Eye Associates of Central Texas

Patient Registration

ID: _____ Appointment Date _____/_____/_____

Patient Information

Last Name	First Name	Initial	Gender	Marital Status	Date of Birth
				☐ Single ☐ Widowed ☐ Married ☐ Divorced	_____/_____/_____

Phone: (_____) _____-_____ Cell / Home / Work

Alternative Phone (_____) _____-_____ Cell / Home / Work

Address

Apt/Bldg #			Email
City	State	Zip Code	Social Security #
Preferred Language			Ethnicity

Emergency Contact Phone Relationship

Primary Care & Pharmacy Information

Primary Care Doctor	Referring Physician	Referring Office Name
Preferred Pharmacy	Phone	Location

If not referred, how did you hear about us? *Please specify: Website / Friend / Family / Advertisement / Google / Other*

Medical Insurance Information

Primary Insurance Name		HMO / PPO / Other:	
Member/Subscriber ID	Group Number	Subscriber Date of Birth _____/_____/_____	Relationship to Patient
Secondary Insurance Name		HMO / PPO / Other:	
Member/Subscriber ID	Group Number	Subscriber Date of Birth _____/_____/_____	Relationship to Patient

I certify that the information I have reported regarding my insurance coverage is correct.

X _____

Signature Date (MM/DD/YYYY)

EACTX Financial Policies

PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE:

I, the undersigned, authorize payment of medical benefits to EACTX for any services furnished to me by the physician. I hereby assign all medical and surgical benefits to EACTX, including major medical benefits, to which I am entitled. I authorize and direct my insurance carrier(s) to issue payment checks to EACTX for medical and surgical services rendered to me or my minor children.

I authorize EACTX to release to my insurance company or their agent information concerning health care, advice, treatment, or supplies provided to me; to process insurance claims generated during the examination; and to allow a photocopy of my signature to be used to process insurance claims for the period of my lifetime. This information will only be used for evaluating and administering claims benefits.

I also authorize EACTX to disclose protected health information, including lab results and diagnosis, in messages left on my voicemail at the following number: (_____) _____-_____

HIPAA Approved Contacts: (Individuals who you approve EACTX to release your medical/personal information)

Name: _____ Phone: (_____) _____-_____ Relationship: _____

Name: _____ Phone: (_____) _____-_____ Relationship: _____

Information Regarding Dilating Eye Drops

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye. Dilating Drops frequently blur the vision for a length of time, which varies from person to person and may make bright lights bothersome. In children, the dilation can last up to 24-36 hours and may last longer in those with lighter eyes. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, you may want to make arrangements to not drive yourself, or should you choose to drive, we will provide you with dark sunglasses. Adverse reactions, such as acute angle closure glaucoma may be triggered from dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize EACTX to administer dilating eye drops in my/my child's eyes for the doctor to thoroughly check the nerve and retina, and I acknowledge that the eye drops are necessary to diagnose my condition, if any exists. I understand that pupil dilation may affect my ability to safely operate a motor vehicle and the staff and doctors at EACTX recommend I find alternative transportation if necessary, unless I choose to drive myself with dark sunglasses.

Refraction Services and Fees

A refraction is a mandatory step for most exams, and is the process of determining your best corrected vision. It allows us to determine what you CAN and CAN'T see on your exam day. It also shows if there is a need for corrective eyeglasses/contact lenses, or if there is a medical issue going on. It is an essential part of the eye exam and also allows us to write a prescription for glasses or contact lenses. This is a separate, billable code per insurance companies. A refraction is NOT a covered service by Medicare or most medical insurance plans. These plans consider a refraction a "vision" service not a "medical" service. Our office fee for a refraction is $45.00 along with any co-payments required by your insurance plan. We will NOT file the charge for a refraction with health insurance unless we know that your plan covers the refraction charge.

Cancellations and No-Shows

Should you need to cancel or reschedule an appointment, please contact our office as soon as possible and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

Any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24 hours' notice will be considered a "No Show" and charged a fee of $50. After a third, "No Show" or failure to cancel/reschedule with 24 hours' notice, a patient may be dismissed from Eye Associates of Central Texas.

Any New patient who fails to show for their initial visit, with no 24-hour notice, may not be rescheduled.

A fee of $100 will be charged for failure to cancel your surgery appointment with at least 48 hours' notice.

The fee is charged to the patient, not to the insurance company, and is due at the time of the patient's next office visit. As a courtesy, we have an after-hours call center that handles our reminder calls for appointments. If you did not receive a reminder, call or message, the above policy does remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience this, please contact our office and we may be able to waive the "No Show" fee. Should it be after regular business hours Monday through Friday or a weekend, you may leave a message.

Paperwork Fee

There is a $25 fee for each document/request made to our office to fill out paperwork. This includes such things as FMLA, disability, or pharmacy related paperwork. Paperwork can take up to 10 business days to be completed depending on the extent of the forms. Paperwork will not be completed the same day it is dropped off to the office, and the fee will be charged at the time of the request.

I certify that the information I have reported regarding my insurance coverage is correct.

X _____

Signature Date (MM/DD/YYYY)

NOTE:
Please attach all pertinent insurance ID cards for photocopying