Granbury Eye Clinic

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,

Doctors and Staff at Granbury Eye Clinic

**Granbury Eye Clinic**

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 _____

**Granbury Eye Clinic**

## 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
☐ Redness ☐ Itching ☐ Sandy/Gritty feeling ☐ Burning
☐ Excess tearing/watering ☐ Glare/Light sensitivity ☐ Eye 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

**Granbury Eye Clinic**

# 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.

**Granbury Eye Clinic**

## 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

**Granbury Eye Clinic**

**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**

**Granbury Eye Clinic**

Patient Name:_____ DOB:_____

## What type of exam do you need?

There are two types of eye exams. How we bill your visit depends on the reason for your exam and your insurance.

• **Medical Exam** – Checks for eye diseases such as glaucoma, cataracts, diabetes, or new symptoms you may be having.

• **Vision Exam** – For glasses or contact lenses. These are only covered if you have **VSP** or **EyeMed**. Other vision plans are not accepted here.

- If you choose a vision exam but a medical problem is found, another exam may be needed (unless it is urgent).
- Once your insurance is billed, it cannot be changed.

**Please choose one**:

☐ Bill as Medical Exam

☐ Bill as Vision Exam

☐ I am not sure. Bill based on the doctor's findings. I understand I may owe a co-pay, deductible, or refraction fee.

**Patient Acknowledgement:**

**I understand:**

- The difference between medical and vision exams.
- That billing depends on the exam type I choose.
- I may owe a co-pay, deductible or refraction fee.

**After insurance is billed, it cannot be reversed.**

Signature: _____ Date: _____

**Granbury Eye Clinic**

Patient Name:_____ DOB:_____

## What is a Refraction?

A **refraction** measures your prescription for glasses or contacts. The doctor or technician uses a phoropter and asks questions like "Which looks better, 1 or 2?"

- This test should be done at your first visit, at yearly exams, and if your vision changes.
- It helps us detect eye problems and provide accurate prescriptions. Sometimes, insurance (like Medicare) requires it before approving surgery.
- If you do not want a refraction, tell us before testing begins. **Skipping it may limit the doctor's ability to fully check your eye health.**

☐ **Yes,** I want a Refraction today.

☐ **No,** I do not want a Refraction today.

**Insurance and Cost:**

- Most insurance plans, including Medicare, do not cover a refraction.
- The fee is $50, due at the time of your visit.

**Patient Acknowledgement:**

**I understand:**

- What a Refraction is
- If not covered by insurance, I am responsible for its cost.

Signature: _____ Date: _____

**Granbury Eye Clinic**

# 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

# 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 $35.00 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: _____

**Granbury Eye Clinic**

## 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 $50.00 fee. If a patient fails to show up for surgery or fails to give 5 days notice for rescheduling, the fee will be $150.00 These fees would be due prior to rescheduling.

_____ _____
Patient Name Date of Birth

_____ _____
Signature Date