Internal Use:
❑ NP
❑ Established
❑ SM ❑ K ❑ W

CENTRAL TEXAS EYE CENTER

Patient's Name:_____ _____
(last) (first) (middle) (Preferred Name)

Mailing Address:_____
(street) (city, state) (zip)

Phone Numbers: Home:_____ **Cell:**_____ **Work:**_____

Email Address_____ **Patient's Social Security #:**_____

Age:_____ **Birthdate:**_____ **Sex:**_____ **Driver's License #** _____

Patient's Status: ❑ Single ❑ Married ❑ Widowed ❑ Student **Spouse Name:**_____

Emergency Contact: _____ **Emergency Phone:**_____

Responsible Party (if other than above)

Name:_____ **Relation to Patient?**_____

Address:_____ **Telephone**_____

How Did You Hear About Us? (Check All That Apply)
❑ I'm a Previous Patient ❑ Doctor Referral ❑ Yelp ❑ Facebook
❑ Patient or Family ❑ Our Website ❑ Google ❑ Health Fair
❑ Chamber of Commerce ❑ Your Insurance ❑ Other: Please Specify_____

Appointment Confirmation Preference: (Must choose one)
❑ Phone Call ❑ Text Message ❑ Email

Insurance Information: Please allow receptionist to photocopy your insurance card.

Insurance Company Name: _____

Policy#: _____ **Group#:** _____

Insurance Subscriber's Name: _____ **SS#:**_____

Medicare and many private insurance carriers do not cover the refraction (the test to determine the power for eyeglasses and best corrected vision) You are responsible for this charge plus any insurance deductibles and/or co-payments. All payments and co-payments are due on the day of service.

Signature:_____ **Date:**_____

Official Policy on Standard Insurance and Managed Care Insurers

In order to accommodate the needs and requests of our patients, we have enrolled in numerous managed care insurance programs.
While we are please to be able to provide this service to you, it is extremely difficult for us to keep track of all the individual requirements of each plan. Each plan has different stipulations regarding how often services may be rendered by whom and, even more importantly, where those services may be performed.

Even within the same insurance company, the plans differ depending upon what type of contract your employer has negotiated.

Unfortunately, if you do not inform us of any special requirements in your contract and we subsequently order services, such as lab work or hospitalization that are not covered, we or the selected medical facility will have no choice but to bill you directly for those charges. Payment for those charges will be your responsibility.

FINANCIAL AGREEMENT: The undersigned agrees, as patient or agent of the patient is accepting financial responsibility for services rendered and is obligated to pay the account balance in full. If there is verifiable Medical Insurance Coverage or other verifiable financial coverage, a claim will be filed as a convenience to the patient. However, it remains the responsibility of the patient/guarantor to follow up with his/her insurance company if the claim is not paid within 45 days. Pre-certification is the responsibility of the patient/guarantor and should be secured prior to services whenever possible, within policy limitations in case of emergencies. Payment for services not covered by the insurance or third party payor is the responsibility of the patient/guarantor.

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1. REMINDER: Payment of co-pays and deductibles are required at the time services are rendered.
2. **HMO and PPO** participants are responsible for verifying that referred specialists are participating providers for their plan and that a referral, if required, is obtained prior to their appointment by your primary care physician. If a referral is needed for any visit, it is the patient's responsibility to obtain that referral.
3. Tissue reports, special lab tests, and other laboratory procedures may be billed to you from a reference lab.
4. Vision Plans require preauthorizations. Please provide us with your vision plan information so that a preauthorization may be obtained. If a preauthorization is not obtained you will be responsible for all charges at the time of service.

We file insurance claims for the physicians' charges to contracted PPO's and HMO's. A copy of your insurance card and a signed form is required. Any remaining balance after the insurance payment is your responsibility. Follow-up with your insurance carrier for reconsideration of your claim is your responsibility. Our office will gladly assist you in any way that we can.

****

I have read and understand the office policy stated above and agree to accept responsibility as described.
I authorize the release of any medical or other information necessary to process any insurance claims.

Signed:_____SS#_____Date:_____

CTEC Medical History Questionnaire

Name _____ Preferred Name _____ Date of Birth ____/____/____

Primary Care Physician: _____ Referring Doctor: _____

Pharmacy: _____ Location (street & city): _____

Race/Ethnicity: _____ Preferred Language: _____

Employer: _____ Occupation: _____

Have you been recently referred to our office? If yes, by whom?: _____

Reason for today's visit: _____

Allergies: Reaction Severity ☐ None Known

_____ Reaction Type _____ mild/moderate/severe

_____ Reaction Type _____ mild/moderate/severe

Past Ocular History: (Previous eye surgeries/laser/trauma/diagnoses) ☐ Overall Healthy

_____

_____

Current Eye Medications: (Please list) ☐ None

_____

_____

Past Medical History: ☐ No history of illness

☐ Heart Problems	☐ Hepatitis	☐ Lung Disease	☐ Lupus	☐ Anemia
☐ COPD	☐ High Blood Pressure	☐ Migraine	☐ Arthritis ☐ *Osteo*	☐ *Rheumatoid*
☐ Diabetes ☐ *Type I* ☐ *Type II*		☐ High Cholesterol	☐ Stroke	☐ Eczema
☐ HIV	☐ Psychiatric Disorder	☐ Asthma	☐ Fibromyalgia	☐ Thyroid
☐ Kidney Disease	☐ Multiple Sclerosis	☐ Headache	☐ Sjrogrens	☐ Liver Disease
☐ Cancer _____		☐ Hearing Loss		

Other _____

Infections: (Please mark all that apply) ☐ Overall Healthy

☐ Herpes Simplex	☐ HIV/AIDS	☐ Syphillis	☐ Chicken Pox
☐ Herpes Zoster / Shingles	☐ Meningitis	☐ Toxoplasmosis	☐ Hepatits A / B / C
☐ Histoplasmosis	☐ MRSA	☐ Wound Infection	☐ Other _____

General Surgeries / Operations: (Please list) ☐ None

_____

_____

Current Systemic Medication and Dosage: (Please use back if need more space) (Include over-the-counter medications)

_____

_____

_____

Family History: ☐ None

☐ Arthritis	☐ Diabetes	☐ Kidney Disease	☐ Stroke	☐ Blindness	☐ Glaucoma
☐ Lazy Eye	☐ TB	☐ Heart Disease	☐ Cancer	☐ Cataracts	☐ Macular Degeneration
☐ Retinal Disease	☐ High Blood Pressure		☐ Other _____		

Social History: (Please mark all that apply)

Smoking: ☐ Current everyday smoker ☐ Current some day smoker ☐ Former smoker ☐ Never smoked

Alcohol Use: ☐ Yes ☐ No If yes, how much and how often _____

Drug Use: ☐ Yes ☐ No If yes, how much and how often _____

Patient Signature: _____ Date _____

Review of Systems: (Please mark all that apply) ☐ None

Eyes
- ☐ Previous Surgery
- ☐ Contact Lens
- ☐ Pain
- ☐ Double Vision
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Dry Eyes
- ☐ Flashes
- ☐ Floaters

Ear, Nose, and Throat
- ☐ Hard of Hearing
- ☐ Ringing in Ears
- ☐ Vertigo

Cardiovascular
- ☐ Chest Pain
- ☐ Dizziness
- ☐ Fainting Spells
- ☐ Shortness of Breath
- ☐ Irregular Heartbeat
- ☐ Difficulty Lying Flat

Constitutional
- ☐ Fatigue / Weakness
- ☐ Fever
- ☐ Weight Gain / Loss

Respiratory
- ☐ Cough
- ☐ Congestion
- ☐ Wheezing
- ☐ Asthma

Gastrointestinal
- ☐ Heartburn
- ☐ Nausea / Vomiting
- ☐ Jaundice / Hepatitis

Genito-Urinary
- ☐ Pain / Difficulty
- ☐ Blood in Urine
- ☐ History of Kidney Stones
- ☐ History of STD's

Psychiatric
- ☐ Anxiety / Depression
- ☐ Mood Swings
- ☐ Difficulty Sleeping

Endocrine
- ☐ Increased Thirst
- ☐ Increased Hunger
- ☐ Increased Urination
- ☐ Increased Sweating
- ☐ Fingernail Changes

Blood / Lymphnodes
- ☐ Easy Bruising
- ☐ Gums Bleed Easily
- ☐ Prolonged Bleeding
- ☐ Heavy Aspirin Use

MusculoSkeletal
- ☐ Stiffness
- ☐ Arthritis
- ☐ Joint Pain / Swelling

Skin
- ☐ Rash / Sores
- ☐ Lesions
- ☐ Hives / Eczema

Neurological
- ☐ Seizures
- ☐ Weakness / Paralysis
- ☐ Numbness
- ☐ Tremors

Immunologic
- ☐ Hives
- ☐ Itching
- ☐ Runny Nose
- ☐ Sinus Pressure

Patient Signature _____ Date _____

CENTRAL TEXAS EYE CENTER
AUTHORIZATION TO RELEASE MEDICAL INFORMATION
NOTICE OF PRIVACY PRACTICES ACKNOWLDEDGES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payments from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy.

The HIPAA privacy act gives patients the right to request a restriction on the uses and disclosures of their protected health information (PIH). The patient is also provided the right to request confidential communications or that a communication PHI made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

You may contact me in the following manner:

Telephone: Home____ Work____ Cell____ Other____ Auto Dial____ Text ____
Mail Address: ____ Fax: ____ Email: _____
May we leave a message on your answering machine? Yes____ No____

I hereby give Central Texas Eye Center permission to release any necessary information including examination results, test results and appointment dates and/or times to the following friends or relatives: (please print)

NAME OF INDIVIDUAL PHONE # RELATIONSHIP TO PATIENT

1_____ _____ _____
2_____ _____ _____
3_____ _____ _____

_____ _____
Patient/Guardian **Signature** Date

_____
Print Name

JOSHUA K. HU, M.D.
Diplomate American Board of Ophthalmology
JAMES E. PICKETT, M.D.
Diplomate American Board of Ophthalmology
CJ DALE, O.D.
Therapeutic Optometrist

CENTRAL TEXAS EYE CENTER

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2430 S. IH 35 #106 · San Marcos, Texas 78666 · Telephone (512) 353-1300 · Fax (512) 353-Phone:512-353-1300 · Fax: 512-353-5135

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name_____ OTHER NAMES USED_____

Date of Birth _____/_____/_____ Dates of Service(s) _____

I HEREBY AUTHORIZE AND REQUEST YOU RELEASE MY MEDICAL RECORDS TO:

Central Texas Eye Center, P.A.
2430 S. IH 35 #106 • San Marcos, Texas 78666
Telephone (512) 353-1300 • Fax (512) 353-5135

ALL RECORDS _____ FOR TREATMENT _____ CONTINUITY OF CARE _____

FROM:

Doctor: _____ Fax: _____

Address: _____ Phone: _____

I HEREBY AUTHORIZE AND REQUEST YOU RELEASE MY MEDICAL RECORDS FROM CENTRAL TEXAS EYE CENTER

TO:

Name/Dr._____ Fax: _____

Address: _____ Phone: _____

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

The authorization will expire 1 year from the date of my signature unless I revoke the authorization prior to that time.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient (If Legal Representative) Printed Name of Patient or Legal Representative