

Patient Information

Morris Neel, O.D. P.A.

Tiffany Tregellas, O.D.

750 S. Main Ste 110 Keller, Tx 76248

817-431-2020

PLEASE FILL OUT COMPLETELY

Mr. Mrs. Miss Ms. Dr. M F DOB _____ Age _____ Today's Date _____

Preferred Language _____ Race _____

First Name _____ Last Name _____ Preferred Name _____

Street Address _____ City _____ State _____ Zip _____

Please indicate your preferred contact number with a star

Home Phone _____ Day Phone _____ Cell Phone _____ Texting ok

Referred by _____ Employer/Occupation _____

PATIENT STATUS (circle)

Single Married Other _____

EMPLOYMENT STATUS

Part-Time Full-Time Not employed FT-Student PT-Student

Primary care Physician _____

Phone Number _____

Vision

Medical

Name of Insurance _____ PPO HMO

Policy Holder _____

Holder's Date of Birth _____

Patient Relationship to Insured Self Spouse Child Other Patient relationship to Insured Self Spouse Child Other

Responsible Party _____ Relationship _____ Address (if different from above) _____

Keller Family EyeCare requires that the patient's portion is due at the time services are rendered. This includes but is not limited to copays, items not payable by insurance, and any co-insurance balances. All professional services and materials are charged to the patient. Insurance is a contract between you and your insurance company. Keller Family EyeCare is not a party to this contract and will not get involved in any disputes between you and your insurance company. Payment from insurance is to be paid directly to Keller Family EyeCare. Only primary insurances will be filed. All benefits quoted are not a guarantee of payment by the insurance company and final determination can only be made when the claim is processed. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Failure to show for an appointment or a last minute cancellation could result in a \$25 fee.

Only certain items may be returned for credit, however restocking fees may apply. No refunds will be given for professional services.

Signed _____

Date _____

(Patient, Parent/Guardian)

Medical History Questionnaire

Name _____

Date _____

Social History

Do you drive? No Yes If yes, do you have visual difficulty when driving? No Yes
 Do you currently use tobacco products? No Yes Have you used tobacco products in the past? No Yes
 Do you drink alcohol? No Social Use Only If more, how many weekly? _____
 Do you use illegal drugs? No Yes _____

Review of systems

Please circle "Yes" if you have any of the following:

System

Constitutional

Fever, Weight Loss/Gain Yes

Integumentary (skin)

Endocrine

Thyroid / Other Glands Yes

Neurological

Headaches Yes

Migraines Yes

Seizures Yes

Eyes

Loss of Vision Yes

Blurred Vision Yes

Distorted Vision / Halos Yes

Loss of Side Vision Yes

Double Vision Yes

Dryness Yes

Mucous Discharge Yes

Tired Eyes Yes

Redness Yes

Sandy or Gritty Feeling Yes

Itching Yes

Burning Yes

Foreign Body sensation Yes

Excess Tearing / Watering Yes

Glare / Light Sensitivity Yes

Eye Pain or Soreness Yes

Chronic Infection of Eyelid Yes

Sties or Chalazion Yes

Flashes of light Yes

Floater in Vision Yes

Endocrine

Thyroid / Other Glands Yes

Ears, Nose, Mouth, Throat

Allergies / Hay Yes

Sinus Congestion Yes

Runny Nose Yes

Post-Nasal Drip Yes

Chronic Cough Yes

Dry Throat/Mouth Yes

Respiratory

Asthma Yes

Chronic Bronchitis Yes

Emphysema Yes

Vascular / Cardiovascular

Diabetes Yes

Heart Pain Yes

High Cholesterol Yes

High Blood Pressure Yes

Vascular Disease Yes

Gastrointestinal

Diarrhea Yes

Constipation Yes

Genitourinary

Genitals / Kidney / Bladder Yes

Bones / Joint / Muscles

Rheumatoid Arthritis Yes

Muscle Pain Yes

Joint Pain Yes

Lymphatic / Hematologic

Anemia Yes

Bleeding Problems Yes

Allergic / Immunologic

Psychiatric Yes

*Having one or more of these may require a medical exam using your medical insurance.

If you answered YES to any of the above or have a condition not listed, please explain: _____

Medical History

Do you have any allergies to medications? No Yes _____

Do you have any other allergies? No Yes _____

List **any** medications you take (including over the counter) _____

List all major injuries, surgeries, and/or hospitalizations you have had _____

List any eye conditions that you may have _____

Do you wear glasses? No Yes If yes, how old is your current pair of lenses? _____

Do you wear contacts? No Yes If yes, how old is your present pair of lenses? _____

Type of contact lenses: Rigid Soft Extended Wear Are they comfortable? No Yes

Are you interested in Lasik through this office? No Yes

Family History

Please mark any family history (living or deceased) for the following conditions:

| Disease / Condition | Self | Mother | Father | Sister | Brother | Grandmother | | Grandfather | | Aunt | Uncle |
|-----------------------------|------|--------|--------|--------|---------|-------------|-------------|-------------|-------------|------|-------|
| | | | | | | Mat. / Pat. | Mat. / Pat. | Mat. / Pat. | Mat. / Pat. | | |
| Blindness | | | | | | | | | | | |
| Cataract | | | | | | | | | | | |
| Crossed Eyes | | | | | | | | | | | |
| Glaucoma | | | | | | | | | | | |
| Macular Degeneration | | | | | | | | | | | |
| Retinal Detachment./Disease | | | | | | | | | | | |
| Arthritis | | | | | | | | | | | |
| Cancer (type) _____ | | | | | | | | | | | |
| Diabetes | | | | | | | | | | | |
| Heart Disease | | | | | | | | | | | |
| High Blood Pressure | | | | | | | | | | | |
| Kidney Disease | | | | | | | | | | | |
| Lupus | | | | | | | | | | | |
| Thyroid Disease | | | | | | | | | | | |
| Other | | | | | | | | | | | |

We provide both vision and medical services. If you have any questions regarding INSURANCE, DIABETIC EXAM, MEDICAL ISSUES and/or TESTING or CONTACT LENS EXAM and FITTING FEES; **PLEASE ASK NOW.**

Any of the above may require additional fees or filing your medical insurance.

Visual Field Examination

A visual field instrument is a sophisticated machine that uses a computer to electronically test the functioning of the retina, optic nerve, and part of the brain used for seeing. It provides additional information we have no other way of obtaining. This allows us to provide a more thorough medical evaluation of your eyes and can assist in the detection of many disorders, including glaucoma and brain tumors. We strongly recommend that all patient receive the "screening" version of this exam, especially those with any of the following:

headaches diabetes high blood pressure circulatory problems
family history of glaucoma strong eyeglass prescription history of head trauma
seeing spots, or flashes of light

The fee for this routine screening is \$24.00

Yes, I want this procedure No, I do not want this procedure Discuss with the doctor

Digital Retinal Photos

This fundus camera allows us to take a photograph of the back part of the eye (retina) and is very valuable in assessing the health of your eye. These pictures are necessary to document the health of the optic nerve, retinal blood vessels and macula. This procedure assists in the early detection of many disorders including cataracts, diabetic retinopathy, retinal detachments and other vision threatening conditions. Your digital images will be stored and compared with images from future exams. This allows the doctor to observe even the smallest changes. We recommend these photos if:

You are new or have never had photos in this office you are 65 or older

You have family history of: high cholesterol or blood pressure, diabetes, elevated eye pressure or glaucoma,

You have any retinal disorders such as: a detachment, tear, floaters, veils, flashing lights or macular degeneration

The fee for this routine screening is \$35.00

Yes, I want this procedure No, I do not want this procedure Discuss with the doctor

* If both screenings are performed the discounted fee for these is \$45.00

** Be aware these are for screening purposes. If there is a medical reason to perform a more detailed test we *maybe* able to file on your medical insurance.

Morris Neel O.D. and Associates

OUR FINANCIAL POLICY

OUR FINANCIAL POLICY

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. A clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. We accept cash, check, Visa/Mastercard, and Discover, as payment for professional services.

MINORS: Parents or legal guardians are responsible for full payment at the time of service. Minors not accompanied by a parent or legal guardian must have method of payment at time of service.

INSURANCE: INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. We are not a party to this contract. (We will advise you if we are a participating provider with your insurance company, and we will handle your claims according to our agreement with the insurance company.) We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual & customary" charges, etc. other than to supply factual information as necessary. **YOU ARE RESPONSIBLE FOR PAYMENT OF YOUR ACCOUNT INCLUDING DEDUCTIBLES, CO-PAYS, AND CO-INSURANCE AT THE TIME OF TREATMENT.** In order to keep our fees as low as possible, it is impossible to spend the amount of time on paperwork necessary to receive payment from more than one insurance company. **WE WILL REQUIRE PAYMENT OF ANY BALANCE NOT PAID BY THE PRIMARY INSURANCE.** If you receive payment from the insurance company for services rendered by Morris Neel, O.D., you must reimburse Morris Neel, O.D. immediately upon receipt of such payment. If your insurance company pays us more than the balance due, our office will refund the amount owed to you. We do not represent insurance companies and you should discuss your specific coverage with your carrier yourself.

IT IS YOUR RESPONSIBILITY TO NOTIFY US OF ANY CHANGES IN YOUR COVERAGE. IT IS YOUR RESPONSIBILITY TO KNOW YOUR BENEFITS. Any visits that are not covered by your insurance company because you have not obtained authorization or have not presented a valid referral become solely your responsibility. We will bill your insurance company no more than two (2) times. If repeated billing of your insurance carrier does not provide payment of your bill, we will have no choice but to look to you for full settlement of your account. Please ensure that you have submitted the appropriate insurance.

MEDICARE: If you are covered by Medicare or any other government program, please discuss your payment situation with our office staff prior to your examination. **DEDUCTIBLES, CO-PAYMENTS AND NON-COVERED SERVICES MUST BE PAID BEFORE LEAVING THE OFFICE.**

MISSED APPOINTMENTS & LATE CANCELLATIONS: If you must cancel, PLEASE PROVIDE 24 HOURS NOTICE so we have time to fill your appointment. Cancellations with less than 24 hour notice or "no show" appointments are subject to a **\$25 fee**. These charges will be billed to you, not your insurance carrier.

COLLECTION AGENCY FEES: If Morris Neel, O.D. must engage the services of an attorney, collection agency, or other lawful method of collection, you will be responsible for the original balance, late fees and all additional costs that our office incurs for the collection process.

AUTHORIZATION TO RELEASE INFORMATION: I understand and agree that (regardless of my insurance) I am ultimately responsible for charges to my account for all services rendered to me or my dependent. I authorize Morris Neel, O.D. to furnish the appropriate agencies, for the purpose of billing, any information acquired during the course of my examination. I understand that I could be charged for late cancellation and failure to show up for appointments. I understand and agree to this Financial Policy.

Signed _____
(Patient, Parent/Guardian)

(Date)

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Due to these Privacy Laws please list family members we can disclose your private health information to.

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

| | |
|-------------------------|-------|
| Patient Name | _____ |
| Relationship to Patient | _____ |
| Signature | _____ |
| Date | _____ |