Stone Oak Ophthalmology Center
Lifelong Comprehensive Eye Care

Allison Paige Young, M.D. *Teresa Treviño Whitney M.D.*

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

We are happy to file the forms necessary for you to 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 or does not pay. If you should have any questions regarding your charges for each appointment, please feel free to ask.

**** Please note that we are an office of Medical Doctors and, therefore, we fall under your Medical Insurance, NOT Vision Insurance. We do not accept Vision Insurance for any services.**

DILATION POLICY

A complete eye exam requires dilation of your eyes. If you are a new patient or are being seen for your annual exam, please plan on having your eyes dilated.

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 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; it is often the sole reason for the appointment. Please be aware that Medicare and many insurance's **DO NOT COVER** the refraction (measurement for glasses prescription). In this case the patient would be responsible for the bill, which is **$50.00**. Additionally, all contact lens charges $55.00 must be paid by the patient, as 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

Stone Oak Ophthalmology Center
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Patient Account Number
(For Office Use Only)

_____

Allison Paige Young, M.D. // Teresa Treviño Whitney M.D.
325 E. SONTERRA BLVD., SUITE 100 SAN ANTONIO, TX 78258
(210) 748-2727

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: _____DATE OF BIRTH:_____

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)

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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325 E. SONTERRA BLVD., SUITE 100 SAN ANTONIO, TX 78258

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

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.** While the government department HHS requires me to give this to you, it is your choice whether or not to sign it. I believe it is my professional duty and promise to keep your information private.

_____ _____

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
- ☐ Text 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**

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No-Show Policy For Doctor Appointments

We understand that there are times when you must miss an appointment due to emergencies or obligations to work or family. If you need to cancel an appointment, we would appreciate a call 24 hours prior to your appointment, if possible, as we like to open late cancellations to patients on our wait list. We understand that it is not always possible to call 24 hours prior, but a phone call is still very much appreciated.

If a patient "no-shows" for an appointment 3 times, the patient may by dismissed from the practice at the doctor's discretion.

_____ _____

Patient signature Date

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CONTACT LENS POLICY

At Stone Oak Ophthalmology, we do not prescribe contact lenses without a complete eye examination by our physicians. We believe it is extremely important to be certain that there is no medical contraindication to wearing contacts and to diagnose any other potential problems that might be detected unrelated to contact lens wear. If a "contact lenses only" exam is what you desire, please feel free to see a local optometrist.

We **do not accept vision insurance nor do we file a claim to your health insurance**; therefore our refraction and contact lens fees are collected at the time of the visit. These fees are non-refundable.

Refraction (performed at every annual visit to determine the prescription): **$50**

Contact lens fitting and training fee (for first time contact lens wearers): **$100**

Contact lens fitting fee (for patients already wearing contacts): **$55**

The fees include:

- Contact lens fitting, including the necessary imaging of the cornea (corneal topography)
- Patient training of contact lens insertion and removal techniques and initial contact lens care kit (for new wearers)
- Follow up care and "contact lens checks" with a technician for up to 60 days from the initial contact lens exam
- Lab changes and modifications of new contact lenses for 60 days from the initial contact lens exam if a power change is required (this does not include change in tint or upgrade in contact lens brand)
- Contact lens trials and review of contact lens care

Contact lenses are purchased separately. Should soft contact lenses need to be returned, the original packaging must be **unopened**, with a **non-expired expiration date** to receive credit (no refunds). Gas permeable lenses must be returned in good condition for remakes (no refunds); lost or damaged gas permeable lenses are not refundable.

ORDERING CONTACTS

To re-order contacts, please call our Contact Lens department. Once ordered, we typically receive the contacts in 3-7 business days. Special order contact lenses may take longer. We will contact you as soon as we receive your lenses. To order:

- Leave your name, daytime phone number, number of contact lenses you are ordering,

CONTACT LENS POLICY (cont.)

PATIENT AGREEMENT

I understand that there are alternatives to contact lenses for the correction of my vision and that, even with proper care, there are risks associated with contact lens wear, including:

- Soft lenses: intolerance, irritation from solutions or protein build-up, conjunctivitis, corneal vascularization, severe and potentially blinding corneal infections, loss of eye
- Rigid gas permeable lenses: intolerance, corneal swelling, corneal warping, severe and potentially blinding corneal infection or ulceration

I acknowledge that I have been properly instructed in the care of my contact lenses and that, if I do not properly care for my lenses, I put myself at risk for developing serious infections that could lead to vision loss or even loss of an eye.

I understand the fragility of contact lenses and that there is no warranty against damage of the lenses.

I understand that this contact lens prescription is valid for replacement lenses for ONE YEAR. After one year, I will need to be seen by the ophthalmologist for my annual eye and contact lens exam to receive an updated prescription for contact lenses.

I understand that the following symptoms are normal when first wearing contact lenses:

- My lenses itch or feel unusual
- I feel one lens more than the other at times
- My vision seems fuzzier with my contacts than with my glasses
- One eye sees better than the other

I understand that full payment is expected at the time of contact lens fitting.

_____ _____

Patient Signature/Patient's Guardian Date