a few months to years. We commit to providing the insurance company with all documentation they request to approve a claim for payment. The insurance company may request additional information from you directly and it is the patient's responsibility to provide the requested information to the insurance in a timely manner. We cannot guarantee responses from insurance companies as to when they will reimburse the claims we submit. Therefore, **YOU MAY RECEIVE A BILL THAT OCCURS OVER A YEAR SINCE THE VIST.**
2. **REFERRALS AND PRE-AUTHORIZATION:** *You may be required to obtain and maintain a current referral from your Primary Care Physician (PCP).*
   a. Your Responsibility: Know if your insurance company requires a referral for medical and/or surgical treatment and obtain the referral prior to your visit. Referrals are often limited by an expiration date or number of visits and you must maintain this status.
   b. We can assist you in determining whether our doctors are participating or non-participating provider. This does not guarantee coverage of services. **You will be responsible for additional charges if a referral cannot be obtained and your insurance company denies payment.**
3. **NO INSURANCE OR SELF-PAY:** If you are not covered by insurance or otherwise self-pay, you are expected to pay in full at the time of service unless prior arrangements have been made. You will receive an immediate discount on services provided when paid at the time of service.
4. **SURGERY OR APPOINTMENT CANCELLATIONS AND NO-SHOWS:** As a courtesy to our patients on our waitlist, we ask that you provide us with advance notice at least 24-hours before your scheduled appointment or at least 2 weeks prior to scheduled surgery. **There is a $25 fee for a no-show appointment**. **There is a $350 fee for cancelling or rescheduling your surgery less than 2 weeks prior notice.**
5. **PAST DUE ACCOUNTS**: A finance charge of 1.5% per month is assessed on all accounts not paid within 30 days. Patients who have not made payment arrangements or have not met their financial obligation will be turned over to a collection agency. Once this occurs, the patient must contact the collection agency for all correspondence regarding the balance. Lake Austin Eye is authorized to automatically collect payment via credit card for past due balance when a credit card information is on file.
6. **RETURNED CHECKS**: There is a $50 fee for each returned check. Payment must be made by cash or credit card for the total cost of the returned check plus the $50 fee.

I have read the above financial policy. I understand my responsibilities for payment of services rendered and agree to fulfill my financial obligations for services rendered at Lake Austin Eye, including all applicable fees not covered by my insurance benefits. I understand that payment is due on the date that services are provided and agree to pay such charges in full.

Signature (Patient, Guardian or Parent if child is under 18):_____ Date: _____

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The following is a partial list of services commonly not covered by most medical insurance plans.

1. **NON-COVERED SERVICES:** Lake Austin Eye makes a concerted effort to provide services that in our professional judgement are necessary to render the highest quality medical care. We will file all services that we provide to your medical insurance, however some services may be denied coverage. You will be expected to pay for such services, even if your insurance company denies payment. These services may include but are not limited to:
    a. OCT Macula (Image of retina or macula)
    b. OCT Nerve (Image of the optic nerve)
    c. Topography (Mapping of the cornea)
    d. Endo cell count (Endothelial cell counts for cataract/cornea consultations)
    e. Tear Osmolarity (Testing for dry eyes)
    f. InflammaDry (Testing for dry eyes)

2. **REFRACTIONS:** A refraction determines your glasses or contact lens prescription and is an essential part of a complete eye exam and is often necessary to rule out certain eye problems. A refraction occurs when your doctor shows you a variety of corrective lenses and asks you to say which lens makes the images you view better or worse. A refraction is NOT a covered service by most medical insurance plans, including Medicare regardless of the reason the doctor performs the test. Please be aware that if this service is performed during your examination, **an additional fee of $65 may be due on the day of service in addition to your copayment for the visit.**

3. **PAPERWORK FEE: There is a $50 fee for requests made to our office to fill out paperwork.** This includes FMLA, disability, referrals, or pharmacy related paperwork. We will do our best to get paperwork filled out in a timely manner, but may take up to 3-5 business days. Please speak with your front desk if you have questions regarding this fee.
4. **CONTACT LENS POLICY:** Contact lens evaluations and fittings are not included in the cost of a complete eye exam. Most insurance companies do not cover contact lens evaluations. Payment for a contact lens evaluation is due at the time of service. The patient is responsible for payment in full but you may file your payment to your insurance if you choose. Payment for contact lenses is due at the time of disbursement. Contact lens evaluations are good for 90 days from initial fitting. Charges and fees are as follows:
    a. New patient soft contact lens fit: $179
    b. Established patient soft contact lens fit: $149
    c. New contact lens fit – Toric lens: $189
    d. Bifocal contact lens fit: $259
    e. Specialty contact lens evaluations: Determined at time of service

Acknowledgement: I have read the above information and understand that certain test(s) or services may not be covered by my insurance company. I understand that the co-pay for the exam is separate from and not included in the fees above. I understand that I will only be charged a fee when the test or service is done during my exam. I accept full financial responsibility for the costs of these services if they are done during my examination.

Signature (Patient, Guardian or Parent if child under 18):_____ Date: _____

A. Notifier:

LAKE AUSTIN EYE

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare/private insurance doesn't pay for **D.** _____ below, you may have to pay. Medicare/private insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare/private insurance may not pay for the **D.** _____ below.

D.	E. Reason Medicare/Private Ins. May Not Pay:	F. Estimated Cost
ENDO CELL 92286	EXPERIMENTAL	$80.00
TOPOGRAPHY 92025	EXPERIMENTAL	$65.00
INFLAMMA DRY 83615	EXPERIMENTAL	$40.00
LIPISCAN 92285	EXPERIMENTAL	$35.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare/ private insurance cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

□ **OPTION 1.** I want the **D.** listed above. You may ask to be paid now, but I also want Medicare/private insurance billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN) or EOB. I understand that if Medicare/private insurance doesn't pay, I am responsible for payment, but **I can appeal to Medicare/private insurance** by following the directions on the MSN or EOB**.** If Medicare/private insurance does pay, you will refund any payments I made to you, less co-pays or deductibles.

□ **OPTION 2.** I want the **D.** listed above, but do not bill Medicare/private insurance. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare/private ins. is not billed**.

□ **OPTION 3.** I don't want the **D.** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare/private Ins. would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare/private insurance decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). If you do not have **Medicare** you will need to contact your Insurance company and request to speak with someone in billing. Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

LAKE AUSTIN EYE

Form CMS-R-131 (Exp. 03/2020) Form Approved OMB No. 0938-0566

Please detach and return pages 1-7 to the front desk

Dry Eye Questionnaire: *Please return this page to the Technician*

For office use only: **Total Speed Score** (Frequency + Severity) =_____

Name: _____, _____ **Date**: _____/_____/_____
(Last) (First)

Date of Birth: _____/_____/_____ **Sex:** (Circle) M F

Dry Eye Disease is the most frequent reason that patients visit eye doctors. We are concerned that you may be suffering with this condition as well. Therefore, we ask that you take a few moments and thoughtfully complete the questionnaire below.

1) Report the **FREQUENCY** of dry eye symptoms you are experiencing by checking below using the numbering system: 0 = Never, 1 = Sometimes, 2 = Often, 3 = Constant

SYMPTOMS	0	1	2	3
Dryness, Grittiness or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

2) Report the **SEVERITY** of your symptoms using the ratings list below:

0 = No problems
1 = Tolerable – not perfect but not uncomfortable
2 = Uncomfortable – irritating but does not interfere with my day
3 = Bothersome – irritating and interferes with my day
4 = Intolerable – unable to perform my daily tasks

SYMPTOMS	0	1	2	3
Dryness, Grittiness or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

3) Please mark with an X if you have experienced symptoms:
1) Today _____ 2) Within the last past 72 hours _____ 3) Within past 3 months_____

4) Do you use eye drops and/or ointment? (Circle) YES NO

5) If yes, which drops do you use?

_____

6) Have you been told that you have blepharitis or have you been treated for a stye?
Blepharitis: YES NO (Circle) Stye: YES NO (Circle)

7) Do you have fluctuating vision problems? (That can be corrected with blinking)
(Circle): Never Sometimes Frequently A Lot/Always