Coversheet: Patient Registration Packet

TVLC

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www.theTVLC.com

Welcome to the Texas Vision & Laser Center! Please print and fill out all forms in this packet completely, and **FAX the entire packet back to us at 972-548-2014**. Please be confident that we keep all patient information strictly confidential. We will prepare your medical record before you arrive, to expedite your visit, and to minimize your wait. If you are unable to fax these forms to us please complete them at home and bring them with you on your appointment day. If you are unable to print out the forms, please arrive at your appointment thirty minutes early to complete the pre-registration process. Be sure and bring your medicine list, and all pertinent insurance and health related information with you. In order to read our Privacy Practices Policy (Form #1433), please visit our website and click on the "Patient Info & Resources" tab on the homepage to access the link to this document.

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Patient Registration Form

Welcome to the Texas Vision & Laser Center. Please fill out this form **completely**. Your Insurance Company may not pay if we cannot provide all of this information. If a question is not applicable, please enter "n/a".

General Patient Information

Prefix:
☐ Mr.
☐ Mrs.
☐ Ms.
☐ Doctor
☐Other _____

Last: _____ First: _____ MI: _____

SSN #: _____-_____-_____ Date of Birth: _____/_____/_____ Gender: ☐Male ☐Female

Mailing Address: _____

City: _____ State: _____ Zip: _____

Race: ☐Black/African American ☐Asian ☐Caucasian/White ☐Multi-racial ☐Hispanic or Latino ☐Decline

Ethnicity: ☐Other ☐Hispanic or Latino ☐Decline

Patient Employment Status: ☐Full-Time ☐Part-Time ☐Retired ☐Unemployed ☐Active Military

Are you a Veteran? ☐Yes ☐No **Are you a Smoker?** ☐Yes ☐No

Primary Care Provider: _____ Phone Number: (_____) _____-_____

Were you referred by your Primary Care Provider? ☐Yes ☐No ☐NA ☐ _____ *(for office use only)*

Eye Doctor: _____ Phone Number: (_____) _____-_____

Did your Eye Doctor refer you? ☐Yes ☐No ☐NA ☐ _____ *(for office use only)*

How did you hear about us? ☐ Primary Care Provider ☐Ophthalmologist ☐Optometrist ☐Friend _____
☐Google ☐Facebook ☐Online Search _____ ☐Other _____

Patient Contact Information

Cell: (_____) _____ - _____ Home: (_____) _____ - _____ Alternate: (_____) _____ - _____

Email Address: _____

Emergency Contact: (_____)_____-_____ Name of Emergency Contact: _____

Spouse/Parent/Legal Guardian Information *(please complete this section if you are **not** the policy holder on your insurance plan)*

Last: _____ First: _____ MI: _____

Contact Number: (_____) _____ - _____ Relationship to Patient: _____

Employment status: ☐Full-Time ☐Part-Time ☐Retired ☐Self-employed ☐Unemployed ☐Active Military

Employer: _____ Occupation: _____Phone Number: (_____) _____-_____

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

Primary Medical Insurance: Name of Insurance Company: _____

Last: _____ First: _____ MI: _____

Date of Birth: _____/_____/_____ Relationship to Patient: _____

Insurance Address: _____ Policy #: _____ Group #: _____

Secondary Medical Insurance: Name of Insurance Company: _____

Last: _____ First: _____ MI: _____

Date of Birth: _____/_____/_____ Relationship to Patient: _____

Insurance Address: _____ Policy #: _____ Group #: _____

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CONSENT TO TREATMENT

I voluntarily consent to receive medical and health care services provided by the Texas Vision & Laser Center physicians, employees and such associates, assistants, and other health care providers as my physicians deem necessary. I understand that such services may include diagnostic procedure examinations, and treatment. I acknowledge that no warranty or guarantee has been made to me as to result or cure. I understand that this consent to treatment will be valid and remain in effect as long as I attend the Texas Vision & Laser Center clinics unless revoked by me in writing.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

In consideration for receiving medical or health care services, I hereby assign my right, title and interest in all insurance, Medicare/Medicaid, or other third party payer benefits for medical or health care services other payable to me to the providers of the Texas Vision & Laser Center. I also authorize direct payments to be made by Medicare/Medicaid and/or my insurance company or other third party payer upon the total amount of my medical and health care charges, to the providers of the Texas Vision & Laser Center. I certify that the information I have provided in connection with any application for payment by third party payers, including Medicare/Medicaid, is correct. I agree to pay all charges for medical and health care services not covered by or which exceed the estimated amount to be paid or actually paid by Medicare/Medicaid, my insurance company, or other third party payer and agree to make payment as requested by the Texas Vision & Laser Center. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance that insures the patient, or any other party liable to the patient, is hereby assigned to the Texas Vision & Laser Center. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to the Texas Vision & Laser Center. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

REFRACTION AND OTHER NON-COVERED SERVICES

I understand that a refraction is an important diagnostic tool used to monitor the health of the eye, that it may also be used for glasses prescription, that this test is not covered by medical insurance and that Texas Vision & Laser Center does not provide prescriptions for contact lenses. I accept full financial responsibility for the cost of this service. The co-pay is separate from and not included in the refraction fee. I understand that the Texas Vision & Laser Center's contracts with health care service plans (i.e. HMOs, PPOs) relate only to items and services that are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans *not* to be covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health service plan. The undersigned agrees to cooperate with the Texas Vision & Laser Center to obtain necessary health care service plan authorizations.

RELEASE OF INFORMATION

The Texas Vision & Laser Center may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to the Texas Vision & Laser Center for reimbursement for services rendered, (2) any health care provider for continued patient care. The Texas Vision & Laser Center may also disclose on an anonymous basis, any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute, or regulation. A copy of this authorization may be used in place of the original.

_____	_____
Date	Time
_____	_____
Signature of Patient/Legally Authorized Person	Witness/Translator
_____	_____
Print Name and Relation to the Patient	Print Name and Translated Language

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Acknowledgement of Receipt of Notice of Privacy Practices

Texas Vision & Laser Center, PLLC

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of the Texas Vision & Laser Center. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy of the revised notice by accessing our website at www.theTVLC.com or by calling the Texas Vision and Laser Center at 972-548-2015. If you have any questions about our *Notice of Privacy Practices*, please inquire at the Texas Vision & Laser Center.

I acknowledge receipt of the *Notice of Privacy Practices* of the Texas Vision & Laser Center.

Print Name of Patient: _____

Signature of Patient or Representative: _____

If Representative, give relationship: _____

Date: _____

Inability To Acknowledge Receipt of Notice of Privacy Practices

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

☐ Patient is unresponsive

☐ Other (specify) _____

Signature of Representative:_____

Date: _____

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Authorization to Disclose Private Healthcare Information

I, _____, do authorize Texas Vision & Laser Center to release information including the diagnosis, records; examination rendered to me, and claims information. Information may be released to:

- ☐ My spouse, _____
- ☐ On my answering machine, _____
- ☐ In a text message to my cell phone, _____
- ☐ My email, _____
- ☐ My child, _____
- ☐ My friend, _____
- ☐ Other, _____

_____ _____

Patient Signature Date of Birth

_____ _____

Witness Signature Date

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Medical History Information Form

(Please fill out completely)

Patient Name: _____ Date of Birth: _____

Do you wear glasses or contact lenses?

Glasses: ☐Yes ☐No If yes what type: ☐Single Vision ☐Readers ☐Bifocals ☐Trifocal ☐Progressive

Contact Lens: ☐Yes ☐No If yes what type: ☐Single Vision ☐Monovision ☐Toric ☐Multifocal

When did you last have your contacts in: _____

Medication Allergies (Please indicate in parentheses the **kind of reaction** you had to the medicine)

Medications (Please list **ALL** of your medications that you currently take; include herbs/vitamins)

Past Ocular History (Please indicate any eye problems/conditions you have or have had and which eye)

☐LASIK/PRK/RK	☐Retinal Laser	☐Injury/Trauma
☐Cataract Surgery	☐Retinal Surgery	☐Glaucoma Surgery
☐Glaucoma	☐Macular Degeneration	☐Other_____

Past Medical History (Please indicate if you have been or are being treated for any of the following conditions)

☐Asthma/Emphysema	☐HIV	☐Stent
☐Arthritis	☐Heart Disease	☐Pacemaker
☐Cancer (type)_____	☐Hepatitis	☐Stroke
☐High Blood Pressure	☐Thyroid Disease	☐Other_____
☐Diabetes	☐High Cholesterol	☐Other_____

Past Surgical History (Please list any surgery you may have had)

Family History (Please indicate which diseases listed below run in your immediate family)

☐Cancer (Type)_____	☐Macular Degeneration	☐Lazy/Crossed Eyes
☐Cataracts	☐Diabetes	☐Heart Disease
☐Glaucoma	☐High Blood Pressure	☐Other _____

Social History

Alcohol	☐Yes	☐No	Type_____	How Often_____
Drugs	☐Yes	☐No	Type_____	How Often_____
Caffeine	☐Yes	☐No	Type_____	How Often_____
Tobacco/Vaping	☐Yes	☐No	Type_____	How Often_____

Preferred Pharmacy

_____

(Name of Pharmacy) *(Address, City, State, Zip)*

Specialist (Please list any specialist that you are under the care of)

1. Specialty (cardiologist, internal medicine, endocrinologist, etc.) _____

Name _____ Phone # _____
(Last) (First)

2. Specialty (cardiologist, internal medicine, endocrinologist, etc.) _____

Name _____ Phone # _____
(Last) (First)

3. Specialty (cardiologist, internal medicine, endocrinologist, etc.) _____

Name _____ Phone # _____
(Last) (First)

Review of Systems (Please indicate if you have any **active** problems in the following areas)

1. Constitutional ☐All Negative

- ☐ Fever
- ☐ Weight loss

2. Eyes ☐All Negative

- ☐ Blurred vision
- ☐ Doubled vision
- ☐ Pain

3. Ears, Nose, Throat ☐All Negative

- ☐ Pain
- ☐ Vertigo
- ☐ Hearing loss

4. Respiratory ☐All Negative

- ☐ Shortness of breath
- ☐ Cough
- ☐ Asthma

5. Cardiovascular ☐All Negative

- ☐ Chest pain
- ☐ Shortness of breath

6. Gastrointestinal ☐All Negative

- ☐ Constipation
- ☐ Diarrhea
- ☐ Vomiting

7. Neurologic ☐All Negative

- ☐ Weakness
- ☐ Tingling
- ☐ Numbness

8. Psychiatric ☐All Negative

- ☐ Emotional Changes
- ☐ Depression
- ☐ Insomnia

9. Musculoskeletal ☐All Negative

- ☐ Joint pain
- ☐ Decreased range of motion

10. Blood/Lymphatics ☐All Negative

- ☐ Anemia
- ☐ Bleeding disorder