Granbury Eye Clinic

Nicole A. Mueller, D.O., FAOCO
Board Certified Ophthalmologist

1201 Medical Plaza Court
Granbury, Texas 76048
ph. 817-279-9044
fax 817-573-6234
granburyeyeclinic.com

Dear Patient:

Thank you for placing your trust in us to provide your eye healthcare needs. Your appointment is scheduled for _____ at _____. First visits usually take approximately 1 1/2 to 2 hours. We will dilate your eyes at this visit. Since this may blur your vision, it is best that you arrange for someone to drive you home.

It is very important that we have an up-to-date list **of all prescription and non-prescription medications or supplements** that you take for your medical record. We also need to know what **medical conditions you are being treated for and any surgical procedures you have had**. Please bring this information to every appointment. Please also bring your **completed patient registration forms**. If you wear glasses or contact lenses, please bring these with you. Following these instructions will speed up your appointment time significantly.

We also need to know about all of your insurance plan information prior to your visit. We will verify your coverage and benefits prior to your visit. Please understand that information we obtain is just an estimate provided to us by your insurance company and is subject to change. Please tell us about any separate vision plans that you have prior to your visit. We accept EyeMed and VSP for routine eye care. **All co-pay, co-insurance and deductible amounts are due at the time of service.**

We always appreciate your feedback about your visit to our office. Please feel free to share any compliments or concerns with any of our staff or myself.

We look forward to meeting you.

Thank you,

Dr. Nicole Mueller and Staff at Granbury Eye Clinic

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Name _____ Date _____

How do you describe your eye problems? _____

How long have you had this problem? _____

What treatments, both home and professional have you tried? _____

_____

Have any of the above treatments helped at all? _____

List all medications (including strength) that you take on a daily basis:_____

_____

List all past medical history::_____

_____

List all previous surgeries:_____

_____

List all medication allergies:_____

_____

Do you smoke? ☐Yes ☐No if yes, how many packs a day? _____
Do you drink Alcohol? ☐Yes ☐ No if yes, how many glasses a day? _____
Marital status ☐Married ☐Single ☐Widowed
Occupation: _____
Hobbies: _____

Family History	Yes	No	Relationship to patient
Macular degeneration	☐	☐	_____
Blindness	☐	☐	_____
Cataract	☐	☐	_____
Glaucoma	☐	☐	_____
Cancer	☐	☐	_____
Diabetes	☐	☐	_____
Heart Disease	☐	☐	_____

Who is your referring physician? _____

Who is your primary physician? _____

Patient's signature _____ Date _____

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MEDICAL HISTORY REVIEW OF SYSTEMS

Name_____ Date_____

Please check any of the following that currently apply to you:

Constitutional:
☐ Fever ☐ Weight loss ☐ No symptoms

Eyes:
☐ Loss of vision or side vision ☐ Double vision ☐ Dryness ☐ Mucous discharge ☐ Itching
☐ Redness ☐ Sandy/Gritty feeling ☐ Burning ☐ Glare/Light sensitivity ☐ Eye
☐ Excess tearing/watering ☐ pain or soreness
☐ No symptoms

Ear/Nose/Mouth/Throat:
☐ Ringing in ears ☐ Poor hearing ☐ Nasal surgery ☐ Mouth sores
☐ Dry mouth ☐ Sinus congestion ☐ Difficulty swallowing ☐ No symptoms

Cardiovascular:
☐ Shortness of breath ☐ Varicose veins ☐ Chest pain ☐ Palpitations
☐ Irregular heartbeat ☐ Peripheral vascular disease ☐ No symptoms

Respiratory:
☐ Shortness of breath ☐ Cough up blood ☐ Productive, prolonged cough ☐ No symptoms

Gastrointestinal:
☐ Nausea ☐ Vomiting ☐ Heartburn ☐ Diarrhea ☐ Constipation
☐ Ulcer ☐ No symptoms

Genitourinary:
☐ Incontinence ☐ Kidney disease ☐ Kidney infections ☐ Reduced urine flow
☐ Bladder infections ☐ Enlarged prostate ☐ Prostate cancer ☐ Burning during urination
☐ Sexually transmitted disease ☐ No symptoms

Bones/Muscles:
☐ Arthritis ☐ Gout ☐ Muscle weakness ☐ Unsteady on your feet
☐ Difficulty walking/standing/sitting ☐ No symptoms

Skin:
☐ Rash ☐ Unexplained bruises ☐ Open sores, If so, where? _____
☐ No symptoms

Neurologic:
☐ Seizures ☐ Loss of sensation ☐ Tingling ☐ Numbness
☐ Tremors ☐ Paralysis ☐ Headache ☐ No symptoms

Psychological:
☐ Unusually stressed ☐ Depressed ☐ Tingling ☐ Numbness
☐ Tremors ☐ Paralysis ☐ Headache ☐ No symptoms

Endocrine:
☐ Recent hair loss ☐ Unusually hungry or thirsty ☐ Cold or heat intolerance
☐ No symptoms

Hematologic/Immunologic:
☐ Anemia ☐ Blood clots ☐ Inability to clot ☐ Environmental allergies ☐ No symptoms
☐

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Patient And Guarantor Information Sheet

Part A: Patient Information

Patient Name:	Sex:	Birth Date:
Address:		
City, State, Zip:		
Preferred Phone Number:	Alternate Phone:	
Email Address:		
Patient & Guarantor The Same? Yes Or No If no, please explain:		

Part B: Policy Holder/Guarantor Information
(If Other Than Self)

Name:	Sex:	Birth Date:
Address:		
City, State, Zip:	Work #:	
Phone Number:	Work #:	

Please make sure that you've given your current insurance card and a photo ID to the Receptionist for your record.

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HIPAA Acknowledgment

Due to the **HIPAA Compliance Privacy Laws of the Federal Government**, it is mandatory that we ask you to review and answer the following questions.

In the event a family member or caregiver attends my office visit and is in the exam room at the time of any evaluation and/or treatment, I give Granbury Eye Clinic and its physicians or employees my permission to discuss freely my condition, treatment, or diagnosis with that person. *(please circle your answer*) **YES / NO**

HOME PHONE: _____ MAY WE LEAVE A MESSAGE **YES / NO**

WORK PHONE: _____ MAY WE LEAVE A MESSAGE **YES / NO**

CELL PHONE: _____ MAY WE LEAVE A MESSAGE **YES / NO**

***(please circle your answers to the above statements/questions*)**

With whom may we discuss or release information about your care, treatment or diagnosis?

_____Relationship _____Phone Number _____

_____Relationship _____Phone Number _____

Are either of these people your Power of Attorney for medical or financial purposes?

_____

I authorize Granbury Eye Clinic to obtain or release my medical or insurance information as necessary to assist with my ongoing treatment to or from other health care providers, laboratories, radiology facilities or other institutions or to process my medical claims.

I understand that I may revoke or amend this authorization by requesting so in writing.

_____
Signature of Patient or Legal Guardian of Power of Attorney

_____
Printed name

_____
Date

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Insurance authorization and assignment:

I request that payment of medical benefits be made on my behalf to Granbury Eye Clinic for any services furnished to me.

I authorize Granbury Eye Clinic to release any medical or other information needed to process my claims.

In the case of a Medicare claim, my signature authorizes Granbury Eye Clinic to release to Medicare, medical and non-medical information, including employment status, and whether I have employer group health insurance, liability, no-fault, or other insurance which is responsible to pay for the services for which the Medicare claim is made.

Private pay patients:

By signing below I acknowledge my financial responsibility for services rendered by Granbury Eye Clinic. I understand that payment is due at the time of service unless prior arrangements have been made.

Financial policy:

I have reviewed a copy of the financial policy from Granbury Eye Clinic.

By signing below, I acknowledge that I have read, understood and agree to the Insurance Authorization and Assignment, the Private Pay (if applicable), and Financial Policy:

_____ _____

Patient/parent/guardian signature **Date**

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Dear Patient:

Please review the information below so that you can make an informed decision about your eye examination appointments. You will be required to sign this form at all annual eye exam appointments.

Vision Eye Exam (Routine Visit):
These examinations determine if vision can be improved with glasses or contact lenses and screen for eye diseases.

!IMPORTANT!
Most health insurance plans do not cover these - you must have routine vision coverage.
This office accepts Eyemed and VSP vision coverage plans only and we must have this information on the date of service in order to file a claim. Information given regarding a vision plan after the date of service will be retained for the next visit, but will not be filed for previous dates of service.

Medical Eye Exam: These are examinations for diagnosis and treatment of eye diseases such as, but not limited to: Cataracts, Glaucoma, and Macular Degeneration. Examinations for medical care, evaluation of an eye complaint, or to follow an existing medical condition are billed to the patient's medical insurance.

Vision Exam: Insurance companies define a "routine" or annual vision examination as an office visit for the purpose of checking vision, screening for disease, and/or updating eyeglass or contact lens prescriptions**.**

CIRCLE THE TYPE OF EXAM YOU ARE HAVING TODAY:

MEDICAL VISION

_____ _____
Patient Signature **Date**

Refraction:

Refraction is the optical determination of the best possible eye vision. It is needed to determine if any medical, optical, or surgical treatment may be indicated. It is NOT a covered service by most insurance plans.

Do you want an eyeglasses and / or contact lens prescription today? **YES NO**

Do you want to change the lens and / or frame of your prescription today? **YES NO**

If you answered yes to any of the above questions, you need a refraction. **Our office fee for refraction is $40.00** , is collected at the time of service, and is in addition to any co-payment.

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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 vision for a length of time which varies from person to person and may make bright lights bothersome. 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, it's best if you make arrangements not to drive yourself.

Adverse reaction, 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 Dr. Mueller / Cox and/or such assistants as may be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

_____ _____
Patient (or person authorized to sign for patient) Date

_____ _____
Witness Date

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CONTACT LENS POLICY

Contact lenses are a pleasure to those who can wear them and we at Granbury Eye Clinic will give you the best fit possible. However, there is no guarantee that you will be able to wear contact lenses.

We want you to fully understand our financial policy regarding contact lenses before you proceed.

- All fees are payable in full when you see the doctor.
- Contact lens fitting fees **do not** include the comprehensive eye exam.

The Contact Lens Fitting Fees Are As Follows:

Soft Daily	$75.00
Soft Toric	$100.00
Soft Bifocal	$125.00
Rigid Gas Perms	$100.00

- A two week recheck is required after initial fitting.
- The contact lens fitting fee includes 3 follow-up visits with Granbury Eye Clinic. These 3 visits must occur within 90 days in order to be included in that fee. All follow–up visits thereafter will be $25.00 each.
- The initial fee also includes instruction on insertion, care of the lenses, and starter kit of solution.
- The evaluation fee for a current lens wearer without changes will be $75.00 for any lens type.

Prices for the contact lenses are determined by the brand and type and are due at the time that they are ordered.

If you are unable to wear the contact lenses for any reason, the contact lens fitting fee will not be refunded. The above mentioned fees are to cover the doctor's time and expertise and are non-refundable.

All contact lens returns will be subject to manufacturer's return policy.

I have carefully read and understand all the above and agree to the conditions stated.

Signature: _____Date: _____

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Financial Policy

Attention Patients:

Our Physicians share your concern about the cost of medical care. We strongly believe that the best medical service is based on a friendly, mutual understanding between the doctor and the patient. With all the changes to medical Insurance and the healthcare field, our office is asking patients to be in charge of confirming with your insurance carrier if our providers are preferred or participating providers for your insurance plan. If your insurance requires a referral or authorization for you to see a specialist, you are responsible for obtaining a referral from your primary care provider **before** being seen in our office. If you anticipate problems with your insurance coverage or personal payment, you are encouraged to contact our office. The earlier we know about a possible problem, the better we can develop suitable options for you.

Agreement

This is an agreement between Dr. Shannon Mueller / Dr. Nicole Mueller and the patient named on this form. By executing this agreement, you the patient, are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. All balances are expected to be paid in full upon receipt of this statement. A fee of $10.00 will be added each time we have to send more than one statement to collect a balance.

Insurance: Insurance is a contract between you and your insurance company.

- The Insurance company makes the final determination of your eligibility.
- You agree to pay any portion of the charges not covered by your insurance.
- Insurance filing is done as a courtesy to you. It does not dismiss your responsibility to pay for services.
- If the insurance does not pay 45 days from the time of services are rendered, the balance may be billed to you.
- You may choose to pay for services in full and file yourself with your insurance company.

Required Co-Payments: Any co-payment required by an insurance company must be paid at the time of service.

Returned Checks: There is a fee of $25.00 for checks returned by the bank. If a returned check is received on your account, you will be required to pay all fees associated with this check. All future visits will need to be paid in cash prior to being seen.

Past Due Accounts: If your account becomes past due, we will take steps to collect this debt. If we are forced to, we will refer your account to an outside collection agency.

Disputes: You should notify us of discrepancies with your balance immediately. We will investigate and resolve your dispute within 30 days.

Missed Appointments with Dr. Mueller: When a patient does not show for an appointment or cancels with less than 24-hour notice, the patient may be subject to a $25.00 fee. This fee would be due prior to rescheduling.

_____ _____

Patient Name Date of Birth

_____ _____

Signature Date