Clear All Form Fields

CENTRAL TEXAS EYE CLINIC P.A.

OPHTHALMOLOGY

Jeffrey J. Leinfelder, M.D.

P.O. Box 21385 • Waco, Texas 76702-1385
601 W. Hwy. 6 • Suite 108 • Six West Medical Center • Waco, Texas 76710
Phone (254) 752-8328 • Fax (254) 752-7724

Patient Information

Last Name: _____ **First Name:** _____

Date of Birth: _____ **Gender:** ○Male ○Female **Social Security No.:** _____

Marital Status: ○Single ○Married ○Widowed ○Divorced **Spouse Name:** _____

Home Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Mailing Address (if different from physical): _____

Home #: _____ **Cell #:** _____ **Email:** _____

Emergency Contact Name: _____ **Phone Number:** _____

Primary Care Physician: _____ **Referred By:** _____

Responsible Party Information (If patient is under 18): Relationship to Patient: _____

Last Name: _____ First Name: _____

Date of Birth: _____ Social Security No.: _____

Address (If different than above): _____ City/State/Zip: _____

Insurance Information: (Central Texas Eye Clinic will gladly file your insurance claim. Our policy is to file the primary and for one secondary or supplemental policy. However, whatever your insurance does not cover is your responsibility).

Primary Insurance Information (Medicare, Medicaid, or Other):

Insurance Carrier: _____ Is a referral needed? ○Yes ○No

Policy Holder's Name: _____ Date of Birth: _____ Gender ○Male ○Female

Member ID (Policy No.) #: _____ Group #: _____ SS#: _____

Relationship to policy holder: _____

Secondary/Supplemental Insurance Information (Medicare, Medicaid, other Insurance):

Insurance Carrier: _____ Is a referral needed? ○Yes ○No

Policy Holder's Name: _____ Date of Birth: _____ Gender: ○Male ○Female

Member ID (Policy No.) #: _____ Group #: _____ SS#: _____

Relationship to policy holder: _____

******* Please be sure receptionist makes a copy of your insurance cards. *******

I authorize the release of any medical or other information necessary to process my insurance. I also request payment of government benefits to either myself or to the party who accepts assignment. This authorization is in force for all occasions until revoked by the patient or authorized representative in writing.

I authorize payment of medical benefits to Central Texas Eye Clinic for services rendered. This authorization is in force for all occasions until revoked by the patient or authorized representative in writing.

X_____ X_____ _____

Signature of Patient (or Legal Representative) Relationship (if signature is not patient's) Date

CENTRAL TEXAS EYE CLINIC, P.A.
PRIVACY PRACTICES

Patient Name: _____ DOB: _____

I understand that it is the policy of Central Texas Eye Clinic to restrict access to my Protected Health Information (including but not limited to diagnosis, current and potential treatment options, medication prescribed, and billing). In addition to the caregiver(s) providing health services, and my insurance company/companies for payment of my claim, I would like for the following person/people to have access to my Private Health Information:

Name(s) Please Print	DOB	Relationship to Patient & Phone Number
1.		
2.		
3.		
4.		

This authorization is considered in force until Central Texas Eye Clinic is otherwise notified in writing by the patient.

CONSENT TO CALL

Consent to call indicates whether the patient has agreed to receive automated phone calls from Central Texas Eye Clinic on their mobile phone. Phone calls may be about appointments, test results and more.

Please select "I ACCEPT" if the patient has agreed to receive automated phone calls. Select "I DECLINE" if the patient has declined.

☐ I ACCEPT ☐ I DECLINE

MEANINGFUL USE COMPLIANCE

Primary Language:

◯ English ◯ Spanish ◉ Other _____

Race:

◯ American Indian or Alaska Native ◯ Black ◯ Native Hawaiian or other Pacific Islander

◯ White ◯ Decline to Specify ◯ Other _____

Ethnicity:

◯ Non Hispanic or Latino ◯ Hispanic or Latino ◯ Decline to Specify ◯ Other _____

X_____

Signature of Patient (or Legal Representative) Date

X_____

Signature of Staff Member Date

Central Texas Eye Clinic Payment Policy

3/1/2017

Thank you for choosing us as a provider for your Ophthalmology needs. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have provided this payment policy.

Please read it, ask us any questions you may have, and sign in the space provided.
A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. **Non-covered services.** Please be aware that some—and perhaps all—of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. If your insurance denies your claim for these reasons you will be responsible for the balance of the claim.

4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license/identification card and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 15 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis. It is your responsibility to notify us if you have a change to your address and/or telephone number.

8. **Missed appointments.** Our policy is to document any missed appointments not cancelled within a reasonable amount of time (24 hours). Repeat no shows can result in dismissal from our practice. Please help us to serve you better by keeping your regularly scheduled appointment(s).

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party **Date**

Patient Name: _____ Date: _____

1. What is the main difficulty with your eyes?

☐ Decreased Vision	☐ Redness	☐ Dryness	☐ Itching
☐ Burning	☐ Watering	☐ Discharge/Mattering	
☐ Pain	☐ Floaters	☐ Flashes of Light	

- How long have these symptoms been present? _____
- Do your eyes bother you in any other way? _____

2. List any medications to which are you **ALLERGIC**:

_____

_____

3. Do you have a history of:

☐ Eye Injury_____	☐ Diabetes _____ How Long? _____
☐ Glaucoma _____	☐ Heart Trouble _____
☐ Eye Surgery_____	☐ High Blood Pressure _____
☐ Cholesterol _____	☐ Thyroid _____
☐ Other Eye Disease_____	☐ Other serious health problems_____

- Additional Comments:

_____

_____

4. List any medications you take on a regular basis:

_____

_____

_____

5. List the names of any prescription or over the counter eye drops you are using:

_____

_____

6. History of: ☐ Alcohol-if so, how much _____ ☐ Tobacco-if so, how much _____
7. How old is your present glasses prescription? _____
8. Who prescribed your present prescription? _____
9. Do you wear or have you worn contact lenses? ◯ YES ◯ NO
   a. If yes, ◯ Hard Lenses ◯ Soft Lenses
10. Do you have any family history of serious eye disease such as:

    ☐ Cataracts ☐ Glaucoma ☐ Any other eye disorder: _____

    If so, which relative? _____

    Have any relatives had Diabetes? _____