



Terry Perkins, MD ▪ Paul Wuthrich, MD ▪ William Riggs, MD ▪ Joseph Allison, OD

Patient Information:

Patient's Name: _____

SS#: _____ Birth date: _____ Sex: M / F

Local Address: _____

City: _____ State: _____ Zip: _____

Home: _____ Day: _____ Cell: _____

Email Address: _____ Marital Status: S / M / W / D

Ethnicity: Hispanic Non-Hispanic Preferred Language: _____

Race: American Indian or Alaska Native Black or African American
 Asian White
 Native Hawaiian or Other Pacific Islander

Student Status: Full-Time Part-Time Smoker: Yes No Veteran: Yes No

Employer: _____

Address: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Pharmacy: _____ Location: _____

Referred By: _____

Emergency Contact Person: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Insured (Policy Holder) / Responsible Party Information:

****Fill out if different than the patient's information from above****

Name: _____

SS#: _____ Birth date: _____ Sex: M/F

Address: _____

City: _____ State: _____ Zip: _____

Home: _____ Day: _____ Cell: _____

Relationship to Patient: _____

SIGNATURE OF PATIENT / GUARDIAN

DATE

AUTHORIZED PERSONAL REPRESENTATIVE

RELATIONSHIP



3811 Sagebriar Dr. • Bryan, TX 77802
Phone (979) 774-0498 • Fax (979) 774-7673
www.texasregionaleye.com

Insurance Form

Insurance Information

PLEASE COMPLETE THE * LINES OF THIS FORM. UPON COMPLETION, PRESENT TO CHECK-IN WITH INSURANCE CARD FOR COPYING.

*Patient Name: _____

*Primary Medical Insurance Company Name: _____

Address: _____

Phone #: _____ Type of Insurance: _____

Policy #: _____

Group #: _____ Group Name: _____

* Insured's (Policy Holder as it appears on card) Name: _____

* Insured's Date of Birth: ____/____/____ * Insured's Gender: Male / Female

* Patient's Relationship to Insured: Self / Child / Spouse / Other _____

* Secondary Medical Insurance Company Name: _____

Address: _____

Phone #: _____ Type of Insurance: _____

Policy #: _____

Group #: _____ Group Name: _____

* Insured's (Policy Holder as it appears on card) Name: _____

* Insured's Date of Birth: ____/____/____ * Insured's Gender: Male / Female

* Patient's Relationship to Insured: Self / Child / Spouse / Other _____

*Vision Insurance Company Name: _____

Address: _____

Phone #: _____ Type of Insurance: _____

Policy #: _____

Group #: _____ Group Name: _____

* Insured's (Policy Holder as it appears on card) Name: _____

* Insured's Date of Birth: ____/____/____ * Insured's Gender: Male / Female

* Patient's Relationship to Insured: Self / Child / Spouse / Other _____



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Financial Policy

All services performed are the financial obligation of the patient or responsible party. **Payment for services provided are expected at the time they are provided.** You are responsible for payment of any “non-covered” services, such as **refractions**, “covered services” that are denied, co-payments, and deductibles. Insurance companies may deny payment for the submitted charges for a variety of reasons. Canceled insurance, services that do not meet the carriers definition of “medically necessary”, or “excluded services” are a few examples. It is your responsibility to know the terms and coverage of your specific insurance plan. Special billing policies will apply to the following patients:

Medicare: We are participating providers with Medicare. You will be expected to pay your deductible and a 20 percent copayment if you have Medicare Only. If you have a supplemental insurance, we will file that for you, but you must provide us with your card.

Medicaid: We do accept Medicaid patients. We are providers for traditional Medicaid, QMB, MQMB, and PCCM. If your coverage is active, we will file your claim. If you have PCCM (Primary Care Case Management), you must have received prior authorization from your primary care physician (PCP) for each visit. Please contact us prior to each visit to make sure you have an authorization number on file and is not expired.

HMO/PPO/Manage Care: Our physicians have agreed to be specialty providers for many of the HMO/PPO plans. It is the patient’s responsibility to make sure that your doctor is currently enrolled with your plan. It is important for you to consult with your insurance company prior to your visit to determine which services are covered.

Referral Numbers: If you belong to a pre-paid plan, HMO, or Point of Service contract, you have an obligation to provide us with a referral number. There rules are stated in you health plan information book. *This referral number must be obtained prior to each visit.* If your referral has not been completed prior to your arrival in the office, it may delay in being seen by the physician and the possible rescheduling of your appointment. You are obligated by your insurance company to pay the copay at the time of your visit.

Self Pay: All self-pay patients are required to make payment in full at the time of service.

Statements: You will receive a statement from our office for any self-pay balance due after your insurance carrier pays. Statements for your account balance are printed and mailed on the 1st and 15th of each month.

Returned Checks: There will be a \$30.00 service charge for all returned checks.

Refunds: In the event that a credit balance is created on your account and it is determined that the funds belong to you, you will be issued a refund check.

Collection Fee: For any account turned over to collections, an additional 33% fee will be added to the existing past due balance to cover the cost charged by the collection agency to collect the balance.

For you convenience, we accept cash, check, VISA, MasterCard, and Discover.

PLEASE PRESENT YOUR INSURANCE CARD ALONG WITH ANY REQUIRED REFERRALS / AUTHORIZATIONS TO THE RECEPTIONIST.

MEDICARE/INSURANCE PATIENTS: *I request that payment of authorized Medicare/Insurance benefits be made to Texas Regional Eye Center for any services furnished by the provider. If Medicare/Insurance denies payment for any services rendered, I agree to be personally and fully responsible for the payment.*

I have read and understand the above terms and conditions and will verify so by giving my signature.

Name of Patient (Print)

Date

Signature of Patient or Patient Representative



1. Refraction Policy:

During your visit, a refraction may be performed to determine your need for glasses, contact lenses, or to evaluate if any further visual improvement can be achieved. This is a necessary and essential portion of your eye exam and in some cases it is the sole reason for the appointment. However, the refraction is considered a NON-COVERED service by Medicare and some insurance companies.

Please be aware it is the responsibility of the patient to pay for the refraction at the time of service. Our office currently charges \$30.00 for this procedure. The copay is separate from and not included in the refraction fee.

Acknowledgment:

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service. The co-pay is separate from and not included in the refraction fee.

2. Contact Lens Policy:

ALL contact lens wearers will be charged an evaluation fee each year.

There is a fee for this service, which varies greatly depending on the type of contact lenses that are right for you, if you have been fitted before, and other individual factors. The fee can be either \$35, \$75, or \$150. This will be collected **in addition** to any copays or deductibles at the end of your visit.

I acknowledge the contact lens policy and **DO NOT** want contact lenses.

I acknowledge the contact lens policy and **DO** want contact lenses.

**** I have read and understand the above Refraction and Contact Lens Policies. ****

Patient/Guardian's Signature

Date

Patient's Name (printed)

History Summary

Patient Name: _____

Glasses Wearer Yes No

Contact Lens Wearer Yes No

Allergies: No Known Allergies
Allergy Reaction

Ocular Medications: No Ocular Meds at This Time
Medication Dose Label Description

Systemic Medications: No Systemic Meds at This Time
Medication Dose

Patient taking unknown cardiac meds.

Patient taking unknown high blood pressure meds.

Patient taking unknown diabetic meds.

Patient taking unknown cholesterol meds.

Patient taking other unknown meds. _____

If you need more space, please ask for additional form.

Past Ocular History: No past ocular history noted.
Disease Eye When

Patient has prosthetic Right eye Left eye
Surgical Procedure Eye When

Past Systemic History:
Disease Year Diagnosed

Surgical Procedure Year Outcome

Family History: No relevant family history
 Adopted
Relation Diagnosis

Social History:

Smoke? Yes No Formerly

Amount _____

Years _____

Drinks alcohol? Yes No Formerly

Amount _____

Frequency _____

Caffeine? Yes No

Amount Per Day _____

Recreational Drugs? Yes No Formerly

Name: _____

Review of Systems

Please check box that applies to you.

<u>Constitutional</u>	No	Yes
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

<u>Ears, Nose & Throat</u>	No	Yes
Exophthalmos (bulging eye)	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>
Lump in neck	<input type="checkbox"/>	<input type="checkbox"/>
Nasal congestion	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>
Tinnitus	<input type="checkbox"/>	<input type="checkbox"/>
Vertigo	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

<u>Respiratory</u>	No	Yes
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Dyspnea (shortness of breath)	<input type="checkbox"/>	<input type="checkbox"/>
Dyspnea on exertion	<input type="checkbox"/>	<input type="checkbox"/>
Hemoptysis (coughing blood)	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

<u>Cardiovascular</u>	No	Yes
Arrhythmia (irregular heart rate)	<input type="checkbox"/>	<input type="checkbox"/>
Calf pain	<input type="checkbox"/>	<input type="checkbox"/>
Chest pressure	<input type="checkbox"/>	<input type="checkbox"/>
Irregular heartbeat/palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Leg swelling	<input type="checkbox"/>	<input type="checkbox"/>
Tachycardia (rapid heart rate)	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

<u>Gastrointestinal</u>	No	Yes
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>
Black tarry stools	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Decreased appetite	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>

	No	Yes
Dysphagia (Difficulty Swallowing)	<input type="checkbox"/>	<input type="checkbox"/>
Food intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Increased appetite	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

<u>Genitourinary</u>	No	Yes
Dysuria (painful urination)	<input type="checkbox"/>	<input type="checkbox"/>
Genital lesions	<input type="checkbox"/>	<input type="checkbox"/>
Hematuria (blood in urine)	<input type="checkbox"/>	<input type="checkbox"/>
Irregular menstrual cycle	<input type="checkbox"/>	<input type="checkbox"/>
Urethral discharge	<input type="checkbox"/>	<input type="checkbox"/>
Urgency	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

<u>Metabolic/Endocrine</u>	No	Yes
Cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Hot intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Polydipsia (excessive thirst)	<input type="checkbox"/>	<input type="checkbox"/>
Polyphagia (excessive hunger)	<input type="checkbox"/>	<input type="checkbox"/>
Polyuria (excessive urine)	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

<u>Neurological</u>	No	Yes
Balance disturbances	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Focal weakness	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>
Memory difficulty	<input type="checkbox"/>	<input type="checkbox"/>
Numbness of extremities	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

<u>Psychiatric</u>	No	Yes
Depressed mood	<input type="checkbox"/>	<input type="checkbox"/>
Emotional changes	<input type="checkbox"/>	<input type="checkbox"/>
Euphoria (emotion)	<input type="checkbox"/>	<input type="checkbox"/>
Frequent nightmares	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Irritability	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>

	No	Yes
Stress	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

<u>Integumentary</u>	No	Yes
Abnormal hair distribution	<input type="checkbox"/>	<input type="checkbox"/>
Dry skin	<input type="checkbox"/>	<input type="checkbox"/>
Hives	<input type="checkbox"/>	<input type="checkbox"/>
Itching skin	<input type="checkbox"/>	<input type="checkbox"/>
Nail changes	<input type="checkbox"/>	<input type="checkbox"/>
Rash	<input type="checkbox"/>	<input type="checkbox"/>
Skin changes	<input type="checkbox"/>	<input type="checkbox"/>
Skin lesion	<input type="checkbox"/>	<input type="checkbox"/>
Skin nodules	<input type="checkbox"/>	<input type="checkbox"/>
Skin sores	<input type="checkbox"/>	<input type="checkbox"/>
Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

<u>Musculoskeletal</u>	No	Yes
Arthralgias (joint pain)	<input type="checkbox"/>	<input type="checkbox"/>
Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Fracture	<input type="checkbox"/>	<input type="checkbox"/>
Gait disturbance - (difficultly walking solo)	<input type="checkbox"/>	<input type="checkbox"/>
Joint stiffness	<input type="checkbox"/>	<input type="checkbox"/>
Joint swelling	<input type="checkbox"/>	<input type="checkbox"/>
Muscle cramping	<input type="checkbox"/>	<input type="checkbox"/>
Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

<u>Hematologic/Lymphatic</u>	No	Yes
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Bruising	<input type="checkbox"/>	<input type="checkbox"/>
Lymphadenopathy - (Swollen lymph nodes)	<input type="checkbox"/>	<input type="checkbox"/>
Tender lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

<u>Immunologic</u>	No	Yes
Environmental allergies	<input type="checkbox"/>	<input type="checkbox"/>
Food allergies	<input type="checkbox"/>	<input type="checkbox"/>
Seasonal allergies	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		



Notice of Privacy Practices

1. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

2. How we may use and disclose your health information. We use health information about you for treatment, to get paid for treatment, for administrative purposes, and to evaluate the quality of care that you receive. For example, your health information may be shared with other providers to whom you are referred. Information may be shared by paper, mail, electronic mail, fax, or other methods. We may use or disclose your health information without your authorization for several reasons. If you sign an authorization to disclose information, you can later revoke it to stop any further disclosures.

3. Your rights. In most cases, you have the right to look at or get a copy of your health information that we use to make decisions about you. You may request that we limit disclosure to family members, other relatives, caregivers, or close personal friends who may or may not be involved in your care. If you request copies, we may charge you a cost-based fee. You also have the right to request a list of certain types of disclosures of your information that we have made. If you believe that your health information is incorrect or information is missing, you have the right to request that we correct the existing information or add the missing information.

4. Our legal duty. We are required by law to protect the privacy of your health information, provide this notice about our privacy practices, follow the privacy practices that are described in this notice, and seek your acknowledgement of receipt of this notice. We may change our privacy policies any time. Before we make a significant change in our policies, we will change our notice. You can request a copy of our notice at any time. For more information about our privacy policies, contact our privacy officer.

5. Privacy complaints. If you are concerned that we have violated your privacy rights, our privacy policies, or if you disagree with a decision we made about access to your health information, you may contact our privacy officer. You may send a written complaint to the U.S. Department of Health and Human Services. Our privacy officer can provide you with the appropriate address upon request.

If you have any questions or complaints, please contact: Texas Regional Eye Center, Privacy Officer, 3811 Sagebriar Drive, Bryan, Texas 77802. Phone number: (979) 774-0498 Fax number: (979-774-7673).

Acknowledgement of receipt of Notice of Privacy Practices: Please sign, print your name and date, and provide anyone authorized to have access to your medical and/or billing records below.

Patient/Guardian's Signature

Date

Printed Name

Name of Personal Representative & Relationship

Name of Personal Representative & Relationship