Cataract & Eye Center of Cleburne

Personal Information (please print)

Name _____ Date_____
Date of Birth_____ Age_____ M/F _____ SS#_____
Address _____
Street City State Zip
Phone: Home_____Cell_____
Employer_____ Phone#_____
Address_____
Street City State Zip
Marital Status**:** Single / Married Spouse Name _____Wk# _____
Employer_____ Address_____
Primary Physician:_____ Phone Number:_____
REFERRED BY:Friend/Relative/Doctor _____
Name
Yellow Pages/Newspaper/Other(list) _____

COMPLETE IF PATIENT IS UNDER THE AGE OF 18 OR A FULL TIME STUDENT

Name of Father_____ Employer_____
Work Address _____Work Phone_____
Name of Mother _____Employer_____
Work Address _____Work Phone_____

INSURANCE INFORMATION

Medicare#_____ Medicaid#_____
Workers compensation (job injury) to whom is bill to be sent?_____
Other Medical Insurance _____
Subscribers Name _____DOB:_____
SS# of subscriber_____ Relationship to patient _____
Employer _____
Home Phone_____ Work_____

Who to notify in emergency (nearest relative or friend)?

Name _____ Relationship_____
Home Phone_____ Work Phone_____

FINANCIAL ASSIGNMENT AND AGREEMENT:

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.**

2. IN ORDER TO CONTROL YOUR COST OF BILLING, WE REQUEST THAT YOUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT UNLESS YOU ARE COVERD BY MEDICARE.

3. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, My information needed to determine these benefits payable for related services.

4. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Patients Signature (Parent if a minor)_____ Date_____

PATIENT CONSENT FORM

Cataract Eye Center of Cleburne

Patient consent for use and disclosure of protected health information.

I hereby give my consent for Cataract & Eye Center to use and disclose protected health information **(PHI)** about me to carry out treatment, payment and health care operations. The Notice of Privacy Practices provided by Cataract & Eye Center describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Cataract & Eye Center reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Cataract & Eye Center, 1665 Woodard Ave, Cleburne, TX 76033.

With this consent, Cataract & Eye Center may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out health care operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Cataract & Eye Center may mail to my home or other alternative location any items that assist the practice in carrying out health care operations, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

By signing this form, I am consenting to allow Cataract & Eye Center to use and disclose my PHI to carry out health care operations. I have the right to request that Cataract & Eye Center restrict how it uses or discloses my PHI. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Cataract & Eye Center may decline to provide treatment to me.

Signed by: _____ _____ _____

Signature of Patient or Legal Guardian **Date** **Relationship to Patient**

_____ _____

Print Patient's Name **Print Name of Legal Guardian, if applicable**

INFORMATION RELEASE FORM

I , _____, authorize

Please print name

Cataract & Eye Center of Cleburne to release medical information to the below named persons. This authorization will be valid for the length of 6 months or until I revoke it in writing.

Signature: _____ Date _____

Name	Phone	Relationship
_____	___-___-____	_____
_____	___-___-____	_____
_____	___-___-____	_____
_____	___-___-____	_____
_____	___-___-____	_____

Cataract & Eye Center of Cleburne

Steve G. Surratt, M.D.

PLEASE READ THE FOLLOWING:

Billing Policies For Refraction

-Your signature below states that you understand that **if** you are refracted you are responsible for the refraction charge.
-A "refraction" is a measurement of the lens power necessary to prescribe glasses or other corrective lenses.
-This procedure **is not covered** by most insurance plans including Medicare.
-The fee for refraction is $35.00 and is due at the time of service.

_____

Patient Signature

_____

Date

CATARACT AND EYE CENTER OF CLEBURNE

NAME _____ DATE_____

1. CHIEF COMPLAINT: Please state the problem you are having that we are seeing you for today.

_____

_____.

2. HISTORY OF PRESENT ILLNESS: How did this condition happen? _____

_____.

3. EYE HISTORY: Circle conditions that apply to you.

Glasses: Full time/ Distance / Reading ; Contacts: Hard / Soft ; Cataracts; Diabetes; Lazy Eye;

Poor Color Vision; Glaucoma; Retinal Detachment; Crossed Eyes; Poor Night Vision.

Previous Eye Surgery_____

Previous Eye Injury_____

Current Eye Medications_____

4. FAMILY EYE HISTORY: Circle conditions that apply.

Cataracts; Glaucoma; Diabetes; Retinal Detachment; Lazy Eye; Crossed Eyes; Blindness.

Other_____

5. MEDICAL HISTORY: Circle any condition you have presently or have had previously.

High Blood Pressure; Heart Attack; Stroke; Diabetes; Thyroid Disease; Asthma; Lung Disease; Arthritis;

Lupus; Cancer of _____; Migraines; High Cholesterol; Hepatitis; HIV or AIDS;

Previous Surgery other than eye:_____

Medications other than eye medications _____

Drug allergies_____

6. SOCIAL HISTORY: Smoking: No / Yes Alcohol: No / Yes
Your current occupation: _____
-If retired: former occupation:_____
-If a student: current grade level:_____

7. SYSTEM REVIEW: Please circle YES or NO. If YES, please explain.

DOUBLE VISION	NO/YES_____
BLURRED VISION	NO/YES_____
FLOATERS	NO/YES_____
FLASHES OF LIGHT	NO/YES_____
TEARING	NO/YES_____
EYE IRRITAION	NO/YES_____
CHRONIC FEVER	NO/YES_____
UNEXPECTED WEIGHT GAIN OR LOSS	NO/YES_____
FATIGUE	NO/YES_____
EAR, NOSE, THROAT	NO/YES_____
HEART PROBLEMS	NO/YES_____
RESPIRATORY PROBLEMS	NO/YES_____
GASTROINTESTINAL PROBLEMS	NO/YES_____
URINARY PROBLEMS	NO/YES_____
SKIN PROBLEMS	NOYES_____
MUSKULOSKELETAL PROBLEMS	NO/YES_____
NEUROLOGIC PROBLEMS	NO/YES_____
PSYCHIATRIC PROBLEMS	NO/YES_____
HEMATOLOGIC/LYMPHATIC PROBLEMS	NO/YES_____