Stone Oak Ophthalmology Center
Lifelong Comprehensive Eye Care

Allison Paige Young, M.D. // Teresa Treviño Whitney M.D.
325 E. SONTERRA BLVD., SUITE 100 SAN ANTONIO, TX 78258

Patient Account Number
(For Office Use Only)
_____

Welcome to our office and thank you for selecting our healthcare team! To assist us in serving you, please fill out the confidential forms.

PATIENT INFORMATION (PLEASE PRINT)

FIRST NAME: _____ **INITIAL:** _____ **LAST NAME:** _____

ADDRESS: _____
Street/Apt # City State Zip

HOME PHONE: (_____)_____ **WORK PHONE:** (_____)_____ EXT:_____ **CELL:** (_____)_____

EMAIL: _____

DATE OF BIRTH: _____ **AGE:** _____ **SEX:** ☐ MALE ☐ FEMALE **MARITAL STATUS:** ☐ S ☐ M ☐ D ☐ W

SOCIAL SECURITY #:_____**DRIVERS LICENSE #:** _____ **OCCUPATION:** _____

FOR MEDICARE AND GOVERNMENT INSURED PATIENTS ONLY:
PRIMARY LANGUAGE: _____
RACE: ☐ WHITE ☐ BLACK/AFRICAN AMERICAN ☐ ASIAN ☐ OTHER _____
ETHNICITY: ☐ HISPANIC/LATINO ☐ NOT HISPANIC/LATINO

How did you hear about our office?

☐ Yellow Pages ☐ Friend ☐ Family Member ☐ Magazine ☐ Internet Search ☐ Website ☐ Other: _____

Another patient, who? _____ Another doctor, who? _____

PARENT/GUARDIAN/RESPONSIBLE PARTY INFORMATION (PLEASE PRINT)

FULL NAME: _____ RELATIONSHIP _____ PHONE: (_____)_____

ADDRESS: _____

EMERGENCY CONTACT INFORMATION (PLEASE PRINT)

FULL NAME: _____ **RELATIONSHIP** _____ **PHONE** (_____)_____

INSURANCE INFORMATION (PLEASE PRINT)

☐ **PRIVATE PAY** (No insurance/insurance not taken)

PRIMARY INSURANCE: _____

POLICY HOLDER NAME: _____ DATE OF BIRTH: _____

PATIENT RELATION TO POLICY HOLDER: ❑ SELF ❑ SPOUSE ❑ CHILD ❑ Other _____

SECONDARY INSURANCE: _____ ☐ **Not Applicable**

POLICY HOLDER NAME: _____ DATE OF BIRTH: _____

PATIENT RELATION TO POLICY HOLDER: ❑ SELF ❑ SPOUSE ❑ CHILD ❑ Other _____

Patient's or Authorized Person's Signature

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. PAYMENT IS EXPECTED IN FULL EACH VISIT.

_____ DATE: _____
SIGNATURE (PATIENT, GUARDIAN, OR PARENT OF MINOR)

STONE OAK OPHTHALMOLOGY

WELCOME TO OUR PRACTICE

REFERRALS

If you have an insurance which requires a referral **it is your responsibility to obtain the referral from your primary care physician before your appointment**. Otherwise, the visit will not be covered by insurance and you will be responsible for the payment. Please notify us if your insurance requires pre-authorization for office procedures.

INSURANCE POLICY

In order to serve you properly and keep cost down we feel it necessary to define our financial policies. We are happy to file the forms necessary to see that you receive the full benefits of your coverage; however, we cannot guarantee any estimated coverage. Because the insurance policy is an arrangement between you and the insurance company, we ask that all patients be directly responsible for all charges. Please know that we will do everything possible to see that you receive the full benefits of your policy. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance, and "usual and customary" fees. Additionally, we are not responsible if your insurance company representative tells us something is covered at X% and then later denies payment or pays less than stated. Our involvement will be limited to supplying factual information to facilitate claim processing. If for some reason your insurance company has not paid their portion within 30 days from the start of the treatment, you are responsible for the payment at that time. All charges are your responsibility whether your insurance company pays of does not pay. If you should have any questions regarding your charges for each appointment, please feel free to ask.

REFRACTION POLICY

The Center for Medicare and Medicaid Service (CMS) uses a system – the Resource Based Relative Value Scale (RBRVS) – to determine the fees for all Medicare providers. Most of the other insurance companies use this same system to et their payment schedules. During your visit a refraction may be performed to determine your need for glasses or to evaluate if any further visual improvement can be achieved. This is not only a necessary and essential portion of your eye exam, and in many cases is the sole reason for the appointment. Please be aware that Medicare and many insurance's **DO NOT COVER** the refraction (measurement for glasses prescription) or routine eye exams. In this case the patient would be responsible for the bill, which is $50.00. All contact lens charges must be paid by the patient, we do not file contact charges to insurance. We appreciate your cooperation in collecting this fee at the time of service.

I have read the above and fully understand my financial responsibility

Signature: _____ Date: _____

MEDICARE REFRACTION DISCLOSURE

Medicare allows the physician to charge for the refraction (measurement for glasses prescription). Although this service is necessary, it is not covered by Medicare. We are required by law to have your signature acknowledging your responsibility for this payment.

Signature: _____ Date: _____

ACKNOWLEGMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES/PHI

I have reviewed the office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of the document.

_____ _____

Patient Signature or Signature of Legal Representative Date

Name:_____ DOB:_____ MRN: (office use)_____

OCULAR HISTORY (Please print)

Have you had any of the following eye conditions?

(Please check all that apply and circle the appropriate eye)

- ☐ Acephalgic (ocular) migraines
- ☐ Allergic conjunctivitis
- ☐ Amblyopia (weaker eye) right/left eye
- ☐ Anterior basement membrane dystrophy right/left/both eye(s)
- ☐ Blepharitis
- ☐ Cataract right/left/both eye (s)
- ☐ Contact lenses
- ☐ Diabetic retinopathy right/left/both eye(s)
- ☐ Dry eyes
- ☐ Fuchs dystrophy right/left/both eyes(s)
- ☐ Glasses
- ☐ Glaucoma right/left/both eye(s)
- ☐ Glaucoma suspect right/left/both eye(s)
- ☐ Herpes simplex virus right/left/both eye(s)
- ☐ Herpes zoster virus right/left/both eye(s)
- ☐ Keratoconus
- ☐ Dry macular degeneration right/left/both eye(s)
- ☐ Wet macular degeneration right/left/both eye(s)
- ☐ Macular pucker right/left/both eye(s)
- ☐ Narrow angles right/left/both eye(s)
- ☐ Pigment dispersion syndrome
- ☐ Posterior vitreous detachment right/left/both eye(s)
- ☐ Pseudoexfoliation
- ☐ Retinal detachment right/left/both eye(s)
- ☐ Retinal tear right/left/both eye(s)
- ☐ Strabismus right/left/both eyes(s)
- ☐ Thyroid eye disease/Graves
- ☐ Uveitis right/left/both eye(s)
- ☐ Other_____

Do you have a family history of the following?

- ☐ Fuchs dystrophy _____
- ☐ Glaucoma _____
- ☐ Keratoconus _____
- ☐ Macular degeneration _____

Have you had any of the following eye surgeries?

(Please check all that apply and include the date)

	Date:
☐ Blepharoplasty right eye	_____
☐ Blepharoplasty left eye	_____
☐ Cataract surgery right eye	_____
☐ Cataract surgery left eye	_____
☐ Corneal transplant right eye	_____
☐ Corneal transplant left eye	_____
☐ DSEK/DMEK right eye	_____
☐ DSEK/DMEK left eye	_____
☐ Intravitreal injections right eye	_____
☐ Intravitreal injections left eye	_____
☐ LASIK right eye	_____
☐ LASIK left eye	_____
☐ Laser iridotomy right eye	_____
☐ Laser iridotomy left eye	_____
☐ PRK right eye	_____
☐ PRK left eye	_____
☐ Ptosis repair right eye	_____
☐ Ptosis repair left eye	_____
☐ Punctal plug right eye	_____
☐ Punctal plug left eye	_____
☐ RK right eye	_____
☐ RK left eye	_____
☐ Retinal detachment repair right	_____
☐ Retinal detachment repair left	_____
☐ Retinal laser right eye	_____
☐ Retinal laser left eye	_____
☐ SLT right eye	_____
☐ SLT left eye	_____
☐ Strabismus surgery right eye	_____
☐ Strabismus surgery left eye	_____
☐ Trabeculectomy right eye	_____
☐ Trabeculectomy left eye	_____
☐ Vitrectomy right eye	_____
☐ Vitrectomy left eye	_____
☐ YAG capsulotomy right eye	_____
☐ YAG capsulotomy left eye	_____
☐ Other_____	_____
☐ Other_____	_____

Name:_____ DOB:_____ MRN:_____

MEDICAL HISTORY (Please print)

Do you have or have you had any of the following?
(Please check all that apply)

- ☐ Abnormal bleeding after extractions/surgery
- ☐ AIDS or HIV positive
- ☐ Anxiety
- ☐ Allergies
- ☐ Anemia or blood disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Bell's palsy
- ☐ Breast cancer
- ☐ Colon cancer
- ☐ COPD
- ☐ Coronary artery disease
- ☐ Depression
- ☐ Diabetes
- ☐ Kidney disease
- ☐ GERD (reflux)
- ☐ Hearing loss
- ☐ Hepatitis
- ☐ Heart attack
- ☐ Hypercholesterolemia
- ☐ Hypertension
- ☐ Hyperthyroidsim
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung cancer
- ☐ Lupus
- ☐ Lymphoma
- ☐ Prostate cancer
- ☐ Rheumatoid arthritis
- ☐ Seizure disorder
- ☐ Sjogren's syndrome
- ☐ Stroke
- ☐ Other_____

Social history

- ☐ Smoking: daily/sometimes/rarely/quit/never
- ☐ Alcohol: daily/social/occasionally/rarely
- ☐ Recreational drugs

Have you had any of the following <u>treatments or surgeries</u>?
(Please check all that apply and include the date)

	Date:
☐ Appendectomy	_____
☐ Breast cancer surgery	_____
☐ C-section	_____
☐ Chemotherapy	_____
☐ Colon cancer surgery	_____
☐ Cholecystectomy	_____
☐ Heart bypass surgery	_____
☐ Heart stents	_____
☐ Heart valve replacement	_____
☐ Hip replacement (R/L/Both)	_____
☐ Hysterectomy	_____
☐ Kidney stone removal	_____
☐ Kidney transplant	_____
☐ Knee replacement (R/L/Both)	_____
☐ Nephrectomy	_____
☐ Liver transplant	_____
☐ Melanoma	_____
☐ Oophorectomy (ovaries)	_____
☐ Orchiectomy (testicle)	_____
☐ Pancreatectomy	_____
☐ Prostate cancer surgery	_____
☐ Radiation treatment	_____
☐ Sinus surgery	_____
☐ Skin CA (basal/squamous)	_____
☐ Splenectomy	_____
☐ Other_____	_____
☐ Other_____	_____

Do you have a Family History of any of the following?

- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ Heart problems _____
- ☐ Hypertension _____
- ☐ Thyroid disease _____
- ☐ Stroke _____
- ☐ Other _____

Occupation:_____

Name:_____ DOB:_____ MRN:_____

MEDICATIONS (Please print)

Please list all current EYE medications:

_____ _____

_____ _____

_____ _____

Please list all other current medications:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Are you allergic to any of the following?

- ☐ None apply
- ☐ Penicillins
- ☐ Latex
- ☐ Sulfa drugs
- ☐ Other_____

Pharmacy information: Please list your preferred pharmacy's name and phone number

Pharmacy name:_____ Number:_____

Address:_____

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CONTACT LENS POLICY

All of our patients requesting evaluation for contact lenses will be examined by the ophthalmologist in addition to testing for a contact lens fitting. This is done in your own best interest to be certain that there is no medical contraindication to wearing contact lenses or any other problem that might be detected unrelated to contact lens wear. You will also be referred back to the ophthalmologist for a yearly examination and if at any time your condition warrants a medical exam.

Virtually all types of contact lenses will be available for fitting and we will make every attempt to conform to your wishes. However, we will recommend the contact lenses that will give you the best vision possible and fit your individual lifestyle.

Contact lens fitting fees vary depending on the type of contact lens you are fit with. The contact lens fitting fees include the following:

A. Complete contact lens fitting.
B. Patient training of contact lens insertion and removal techniques.
C. Contact lens evaluations and follow-up care for 60 days from the **INITIAL** contact lens exam.
D. Lab changes and modifications of new contact lens for 60 days from the **INITIAL** contact lens exam. If a power change is required. This does not include a change in tint or upgrade in contact lenses.
E. The contact lens trials and training for care of the lenses.
F. Your initial care kit.

***Professional fees paid for contact lens fittings are non-refundable.** Contact lenses are purchased separately and in the case of soft contact lenses any boxes purchased must be returned **unopened** and with **a non-expired expiration date** to receive credit. Gas permeable contacts must be returned in good condition, lost or damaged gas permeable contact lenses are not refundable.

PATIENT AGREEMENT

I am aware of other alternatives for the correction of my vision other than contact lenses. Even with proper care there are risks to wearing contact lenses, which include:

Soft lenses- irritation from solutions or protein build-up, conjunctivitis, corneal vascularization and severe and potentially blinding corneal infections and loss of eye.

Rigid lenses- intolerance, corneal swelling and or ulceration, corneal warping, change in shape of the cornea causing problems seeing well with glasses and irritation from chipped or broken lenses.

Extended wear contact lenses- we do not recommend overnight wear of any contact lenses. Risks include significantly increased risk of corneal

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ulcer and infection and severe and potentially blinding corneal infections and loss of eye. "Extended wear does not imply "continuous wear".

- I acknowledge that I have been properly instructed in the care of my contact lenses. I also understand that if I do not follow the instructions given for the care of my lenses, I put myself at risk to develop infections that can lead to the loss of vision or even the loss of an eye.
- I also understand that poor care of my lenses may make them uncomfortable and not wearable and may increase the cost of my contact lens wear. I understand the fragility of contact lenses and that there is no warranty against damage of the lenses. Also, I have been instructed and have practiced insertion and removal of my lenses. (If applicable)
- I understand that this contact lens prescription is valid for replacement lenses for **ONE YEAR** and that an annual eye and contact lens examination will be required to update this prescription for replacement lenses after one year. I understand that if I do not have an exam after one year, then my risk of infection, discomfort, or ruined lenses becomes greater as time passes.
- To reorder contacts, call the contact lens department. Leave your name, daytime phone number, number of contact lenses you are ordering, the eye you are ordering for, and color of contacts. Please leave credit card information for the prepaying of contact lens orders. Leave the credit card holders name, credit card number, and expiration date on the card. They usually take 3-7 working days to come in, unless we have them in stock in our office. Special order contact lenses can take longer. We will contact you when we receive your lenses.
- I understand that it is normal if at first:
  - My lenses itch or feel unusual.
  - I feel one lens more at times.
  - My vision seems fuzzier than with glasses.
  - One eye sees better than the other.
- I will remove my lenses and call the office if:
  - I develop unusual pain or redness.
  - I experience decreased vision that does not get better.
  - I suspect something is wrong.

- I understand that full payment is expected at the time a contact lens fitting is performed.
- We are pleased that you have chosen Stone Oak Ophthalmology for your contact lens care and look forward to a very pleasant experience with you.

*Prices Subject to Change

Patient Signature or Patient's Guardian _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement, but in refusing we *will not be allowed* to process your insurance claims.

Stone Oak Ophthalmology Center
Lifelong Comprehensive Eye Care

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for **Stone Oak Ophthalmology Cente**r. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS IN THE FUTURE.**

_____ _____
Please ***print*** your name Please ***sign*** your name

_____ _____
Legal Representative Description of Authority

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY HEALTH APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- ☐ Cell Phone Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone Confirmation
- ☐ Email Confirmation
- ☐ U. S. Mail / Postcard

I AUTHORIZE **INFORMATION ABOUT MY HEALTHCARE HEALTH** BE CONVEYED VIA:

- ☐ Message on Cell Phone
- ☐ Message on Home Phone
- ☐ Message on Work Phone
- ☐ Email Message
- ☐ U. S. Mail / Postcard
- ☐ **Any of the above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS or NEW HEALTH INFO** via:

- ☐ Phone Message
- ☐ Email
- ☐ U. S. Mail / Postcard
- ☐ **Any of the above**

Office Use Only
As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment _____
I could not communicate with the patient _____
The patient refused to sign _____
The patient was unable to sign because _____
Other (please describe) _____

_____
Signature of Privacy Officer

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325 E. SONTERRA BLVD., SUITE 100 SAN ANTONIO, TX 78258
TELEPHONE 210-490-6759 || FAX 210-490-6507

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize **Allison Paige Young M.D.//Teresa Treviño Whitney M.D.** to disclose my complete ophthalmic records including visual fields and fluorescein angiography (if performed) to:

_____

_____

_____

In furtherance of this authorization, I do hereby waive all provision of law and privileges relating to the disclosures hereby authorized.

Dated this _____ day of _____, 20_____.

_____
Patient's name (please print)

_____
Patient's Date of Birth

_____
Patient's signature (or responsible party)

Stone Oak Ophthalmology Center
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Allison Paige Young, M.D. // Teresa Treviño Whitney M.D.

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TELEPHONE 210-490-6759 || FAX 210-490-6507

REQUEST FOR MEDICAL RECORDS

Please send a copy of this patient's complete ophthalmic records including visual fields and fluorescein angiography (if performed) to Allison Paige Young M.D//Teresa Treviño Whitney M.D. or OTHER medical records

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize: _____

_____

_____

to disclose the above information to Allison Paige Young, M.D.// Teresa Treviño Whitney M.D., in furtherance of this authorization, I do hereby waive all provision of law and privileges relating to the disclosures hereby authorized.

Dated this _____ day of _____, 20____

_____
Patient's name (please print)

_____
Patient's Date of Birth

_____
Patient's signature (or responsible party)

Stone Oak Ophthalmology Center

Lifelong Comprehensive Eye Care

Cancellation Policy/No-Show Policy

For Doctor Appointments

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty dollar ($50) fee; this will not be covered by your insurance company.

_____ _____

Patient Signature **Date**