

Patient Information

Morris Neel, O.D. P.A.

8329 Whitley Rd, Watauga, TX 76148 817-431-2020

Tiffany Tregellas, O.D.

Emily Horn, O.D.

PLEASE FILL OUT COMPLETELY

Mr. Dr. Mrs. Ms. Miss Name _____ Date _____

Nickname _____ Birth Date _____ Age _____

Preferred Language _____ Race _____

Address _____ City _____ State _____ Zip _____

****Please indicate your preferred contact number with a star ****

_____ Texting OK
Home Phone _____ Day Phone _____ Cell Phone _____

Email address _____ Preferred Method of Contact _____

Patient Status Single Married Other _____ Employment Status F/T P/T Other _____

Occupation: _____ Referred by: _____

Primary Care Physician _____ Phone _____

****If you have any questions regarding your insurance or fees for today's visit please speak with office staff.****

Please check all that apply:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> High Blood pressure | <input type="checkbox"/> Runny Nose |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Dry Throat/Mouth | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Sinus Congestion |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Fever | <input type="checkbox"/> Lupus | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Genitals/Kidney/Bladder | <input type="checkbox"/> Migraines | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Headaches | <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Vascular Disease |
| <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Post-Nasal Drip | <input type="checkbox"/> Weight Loss/Gain |
| <input type="checkbox"/> Constipation | | | |
| <input type="checkbox"/> Blindness | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Glare/Light Sensitivity | <input type="checkbox"/> Redness |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Dryness | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Retinal Detachment |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Excess Tearing/Watering | <input type="checkbox"/> Itching | <input type="checkbox"/> Sandy or Gritty Feeling |
| <input type="checkbox"/> Cataract | <input type="checkbox"/> Eye Pain or Soreness | <input type="checkbox"/> Loss of Side Vision | <input type="checkbox"/> Sties or Chalazion |
| <input type="checkbox"/> Chronic Infection of Eyelid | <input type="checkbox"/> Flashes of Light | <input type="checkbox"/> Loss of Vision | <input type="checkbox"/> Tired Eyes |
| <input type="checkbox"/> Crossed Eyes | <input type="checkbox"/> Floaters in Vision | <input type="checkbox"/> Macular Degeneration | |
| <input type="checkbox"/> Distorted Vision/Halos | <input type="checkbox"/> Foreign Body Sensation | <input type="checkbox"/> Mucous Discharge | |

List all major surgeries you have had _____

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

Do you have any allergies to medications? No Yes _____

Do you have any other allergies? No Yes _____

Please list any eye conditions you may have: _____

Do you drive? No Yes If yes, do you have difficulty when driving? No Yes

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? Yes No

Have you had: Lasik Surgery PRK Surgery RK Surgery Cataract Surgery

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

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

What is your height? _____ Current Weight? _____

Do you use tobacco products? No Yes Have you in the past? No Yes If yes, how long ago? _____

Do you drink alcohol? No Social Use Only If more how many weekly? _____

Do you use illegal drugs? No Yes _____

iWellness Exam

Dr. Neel, Dr. Tregellas and Dr. Horn have incorporated the iWellness Exam TM SD-OCT as a supplement to their comprehensive eye exam.

As part of your pre-examination work up, our technician will perform the iWellness Exam, which your doctor will review with you during your examination today. The results of this screening will become part of your permanent record. Early detection of sight threatening diseases such as glaucoma, macular degeneration, and diabetes is crucial as there are no outward signs of symptoms in early stages. We highly recommend this Scanning Laser be performed if you have any of the following:

- | | | | |
|---|----------|------------------------------|----------------------|
| Headaches | Diabetes | High Blood Pressure | Circulatory Problems |
| Family History of Glaucoma/Macular Degeneration | | Strong Eyeglass Prescription | |
| History of Head Trauma | | Spots or Flashes of Light | |

This procedure is typically not covered by your medical or vision insurance unless being used to actively follow disease. This cost will be added into the price of your visit today. Any questions you have about these tests can be discussed with your doctor. The iWellness Exam is an eligible expense for Flexible Spending Accounts.

The fee for this routine screening is \$39.

_____ Discuss with doctor _____ Yes, I want this screening _____ No, I do not want this screening

Date: _____

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 the 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. We strongly recommend that all patients receive the "screening" version of this exam, especially those with any of the following:

Family history of high cholesterol, high blood pressure, diabetes, retinal detachment/tear, glaucoma, brain tumors, floaters, flashes of light and macular degeneration.

The fee for this routine screening is \$29.

_____ Discuss with doctor _____ Yes, I want this screening _____ No, I do not want this screening

Date: _____

*If both of these screeners are done there is a discounted fee of \$54.

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

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

Any of the above may require additional fees or for us to file on your medical insurance.

Morris Neel O.D. and Associates

Financial Agreement / Signature on File

- * In signing this statement I agree to be financially responsible for all charges for this and all subsequent office visits.
- * \$30 will be billed for returned checks.
- * Accounts will be considered past due 60 days from the date a service is billed. In the event that your account is turned over to collections, a fee equal to the amount charged by the collections agency will be assessed.
- * If you must cancel, please provide 24 hour notice. 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.

INSURANCE

- * I hereby authorize payment directly to Morris Neel O.D. and Associates for services and materials.
- * I authorize the release of medical information to the appropriate agencies, for the purpose of billing, any information acquired during the course of my examination.
- * Insurance is a contract between you, your employer, and the insurance company. We are not a party to this contract. It is your responsibility to be aware of plan benefits and your rights to appeal claims.
- * Insurance contracts vary greatly; in-network and out-of-network providers are often covered at different levels. It is your responsibility to know your benefits; we recommend you contact your employer or insurance company directly for the most accurate information. However, we will do our best to assist with your insurance coverage information and questions.
- * If your insurance is through the Texas Health Marketplace and your insurance does not pay at the end of the three month grace period, you are responsible for payment in full.
- * If you have an HMO or plan that requires a referral, you are responsible for bringing a current referral to each visit.
- * As a courtesy we will electronically file your primary insurance claim on your behalf. If you are covered by a secondary plan, we will be happy to provide forms to enable you to file your secondary insurance.
- * In the event insurance denies a claim, it is your responsibility to pursue action with the carrier.
- * I understand the fees quoted for services rendered are an **ESTIMATE ONLY** AND NOT A GUARANTEE OF PAYMENT BY MY INSURANCE COMPANY.

Patient Name Printed: _____

Patient/Guardian Signature: _____ Date: _____

Patient Acknowledgment of Receipt of Privacy Practices Notice

I hereby acknowledge that I have reviewed and received a copy of this office's *Notice of Privacy Practices* explaining:

- How this office will use and disclose my protected health information.
- My privacy rights with regard to my protect health information.
- This office's obligations concerning the use and disclosure of my protected health information.

I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of any revised *Notice of Privacy Practices* upon request.

I also understand that if I have any complaints, I may contact: **Morris Neel, O.D. & Associates 817-431-2020**

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities and health care operations. Upon request, we can issue a copy of this policy.

By signing this form, you will consent to our use and disclosure of your protected health information to only carry out treatment, payment activities and submission of insurance.

Due to the Privacy Laws please list family members we can disclose your private health information to:

Patient or Personal Representative

Signature _____ Date _____

Name: _____

Please Print

Relationship to Patient: _____

*****For Office Use Only*****

We made a good-faith effort to obtain an acknowledgement of _____'s receipt of our Notice of Privacy Practices. In spite of these efforts, our office has been unable to obtain a signed acknowledgement of receipt for the following reasons:

- Patient refused to sign on _____
- Communication barriers prohibited obtaining an acknowledgement.
- An emergency situation prevented us from obtaining an acknowledgement.

Attempt was made by _____ Date _____