DRY EYE INSTITUTES of America™

Dear New Patient,

Thank you for choosing Dry Eye Institutes of America. We strongly believe in a **TEAM** approach to patient care and our team is committed to providing a smooth patient experience. Our holistic approach working with cooperating doctors enables us to collect unbiased information in order to track our results and better our outcomes.

Your appointment at Dry Eye Institutes of America is scheduled on _____, _____at _____am/pm at our Grapevine location.

We have enclosed patient information sheets for you to complete prior to your appointment. Hopefully, this will help expedite your time in our office. **Please do not mail these forms back to us.**

Please bring the completed forms plus your insurance card(s) and driver's license with you to your appointment. A copy will be made and kept on file with our office in order to improve our billing process.

Please be aware that both of your eyes may be dilated at your visit. The process for testing, diagnosing and treating your eye concerns can take up to 2 hours or more, so please plan accordingly.

Our office policy states that co-payments and or deductibles are due at the time of your visit. If you do not have insurance to cover your visit, payment will be due at the time of your visit. We accept Visa, MasterCard, American Express and Discover.

We look forward to seeing you on your appointment day. If you have any questions, please feel free to contact our office at 817-488-3490 and we would be glad to answer them for you.

Sincerely,

The Dry Eye Institutes of America Team

2201 Westgate Plaza
Grapevine, Texas 76051

DRY EYE INSTITUTES *of America*™

PATIENT REGISTRATION FORM

PATIENT NAME: DR. MR. MRS. MS._____ DATE:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

HOME PHONE:_____ WORK PHONE:_____

CELL PHONE:_____ PHARMACY:_____

E-MAIL ADDRESS: _____ □ Check here if ok to receive appt reminders via email

SEX: M F MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

ETHNICITY: ☐ HISPANIC or LATINO ☐ NOT HISPANIC or LATINO ☐ UNKNOWN ☐ DECLINE to SPECIFY

RACE: ☐ AMERICAN INDIAN or ALASKAN NATIVE ☐ASIAN ☐ BLACK or AFRICAN AMERICAN ☐ WHITE

☐ NATIVE HAWAIIAN or OTHER PACIFIC ISLANDER ☐ OTHER RACE ☐ DECLINE TO SPECIFY

SSN:_____ DATE OF BIRTH:_____

REFERRED BY:_____ PHONE:_____

PRIMARY PHYSICIAN:_____ PHONE:_____

EMERGENCY CONTACT AND RELATIONSHIP:_____

PHONE: _____

PATIENT EMPLOYER/OCCUPATION:_____

REASON FOR VISIT: ___CATARACT EVALUATION ___MEDICAL EYE EXAM ___OTHER

IF OTHER, PLEASE EXPLAIN_____

_____

HOW DID YOU HEAR ABOUT OUR OFFICE:_____

INSURANCE INFORMATION ~ PLEASE PROVIDE INSURANCE CARD(S) TO RECEPTIONIST

PRIMARY INSURANCE _____ POLICY#_____

INSURANCE PHONE #_____ GROUP#_____

SUBSCRIBER NAME & DATE OF BIRTH_____

SECONDARY INSURANCE_____ POLICY#_____

INSURANCE PHONE #_____ GROUP#_____

SUBSCRIBER NAME & DATE OF BIRTH_____

DRY EYE INSTITUTES *of America*™

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date: _____
Date of Birth: _____ Date of last eye exam: _____
Ht.:_____ Wt.:_____

List any medications you currently take (prescription and over-the counter, especially FLOMAX)
_____
_____
Do you have allergies to any medication? **YES** **NO**
If YES, list all medications _____
List all major illnesses and injuries (glaucoma, diabetes, high blood pressure, heart attack, concussion, etc.)
_____
Do you wear contact lenses? _____ Have you had eye surgery? _____ If yes, when? _____
List any surgeries you have had (cataract, appendectomy, etc) _____
List previous eye doctors within the last 7 years: _____
I or a family member is/are interested in (please circle):
LASIK Cataract Surgery Premium IOL Contact Lenses Conductive Keratoplasty
Do you currently have any problems in the following areas? If YES, please explain.

	YES	NO	DETAILS
EYES (poor vision, pain, tearing, redness, etc.)			
GENERAL / CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, etc.)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc)			
RESPIRATORY (congestion, wheezing, etc.)			
GASTROINTESTINAL (hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (impotence, enlarged prostate, painful/frequent urination, etc.)			
FEMALES (are you pregnant, nursing?)			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (bleeding, anemia, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, etc.)			

FAMILY HISTORY

Has any member of your family had these diseases (circle all that apply)? YES NO UNKNOWN
Blindness Cataract Glaucoma Diabetes Hypertension Heart Disease Stroke Cancer Thyroid Disease Arthritis
Other heritable disease:

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? YES NO
Have you ever had a blood transfusion? YES NO Do you live alone? YES NO
Do you drink alcohol? YES NO If YES, how much? _____
Do you smoke? YES NO If YES, how much? _____ How many years? _____

Doctor's Signature _____ **Date** _____

DRY EYE INSTITUTES *of America*™

PAYMENT

Payment is expected at the time of service. This includes co-pays and/or deductibles if we are filing insurance for you. We accept cash, checks and major credit cards.

REFERRALS

If your insurance plan requires a referral from your primary care physician **you** are responsible for obtaining a referral **PRIOR** to your appointment. **If you do not have a referral, your appointment will need to be rescheduled.**

REFRACTION POLICY

Some insurances do not cover the refraction fee ($45.00); this will be collected at the time of service. If we file insurance other than Medicare and the refraction is not a covered benefit, you will be responsible for the fee (refractions are required annually).

WHEELCHAIR PATIENTS

If you are in a wheelchair, please inform our office ahead of time so that we can make sure we have the larger exam room available in time for your appointment. We also need to know if you are capable of getting out of your chair briefly to allow us to perform the required tests and/or exam.

MEDICAL RECORDS CHARGE

There is a $25.00 fee for copies of medical records.

RETURNED CHECK POLICY

There is a $35.00 fee for returned checks.

NO-SHOW APPOINTMENTS

Dry Eye Institutes of America reserves the right to bill you for a missed or “no show” appointment without appropriate notice of cancellation.

I have read and understand the above policies.

Patient Name_____

Signature_____ Date_____

DRY EYE INSTITUTES of America™

ASSIGNMENT OF BENEFITS

I authorize Dry Eye Institutes of America to act as my agent in helping me obtain payment from my insurance company. I authorize use of this form on all my insurance submissions.

I authorize release of pertinent information required to process my claim to my insurance company.

I authorize payment directly to Dry Eye Institutes of America. This payment will not exceed my indebtedness to Dry Eye Institutes of America and I have agreed to pay any balance of the professional charges over and above this insurance payment.

I further request that supplemental insurance benefits filed on my behalf be paid as stated above.

I understand that I am responsible for my bill regardless of my insurance status. I understand that Dry Eye Institutes of America is not party to the contract between myself, my employer, and my insurance company.

A photocopy of this Assignment of Benefits shall be considered as effective and valid as the original.

_____ **I do not have insurance coverage. I understand that I am responsible for my bill.**

Patient Name (Please Print): _____

Patient Signature or
Responsible Party: _____

Date Signed: _____

DRY EYE INSTITUTES *of America*™

CONSENT FOR MEDICAL RECORDS / INFORMATION

I, _____ (patient name) _____ (date of birth)

_____ (address)

_____ (city, state, zip)

Do hereby authorize: DRY EYE INSTITUTES OF AMERICA
2201 Westgate Plaza
Grapevine, Texas 76051
Fax: 817-251-6261
Phone: 817-488-3490

OFFICE USE ONLY
To release / obtain medical records / medical information from / to:

_____ Name

_____ Address

_____ Telephone Number

_____ Fax Number

_____ Patient will pick up from DEIA

For the purpose of: (please circle)

Medical Care Research Insurance Attorney Other: _____

I am requesting access to my health information through (please circle):

Copies of my records Inspection of my records Summary of my records

I understand that Dry Eye Institutes of America may charge a fee for the costs of sending any information associated with my request.

_____ _____

Patient Signature Date

DRY EYE INSTITUTES *of America*™

Signature on File, Assignment of Benefits, Financial Agreement

Patient Name (print) _____ Medicare Number or SSN _____

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Dry Eye Institutes of America, for services furnished me by Dry Eye Institutes of America. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Dry Eye Institutes of America accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services and/or items. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2. **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Dry Eye Institutes of America if possible or otherwise to me.

3. **RELEASE OF INFORMATION:** Dry Eye Institutes of America may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Dry Eye Institutes of America for reimbursement for services rendered, and (2) any health care provider for continued patient care. Dry Eye Institutes of America may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

4. **OTHER INSURANCE:** I understand that Dry Eye Institutes of America maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office and that Dry Eye Institutes of America has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all items and/or services rendered to me by Dry Eye Institutes of America if I belong to a plan that does not appear on the above mentioned list.

5. **NON-COVERED SERVICES AND ITEMS:** I understand that Dry Eye Institutes of America contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Dry Eye Institutes of America to obtain necessary health care service plan authorizations.

6. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Dry Eye Institutes of America. I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Dry Eye Institutes of America for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient or any other party liable to the patient is hereby assigned to Dry Eye Institutes of America. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Dry Eye Institutes of America. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

Signature_____ Date_____

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PATIENT NOTICE OF PRIVACY PRACTICES

The protection of your health information is important to us at Dry Eye Institutes of America.

During the appointment check-in process you will be asked to sign a medical record document acknowledging you have been provided the opportunity to read the Notice of Privacy Practices.

Please read the following:

Dry Eye Institutes of America is committed to treating and using protected health information responsibly. In using this information, this office will comply with all state and federal laws pertaining to your privacy rights, including the Privacy and security protections provided to you by the Health Insurance Portability and Accountability Act (HIPAA).

Patient health records are the physical and legal property of Dry Eye Institutes of America, but the information belongs to the patient. Patients have access to inspect, amend or obtain a copy of personal health information. Should copies of medical records be requested, costs will be the responsibility of the patient. An appointment must be made with the Privacy Officer to inspect access or amend health information.

Dry Eye Institutes of America is required to maintain the privacy of health information. Dry Eye Institutes of America will require authorization to release health information to outside sources with the exception of disclosures for the purpose of **treatment, payment, and healthcare operations**. Authorization will need to be in writing and it will be specific to the disclosure requested. Authorization for use and disclosure of information, with the exceptions as referenced above, may be revoked in writing at any time.

Please notify this office if you decide to revoke your consent.

If you believe that your privacy rights have been violated, you may submit a written complaint to our HIPPA Privacy Officer at the address below:

Attention: Privacy Officer
Dry Eye Institutes of America
2201 Westgate Plaza
Grapevine, Texas 76051

Patient Name_____

Signature_____ Date_____