CORNEA CONSULTANTS
of Texas

PATIENT INFORMATION

Please print and provide complete information.

Legal First Name _____ MI _____ Legal Last Name _____

Date of Birth _____ Sex _____ Race _____ SS# _____

Ethnicity _____ Primary Language_____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Other Phone _____

Marital Status (*Circle*) S M W D Spouse's Name _____

If you have been seen here before, under what name? _____

Email address _____

Employer _____ Address _____

City _____ State _____ Zip _____ Work Phone _____

Occupation _____

Emergency Contact (*other than spouse*) _____

Relationship to patient _____ Phone _____

Please tell us who referred you

Referred by _____ **OD MD DO** Phone _____

Address _____ City _____ State _____ Zip _____

Family Physician _____ Phone _____

Address _____ City _____ State _____ Zip _____

If Patient is a Minor or Dependent

Name of Responsible Party _____ Phone _____

Address _____ City _____ State _____ Zip _____

Relationship to Patient _____

PLEASE READ AND SIGN BELOW

I authorize the physicians and staff of Cornea Consultants of Texas to perform procedures necessary to assess and diagnose my condition properly and to perform treatments as may be prescribed by my attending physician during any and all visits to Cornea Consultants of Texas. I understand that I am financially responsible for ALL charges for services rendered to me by Cornea Consultants of Texas.

_____ _____

Patient's Signature (or Authorized Representative/Guardian) Date

CORNEA CONSULTANTS
of Texas

INSURANCE INFORMATION

Please print and provide complete information.

There is no guarantee that your insurance company will pay for all services rendered. Any medical services not covered by an individual's insurance plan are the patient's responsibility and payment in full is due at the time of visit. If we have not received payment within sixty days we will notify you and unpaid balances will become your responsibility, and we will expect payment in full at that time.

It is the patient's responsibility to pay any deductible or any portion of the charges as specified by the plan at the time of visit. It is the patient's responsibility to ensure that any required referrals for treatment are obtained before the visit or the patient may be financially responsible due to lack of the referral at time of service.

We are happy to help with insurance questions relating to how a claim was filed, however, specific coverage issues, can only be addressed by the insurance company's member services department (number is on the insurance card).

Our practice firmly believes that a good doctor/patient relationship is based upon understanding and good communication. Questions about financial arrangements may be directed to the physician's office at any time. Please do not hesitate to contact us. We are here to help you!

Primary Insurance Company _____

Phone _____ Group # _____ Subscriber ID# _____

Office Visit Copay _____ Specialist Visit Copay _____ Deductible? ☐ Yes ☐ No

If different from patient: Subscriber Name _____

Date of Birth _____ SS# _____ Relationship _____

Secondary Insurance Company _____

Phone _____ Group # _____ Subscriber ID# _____

Office Visit Copay _____ Specialist Visit Copay _____ Deductible? ☐ Yes ☐ No

If different from patient: Subscriber Name _____

Date of Birth _____ SS# _____ Relationship _____

Assignment of Benefits / Authorization to release information:

I hereby authorize Cornea Consultants of Texas to release any information concerning my care for the purpose of claims to federal, state, city, or town governmental agencies, third party payors of all categories, doctors and hospitals.

I hereby authorize Cornea Consultants of Texas, the group hospital benefits or insurance benefits including Medicare, herein specified and otherwise payable to me, but not to exceed the regular charges for this period of admission. I understand that I am financially responsible to Cornea Consultants of Texas for charges not covered by this authorization.

I permit a copy of this authorization to be used in place of the original.

_____ _____

Patient's Signature (*or Authorized Representative/Guardian*) Date

CORNEA CONSULTANTS
of Texas

Medical History

Date:_____ **Name:** _____ **DOB:**_____

Height:_____ **Weight:**_____

Pharmacy Name:_____ **Number:**_____

Pharmacy Address:_____

_____

Drug Allergies /Reactions: ☐ No Known Drug Allergies ☐ Yes, Please list:

_____

Ocular Medications : **Please list: Name/strength/Dosage/Eye**

_____ _____

_____ _____

_____ _____

_____

Other Medications: **Please List: Name/Strength/Dosage**

_____ _____

_____ _____

_____ _____

_____ _____

Eye Conditions/Surgeries: **Eye** **Doctor** **Date**

_____

_____

_____

Family History:

☐Glaucoma If so, what family member:_____

☐Diabetes If so, what family member:_____

☐Heart Disease If so, what family member:_____

☐Cancer If so, what family member:_____

☐Hypertension If so, what family member:_____

☐Other_____

Past/Present Medical History (check all that applies)

☐ No Known health problems

☐ Ears, Nose, Throat: ☐ Hearing loss ☐ Other:_____

☐ Cardiovascular: ☐ High blood pressure ☐High Cholesterol ☐Heart Attack ☐ Stroke ☐ Heart disease

☐ Other:_____

☐ Respiratory: ☐ Asthma ☐ Emphysema ☐ Other:_____

☐ Gastrointestinal: ☐ Acid Reflux ☐ Hiatal Hernia ☐ Other:_____

☐ Genital/Kidney/Bladder: ☐ Prostate Disorder ☐ Incontinence ☐Other:_____

☐ Muscles/Bones/Joints: ☐Arthritis ☐ Rheumatoid Arthritis ☐Osteoporosis ☐Other_____

☐ Skin: ☐ Rosacea ☐ Eczema ☐Acne ☐Other_____

☐ Neurological: ☐ Migraines ☐ Multiple Sclerosis ☐ Parkinson's ☐Alzheimer's ☐Other_____

☐ Psychiatric: ☐ Anxiety ☐Depression ☐Insomnia ☐ Other:_____

☐ Endocrine: ☐ Diabetes ☐ Thyroid ☐Other:_____

☐ Blood/Lymph: ☐ Anemia ☐ Cancer_____ ☐ Other_____

☐ Allergic/Immunologic: ☐ HIV + ☐Lupus ☐ Sjogren's ☐Allergies ☐Other_____

Social History:

Immunization: ☐Influenza ☐Flu

Tobacco Use: ☐Current ☐Former ☐Never ☐Type of tobacco_____

Drink Alcohol: ☐Yes ☐No ☐How often_____

Street Drugs: ☐Yes ☐No ☐Type_____ ☐How often_____

Use Caffeine: ☐Yes ☐No ☐How Often_____

LIST ALL PRIOR SURGERIES:

_____

_____

Patient's signature_____**Date**_____

(OFFICE USE ONLY)

UPDATED: DATE/INITIALS:_____ _____ _____ _____

CORNEA CONSULTANTS
of Texas

HIPAA PRIVACY
DISCLOSURE & CONSENT
TO THE USE AND / OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, HEALTH CARE OPERATIONS, AND AS OTHERWISE ALLOWED BY LAW.

Cornea Consultants of Texas (hereinafter referred to as "CCT") will maintain a record of the care and services you receive at CCT. This consent only covers your protected health information created while you are a patient of CCT. Your protected health information pertains to your diagnosis and/or treatment at CCT, including but not limited to information concerning mental illness (except for psychotherapy notes), use of alcohol or drugs or communicable diseases such as Human Immunodeficiency Virus ("HIV"), and Acquired Immune Deficiency Syndrome ("AIDS"), laboratory test results, medical history, treatment progress or any other such related information.

By signing this form, you consent to CCT's use and/or disclosure of protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. Our *Notice of Protected Health Information Practices* provides information about how CCT and its physicians may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law.

By signing this form, you also acknowledge that you have received a copy of CCT's Notice of Protected Health Information Practices and an opportunity to review it before signing this consent.

_____ _____
Patient's Signature (*or Authorized Representative/Guardian*) Patient Date of Birth

_____ _____
Staff Signature Date

HIPAA Authorization: I authorize the following person(s) to discuss my medical care and billing/insurance information with the Cornea Consultants of Texas staff on my behalf:

Name _____ Relationship _____

Name _____ Relationship _____

CORNEA CONSULTANTS
of Texas

PATIENT FINANCIAL RESPONSIBILITY

Recognizing the need for patients to understand what is expected regarding payment of medical services, we have established our financial policy. Some of these items are required by law. It is our goal to remain sensitive to our patients' needs while providing quality medical care, and we encourage you to contact our office if a problem should arise regarding your account.

1. **All co-pays and co-insurance required by your insurance company must be paid at the time services are rendered.** We accept cash, checks, and Visa, MasterCard, Discover and American Express cards. There is a $25.00 service charge on all returned checks. After receiving a returned check, Cornea Consultants of Texas will only accept cash, money order, or credit card.

2. **It is the patient's responsibility to be aware of the contract benefits of his/her insurance carrier or any co-payment or deductible obligation.** If your insurance requires referrals for full benefits to be paid, it is your responsibility to verify that the referrals are in place prior to your visit.

3. **Our facility will file both primary and secondary insurance claims for medical services rendered.** Claims for a third insurance contract will not be filed unless required by our contract with the carrier. We cannot file claims correctly without accurate information from you. Proof of insurance must be presented at each visit.

4. **If you do not have insurance,** payment in full is expected at the time of service unless financial arrangements have been made in advance with our billing department.

5. **You will receive a statement from our office within 45 days of your insurance company's response.** If you are dissatisfied with their payment, please contact your insurance carrier. Payment of the patient's portion of the balance is due upon receipt of the statement.

6. **We are participating providers for Medicare.** This means that we must accept Medicare's allowed charge for the services rendered. Medicare will pay 80% of the approved amount. The patient is responsible for the remaining 20%, plus any out-of-pocket deductible. We will write off the difference between what we charge and what Medicare approves. If you have secondary insurance, we will submit the claim for the remaining balance after Medicare has paid. Please remember that although we accept assignment for Medicare, the patient, by federal law, is responsible for any portion of the approved amount not paid by Medicare or a secondary insurance company.

7. **Responsibility for payment for services rendered to the child/children of divorced or separated parents** rests with the parent who seeks treatment. Any court ordered judgment must be between the individuals involved, without including our facility.

8. **In the unlikely event your payment is returned to us unpaid**, we may elect to re-present your payment, either electronically or by paper draft, to your financial institution up to two more times. We may also collect a return processing charge by the same means, in an amount not to exceed that permitted by state law.

It is our hope that you will find this information helpful. If you have questions, please speak with our billing staff at (817) 987-1248.

_____ _____

Patient's Signature (*or Authorized Representative/Guardian*) Patient Date of Birth

_____ _____

Staff Signature Date

RELEASE OF MEDICAL INFORMATION

I hereby authorize: _____

To release the following information from the health records of:

Patient Name: _____

Date of Birth: _____ **Social Security Number:** _____

Covering the period of treatment from: _____ **to:** _____

Information be released:

- Narrative Summaries
- Medical records including copies of diagnostic testing
- Complete medical records
- Financial and billing records

Other:_____

Information is to be released to: **Cornea Consultants of Texas,**
Aaleya Koreishi, M.D. / Patricia Ple-plakon, M.D.
Contact information below

Purpose of Disclosure: **Patient Referral, Continuity of Care.**

I understand that this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this content. If, revocation is not received, authorization will be considered valid for a period of time not to exceed 180 days.

List date, event, or condition upon which this consent expires: _____

The facility, it's employees and officers and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein. I understand the information released could contain references of HIV antibody (AIDS) testing.

_____ _____
Patient Name Date

_____
Patient's Signature (or Authorized Representative/Guardian)