KIRKWOOD EYE CENTER

Welcome To Our Office

Please raise any questions about our fees and policies, insurance coverage, or any other concerns to the technician prior to seeing the doctor. Professional fees for services are non-refundable.

Patient Information:

Last Name:		
First Name:		MI:
Marital Status:		
Address:		
City:	State:	Zip:
Home Phone#:		
Cell Phone#:		
Date of Birth:	Age:	Sex: M F
Employer:		
Occupation:		
Email Address:		

Guardian Information (if patient is under 18):

Last Name:		
First Name:		MI:
Relationship to patient:		
Address:		
City:	State:	Zip:
Home Phone #:		
Cell Phone#:		
Date of Birth:	Age:	Sex: M F
Employer:		
Occupation:		
Email Address:		

- All insurance coverage must be pre-approved prior to your examination. If we are unable to verify coverage, all charges must be paid in full when services are rendered. If you are not eligible for insurance benefits, or if your insurance denies coverage, your signature below indicates that you agree to be financially responsible for any unpaid balance. We accept Vision Service Plan but we are not a preferred provider.

  Your signature below indicates that you agree to forward within 14 days any monies paid to you by your insurance company that is owed to Kirkwood Eye Center.

____________________________ Signature of Patient or Responsible Party

____________________________ Printed Name

______________ Date

HIPAA ACKNOWLEDGEMENT

We are required by law to maintain the privacy of and to provide patients with notice of our legal duties and privacy practices with respect to protected health information.

Signature below is only acknowledgement that you have received our Notice of Privacy Practices

____________________________ Signature of Patient or Responsible Party

_____ / _____ / _____ Date

CONTACT LENSES

If you DO NOT wear contacts: 0 I would like to know my options 0 I am not interested in contacts

If you DO wear contacts: What type of contacts do you wear?

0 Dailies 0 Bi-Weekly 0 Monthly 0 Gas Permeable 0 Monovision/Multi-Focal

0 Toric (astigmatism)

Brand:__________________ How long have your current contacts been in your eyes? __hours __days

Please List Any contact lens complaints:______________________________________

PATIENT HISTORY FORM

Name:________________________________ DOB:___/___/______ Age:______ Exam Date:___/___/______

When was your last eye exam?_______________ By whom?________________________________

MEDICAL & FAMILY HISTORY

Have you had any surgeries? Y/N Please list:________________________________

Are you taking any medications? Y/N Please list:________________________________

Are you allergic to any medications? Y/N Please list:________________________________

Females: Are you pregnant or nursing? Y/N

Have you or a relative been diagnosed with the following? If answering yes for yourself, please indicate the year in which you were diagnosed.

☐ Glaucoma	Family member__________	Self______	Diagnosed______
☐ Cataracts	Family member__________	Self______	Diagnosed______
☐ Macular Degeneration	Family member__________	Self______	Diagnosed______
☐ Retinal Detachment	Family member__________	Self______	Diagnosed______
☐ Turned Eyes	Family member__________	Self______	Diagnosed______
☐ High Blood Pressure	Family member__________	Self______	Diagnosed______
☐ Diabetes	Family member__________	Self______	Diagnosed______

☐ Do you experience any of the following: ☐ Blurred Vision ☐ Burning ☐ Dry Eyes ☐ Double Vision ☐ Eye Strain ☐ Flashes ☐ Floaters ☐ Glare/Halos ☐ Headaches ☐ Itching ☐ Redness ☐ Water

☐ Other related eye problems or eye surgeries? ________________________________

SOCIAL HISTORY

Occupation __________________ Hobbies / Interests________________________________

Does your occupation or hobby require special eyewear? Y/N Please explain________________________

PATIENT HISTORY

Constitutional None____
- ☐ Developmental disability
- ☐ Fever
- ☐ Fatigue
- ☐ Trauma

Endocrine None____
- ☐ Diabetes
- ☐ Thyroid dysfunction

Neurological None____
- ☐ Epilepsy
- ☐ Migraines
- ☐ Seizures

Cardiovascular None____
- ☐ Cholesterol
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Stroke

Respiratory None____
- ☐ Asthma
- ☐ Emphysema
- ☐ COPD
- ☐ Upper Respiratory Infection

Allergic/Immunological None____
- ☐ AIDS/HIV
- ☐ Lupus
- ☐ MS
- ☐ Rheumatoid Arthritis

Psychiatric None____
- ☐ Anxiety
- ☐ Depression
- ☐ Manic Depressive Disorder
- ☐ Panic Disorder

Genitourinary None____
- ☐ Kidney stones
- ☐ STD
- ☐ Urinary tract infection

Musculoskeletal None____
- ☐ Fibromyalgia
- ☐ Osteoarthritis
- ☐ Muscular dystrophy

Integumentary None____
- ☐ Eczema
- ☐ Rosacea

Gastrointestinal None____
- ☐ Crohn's Disease
- ☐ Reflux
- ☐ Ulcer

Other
- ☐ ____________________

TOBACCO USE
- ☐ Never
- ☐ Current Every Day
- ☐ Former

Type:____________________

RACE/ETHNICITY
- ☐ American Indian/Native Alaskan
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian
- ☐ White
- ☐ Hispanic/Latino
- ☐ Non Hispanic/Latino
- ☐ Other

Advanced Beneficiary Notice(ABN)

Insurance Authorization

Providing the best possible eye care involves a mutual understanding between patient and provider. Should you have any questions regarding the following policies, please ask for clarification. Our professional services are rendered to you, not your insurance company. Ultimately, payment for our services is your responsibility.

- I authorize Kirkwood Eye Center to release any information regarding my care to expedite claims or for records transfer should such events be required.

- I hereby authorize Kirkwood Eye Center to bill my insurance company for services provided to me and with payment made directly to the providing doctor's office and that such authorization is valid until written notice is provided to cancel that authorization.

- As a courtesy to our patients, Kirkwood Eye Center makes considerable effort to verify insurance coverage, and provide an ESTIMATE of what insurance will pay for services from information we receive from each patient's insurance representative. I understand that such information is NOT an official or legally binding estimation of my out-of-pocket expenses. Ultimately, my final cost share is dependent on the decision of my insurance carrier. I UNDERSTAND THAT ANY COPAY ESTIMATE GIVEN TO ME PRIOR TO MY EXAMINATION MAY TURN OUT TO BE DIFFERENT FROM THE FINAL DECISION OF MY INSURANCE CARRIER AND I AGREE THAT I AM DIRECTLY AND FULLY RESPONSIBLE TO KIRKWOOD EYE CENTER FOR PAYMENT OF All CHARGES, INCLUDING ANY AMOUNT IN EXCESS OF PREVIOUS COPAY ESTIMATES. I realize that if my insurance company fails to pay its anticipated balance in full or payment is not made within 90 days it is my responsibility to pay the doctor's bill and that I will pay any additional fees incurred for the purpose of collection on delinquent accounts.

- In the event that I receive payment from my insurance company for services provided in this office, I agree to endorse any received payment to the doctor's office.

- I understand there may be medical findings during the course of my exam and grant Kirkwood Eye Center the ability to bill insurances on my behalf as they see necessary. I understand it is a VIOLATION of Kirkwood Eye Center provider agreement with my insurance to bill such medically related services to my Vison plan and that my medical insurance is considered primary by Kirkwood Eye Center. In the event, my medical insurance will be billed, I understand I will be responsible for any applicable copays, and/or deductibles and that my vision benefit will remain intact. I also understand that Kirkwood Eye Center will not neglect medical findings in order to utilize my Vision plan,as that would put Kirkwood Eye Center in direct conflict with its ethical obligations to the Texas Board of Optometry.

- I understand there is a $35 fee for all returned checks.

I understand and agree to all statements made herein and understand this is a legally binding agreement.

Signature:_______________________ Date:____________

Witness:________________________ Date:____________

Taylor Brooks, OD
Peter Zanella, OD
Deborah Zanella, OD

HIPAA RELEASE FORM

Name: ________________________________ Date: ______________________

Privacy regulations require us to have releases signed by our patients for us to speak with family members, friends and other relations regarding medical treatment. Each person must be listed individually and by name.

Please print name, relationship and telephone number for each person to whom you are authorizing release of your private health care information.

______________________________ ________________________ _______________________
Name Relationship Telephone #

______________________________ ________________________ _______________________
Name Relationship Telephone #

______________________________ ________________________ _______________________
Name Relationship Telephone #

Under the new Federal Health Care Law of 2011, we have been asked to request the following information from you.
Email address: ____ Gender: □ Female □ Male

Language (check one):

□ Cantonese □ Mandarin
□ English □ Polish
□ French □ Portuguese
□ German □ Russian
□ Italian □ Spanish
□ Japanese □ Vietnamese
□ Korean □ Other: ________________

Race (check one):

□ American Indian
□ Indian
□ Asian
□ Black or African American
□ Hispanic or Latin American
□ Native Hawaiian
□ White
□ Other: _______________
□ Multiracial
□ Not Identified

Ethnicity (check one):

□ Not Identified
□ Hispanic or Latino
□ Declined to Specify
□ Not Hispanic

Patient Signature:____