NORTH DALLAS EYE ASSOCIATES

PATIENT DEMOGRAPHICS & INSURANCE

W. Stephen Ku, M.D.
Steven L. Elieff, M.D.
Russell W. Snook, M.D.
Allen S. Wang, M.D.
Timothy H. Truong, M.D.

PATIENT INFORMATION

PATIENT Last Name	First Name	MI	Sex (*check one*) ☐ **Male** ☐ **Female**
Street	Apt #	City	State	Zip
Home Phone # ☐ Primary Number ( )	Work Phone # ☐ Primary Number ( )	Cell Phone # ☐ Primary Number ( )	
Email Address	Marital Status (*check one*) ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Legally Separated** ☐ **Widowed**		
Date of Birth (mm/dd/yyyy)	Social Security Number #	Employer Name	
Primary Care Physician Name	Primary Care Phone #	Referring Physician Name	Referring Phone #

RESPONSIBLE PARTY

COMPLETE THIS SECTION ONLY IF THE PATIENT ABOVE IS A MINOR

RESPONSIBLE PARTY Last Name	First Name	MI	Relationship	Sex (*check one*) ☐ **Male** ☐ **Female**
Street	Apt #	City	State	Zip
Home Phone # ( )	Work Phone # ( )	Cell Phone # ( )		
Email Address	Marital Status (*check one*) ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Legally Separated** ☐ **Widowed**			
Date of Birth (mm/dd/yyyy)	Social Security Number #	Employer Name		

INSURANCE & SUBSCRIBER INFORMATION

We will file your claim for covered services with only the insurance companies our doctors are contracted with. **IF YOU HAVE AN HMO INSURANCE, YOU MUST HAVE A REFERRAL; OTHERWISE YOU WILL BE RESPONSIBLE FOR THE CHARGES.**

PRIMARY Insurance Company	Effective Date	**SECONDARY** Insurance Company	Effective Date
Claims Mailing Address (Street or Box)		Claims Mailing Address (Street or Box)	
City / State / Zip		City / State / Zip	
Policy ID Number	Group ID Number	Policy ID Number	Group ID Number
Subscriber Name (policy holder)	Date of Birth	Subscriber Name (policy holder)	Date of Birth
Subscriber Social Security #	Relationship to Patient	Subscriber Social Security #	Relationship to Patient
Subscriber Employer	Work Phone #	Subscriber Employer	Work Phone #
Subscriber Employer Address (Street or Box)		Subscriber Employer Address (Street or Box)	
City / State / Zip		City / State / Zip	

NORTH DALLAS EYE ASSOCIATES

LANGUAGE, ETHNICITY & RACE

W. Stephen Ku, M.D.
Steven L. Elieff, M.D.
Russell W. Snook, M.D.
Allen S. Wang, M.D.
Timothy H. Truong, M.D.

Patient Name: _____ DOB: _____ Date: _____

North Dallas Eye Associates is implementing a systematic method of collecting data on communication needs, ethnicity, and race directly from patients or their caregivers. The purpose of collecting this information is to ensure that all patients receive high-quality care.

We would like for you to provide us with your race and ethnic background. We will only use this information to review the treatment patients receive and make sure everyone gets the highest quality of care.

LANGUAGE

What language do you feel most comfortable speaking with your doctor or nurse?

- ☐ English
- ☐ Spanish
- ☐ Chinese
- ☐ Other _____
- ☐ Dutch
- ☐ Hindi
- ☐ Vietnamese

ETHNICITY

Which category best describes your ethnicity?

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown
- ☐ Patient Declined

RACE

Which category best describes your race?

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White or Caucasian
- ☐ Other Race
- ☐ Patient Declined

Race Definition:

American Indian or Alaska Native: *A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.*

Black or African American: *A person having origins in any of the black racial groups of Africa.*

White or Caucasian: *A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.*

Asian: *A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.*

Native Hawaiian or Other Pacific Islander: *A person having origins in any of the original peoples of Hawaii, Guam, Samosa, or other Pacific Islands.*

NORTH DALLAS EYE ASSOCIATES

PATIENT PREFERENCES REGARDING COMMUNICATION OF PHI

(PATIENT HEALTH INFORMATION)

W. Stephen Ku, M.D.
Steven L. Elieff, M.D.
Russell W. Snook, M.D.
Allen S. Wang, M.D.
Timothy H. Truong, M.D.

Patient Name: _____ DOB: _____ Date: _____

North Dallas Eye Associates staff may need to contact you regarding test results, appointments, financial concerns, or other healthcare operations. Your authorization is required for the following methods of communication.

I authorize the practice to disclose or provide PHI to me as described below. I understand that it is my responsibility to notify the practice of any change in this manner of communication and that any disclosure made to the designated address or number, indicated by me, is subject to the rediscloure statement within this authorization.

PREFERRED METHOD OF COMMUNICATION

My preferred method of communication regarding my medical conditions is indicated below (*check one*):

☐ Home Phone ☐ Cell Phone *(Text Messages Okay?)* ○ **Yes** ○ **No**

☐ Work Phone ☐ Email

Expirations or termination of authorization: *I understand that I must submit a new authorization to continue the authorization after ONE year.*

Right to revoke or terminate: *As stated in the practice's Notice of Privacy Practices, I have the right to revoke or terminate this authorization at any time. This can be done in person or by mailing a written request to the practice,* ***Attn: Privacy Manager****.*

Redisclosure Statement: *I understand that the practice has no control regarding persons who may have access to the mailing or email address, telephone, call or fax number I have designated to receive my PHI. Therefore, I understand that my PHI disclosed under this authorization will no longer be the responsibility of this practice.*

Secure Communication: *Note that regular email is not secure, and it is possible for your PHI to be compromised during transmission to, or from our practice. Do not designate email as your preferred method of communication if this is of concern to you.*

Please note that you are responsible for any charges incurred in receiving our communications. For example, if you provide a cell phone number as a method of contact, then you are responsible for any charges imposed by your mobile carrier for receiving calls or text messages from the clinic.

APPROVED HIPAA CONTACTS

Keeping our patient's information private is important to us and by default we will only disclose information related to the patient's **Billing Account** and **Medical Conditions** to the **patient** or **legal guardian**.

If you would like to add additional contacts (other than the patient or legal guardian) that **North Dallas Eye Associates** (***NDEA***) is allowed to disclose this type of information to, please complete the fields below and select the appropriate checkboxes based on your approval for each person you list. In addition, please choose the person you would like **NDEA** to list as your **Emergency Contact** in the event an emergency situation was to take place at our office.

1. _____ *(Contact Name)* _____ *(Relationship to Patient)* _____ *(Contact Phone Number)*

☐ **Billing Account Information** ☐ **Medical Condition Information** ☐ **Emergency Contact**

2. _____ *(Contact Name)* _____ *(Relationship to Patient)* _____ *(Contact Phone Number)*

☐ **Billing Account Information** ☐ **Medical Condition Information** ☐ **Emergency Contact**

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for health information from persons not listed on this form will require my specific authorization prior to the disclosure of any health information.

_____ *Signature of Patient or Representative* _____ *Date*

NORTH DALLAS EYE ASSOCIATES

NOTICE REGARDING EYE REFRACTION

W. Stephen Ku, M.D.
Steven L. Elieff, M.D.
Russell W. Snook, M.D.
Allen S. Wang, M.D.
Timothy H. Truong, M.D.

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

REFRACTION	**REFRACTION** is a diagnostic test to determine your best correct vision. • The fee for this service is $60 and is collected at the time of service in addition to your copay. • is used to determine an EYEGLASS PRESCRIPTION. • IS REQUIRED BY YOUR INSURANCE COMPANY AS NECESSARY DOCUMENTATION TO EVALUATE FOR POSSIBLE CATARACT SURGERY
POLICY	The refraction fee is due at the time of your visit. Because there is a very small number of medical insurance policies that cover refractions, we will file your eye refraction with your medical insurance for you. If your medical insurance pays for your refraction, we will immediately refund the full amount of the payment you made at the time of your visit.
ACKNOWLEDGEMENT	I have read the above refraction service and policy information and understand that the refraction is most likely a NON-COVERED service. I accept full financial responsibility for the cost of this service. The co-pay is separate from, and not included in, the refraction fee. _____ (Patient/Legal Representative) _____ (Date)

NORTH DALLAS EYE ASSOCIATES

CONSENT TO TREAT AND FINANCIAL RESPONSIBILITY

W. Stephen Ku, M.D.
Steven L. Elieff, M.D.
Russell W. Snook, M.D.
Allen S. Wang, M.D.
Timothy H. Truong, M.D.

Patient Name: _____ DOB: _____ Date: _____

CONSENT TO TREATMENT

I consent to the examination of my eyes by the physicians of **North Dallas Eye Associates**. I realize and understand that my eyes may be dilated for the examination. I realize and understand the potential risk to myself and others if I try to drive a vehicle or operate heavy machinery while the dilating drops are affecting my eyes. I realize and understand that the dilating may last from several hours to two days. I realize and understand that I may not be able to read while the dilating drops are affecting my eyes. I realize and understand that the dilating drops may affect my depth perception / ability to judge distances, and that even walking may cause some risk to me as far as judging the distance of things, (i.e. tripping over items or running into things).

PAYMENT POLICY AND CONSENT FOR PAYMENT

The practice of North Dallas Eye Associates strives to provide comprehensive, ethical and cost-effective eye care for our patients. In order for us to continue this mission, we have instituted the following policy. **If you do not understand these policies, please ask our staff to explain before you are seen.**

1. We will file insurance only with plans the doctors are contracted with. All **insurance co-payment and/or deductible amounts are due at the time of the service.** Any disallowed amounts are due from the patient.
2. If we do not have proof of a valid insurance, we will hold the patient responsible for the full amount of the services. The insurance discounted fees will not be applicable in these circumstances.
3. Your insurance policy is a contract between you and your insurance company. It is important that you understand what physician services are and are not covered, before seeing your doctor. There is no guarantee of payment of your claims, by your insurance company. Reduction or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred. I**f any portion of your claim or any service is not covered by your insurance, you will be responsible. For example, routine eye exams, gonioscopy, therapeutic contact lens, fundus photos, or HRT.**
4. Referral Authorization for HMO and other managed care plans must be obtained prior to your visit. If a referral is not received at the time of the visit, the patient is responsible for payment when services are rendered.

I understand that I am responsible for all charges not paid by my insurance company(ies). I consent to pay for these charges in a timely manner in accordance with office policy. I am also responsible for all charges incurred by the office in collecting on my account if my bill goes unpaid, including but not limited to collection agency fees, attorney fees, and court costs. I authorize the release to my insurance company(ies) any information acquired in the course of my examinations, treatments, or surgeries. I authorize direct payment by my insurance company(ies) to North Dallas Eye Associates. I authorize that a copy of the below signature for insurance purposes is as valid as the original.

NOTICE REGARDING NONCOVERAGE OF EYE REFRACTION

Most insurance companies and Medicare, under section 1862 (a) (1) of the Medicare Law, ***will not pay for eye refractions*** (the procedure used to determine eyeglass prescriptions) because it is considered to be a routine service. **If you choose to have a refraction performed, we will collect this amount at the time of your visit.**

I have been notified by North Dallas Eye Associates that most insurance companies and Medicare will not pay for eye refraction services and agree to be personally responsible for this charge.

CERTIFICATION OF INFORMATION

Any person knowingly and with intent to defraud or deceive with incomplete or misleading information is guilty of a crime. I hereby certify that the information furnished by me in support of the above information is true and correct to the best of my knowledge.

Signature _____ Date _____

(Patient or Legal Representative)

Witness _____ Date _____

NORTH DALLAS EYE ASSOCIATES

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

W. Stephen Ku, M.D.
Steven L. Elieff, M.D.
Russell W. Snook, M.D.
Allen S. Wang, M.D.
Timothy H. Truong, M.D.

Patient Name: _____ DOB: _____ Date: _____

CONSENT FOR USE AND DISCLOSURE OF INFORMATION

I have reviewed the "**NOTICE OF PRIVACY PRACTICES**" of **NORTH DALLAS EYE ASSOCIATES** and have had all questions answered by this office.

I also consent to the use or disclosure of my **protected health information** for the following purposes:

- **TREATMENT**

  It will be necessary to share protected health information with all members of the treatment team for treatment purposes. This can include employees in this office as well as other providers.

- **PAYMENT**

  Necessary information will be shared with appropriate payer sources and their representatives for payment purposes including, but not limited to eligibility, benefit determination, and utilization review. It will also be necessary for your billing personnel including but not limited to employees, case managers, claims representatives, third party billing services or clearinghouses to have access to protected health information to carry out their job functions.

- **HEALTHCARE OPERATIONS**

  Necessary information will be shared for the continuing operations of this office. Some examples include, but are not limited to peer review, accreditation, credentialing processes, and compliance with all federal and state laws.

I understand that my treatment may be conditioned upon my consent. This consent is given freely and I understand that I can revoke this consent at any time in writing which will apply to disclosures and uses made subsequent to the revocation date.

Signature _____ Date _____

(Patient or Legal Representative)

NORTH DALLAS EYE ASSOCIATES

Patient Health History Form

_____ _____

Patient Name **Date of Birth**

General Medical History:

Preferred Pharmacy(Name/Location): _____

Primary Care Physician: _____

List current medications or attach a list.

Please list any medication allergies:

Do you have a history of any of the following medical conditions? (Check all that apply)

- ☐ Diabetes/Pre-Diabetes (Last A1c:_____, Date Taken:_____)
- ☐ High Blood Pressure
- ☐ Thyroid Disease
- ☐ Heart Disease
- ☐ Arthritis
- ☐ Other (Please list: _____)

Ocular History:

Have you ever had eye surgery?

- ☐ Lasik/PRK/RK
- ☐ Cataract Surgery
- ☐ Retina Surgery
- ☐ Glaucoma Surgery
- ☐ Other (Please list: _____)

Do you have a history of any of the following eye conditions?

- ☐ Glaucoma
- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Amblyopia/"Lazy Eye"
- ☐ Other (Please list: _____)

Surgical History:

Please List Past Surgeries:

Family Medical History:

Do your family members (immediate family) have a history of any of the following conditions, and specify who is affected?

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Cancer
- ☐ Glaucoma
- ☐ Macular Degeneration

Social History:

Do you smoke?

- ☐ Yes
- ☐ Former smoker
- ☐ No

Do you consume alcohol?

- ☐ Yes
- ☐ No