Ophthalmology Specialists of Texas, PLLC. Dba
West Texas Retina Consultants/ North Texas Retina Consultants

PATIENT INFORMATION SHEET

First Name: _____ MI: ____ Last Name: _____ Today's Date: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Patient's Date of Birth: _____ Age: _____ Sex: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Marital Status: _____ Social Security Number: _____

Race: _____ Language: _____ E-mail: _____

Receive appointment reminders via: ☐ EMAIL ☐ TEXT ☐ PHONE CALL (You can select up to 3)

Employed: ○ Y ○ N (if yes) ○ Full time ○ Part time ○ Self ○ Retired ○ Military ○ Occupation: _____

PRIMARY INSURANCE INFORMATION: ☐ **Commercial** ☐ **Medicaid** ☐ **Medicare** ☐ **Self Pay**

Insurance Company: _____ ID#: _____ GROUP#: _____

Insured's Full Name: _____ **DOB:** _____ **SSN#:** _____

Relationship to Patient: Self ○ Spouse ○ Child ○

SECONDARY INSURANCE INFORMATION: **PLEASE NOTE WE DO NOT ACCEPT RETRO ACTIVE MEDICAID**

Insured's Full Name: _____ **DOB:** _____ **SSN#:** _____

Relationship to Patient: Self ○ Spouse ○ Child ○

Preferred Pharmacy: _____ ***Town:*** _____ ***Phone #:*** _____

Emergency Contact Name: _____ Relationship: _____

Phone Number: _____ Address: _____

REFERRED BY: **FAMILY PHYSICIAN:**

Name: _____ City: _____ Physician's Name: _____ City: _____

PLEASE READ AND SIGN BELOW

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

Signature: _____ Date: _____

VUELTA PARA EL ESPANOL

OST Doctor _____

History Reviewed by: _____ M.D. _____ Date

Ophthalmology Specialists of Texas, PLLC. Dba
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RELEASE OF INFORMATION:

I hereby authorize Ophthalmology Specialists of Texas to release any information concerning my care for purpose of claims to Federal, State, City, or Town Governmental Agencies, third party payers of all categories, doctors, and hospitals.

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

Signature of Patient: _____ Date: _____
OR
Signature of Other
Responsible Person: _____ Date: _____

ASSIGNMENT OF BENEFITS:

I hereby agree to pay the established charges for services and all other charges incurred as a patient of Ophthalmology Specialists of Texas.

I further hereby authorize payment directly to OST, the group Hospital Benefits or Insurance Benefits, including Medicare, herein specified otherwise payable to me, but not to exceed the regular charges for this period of admission. I understand that I am financially responsible to OST for charges not covered by this authorization.

I will cooperate in seeking, collecting, and paying to OST, any and all insurance proceeds. If the insurance proceeds cannot be paid directly to OST, I agree to collect payment and pay to OST within five (5) days of receipt, unless prior arrangements have been made regarding payment to Ophthalmology Specialists of Texas.

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

Signature of Patient: _____ Date: _____
OR
Signature of Other
Responsible Person: _____ Date: _____

The Following names are of people I would like to be involved in, or have access to my protected health information on a routine basis. I give permission for Ophthalmology Specialists of Texas to share my protected health information with (not including other doctor offices):

_____		_____	
Name	Relationship/Phone No.	Name	Relationship/Phone No.
_____		_____	
Name	Relationship/Phone No.	Name	Relationship/Phone No.

VUELTA PARA EL ESPANOL

Patient Name:_____ **Today's Date:**_____

PLEASE CIRCLE WHICH OF THE FOLLOWING APPLY TO YOU. YOU MAY CIRCLE MORE THAN ONE

Medical:

____ No Medical History

- HIV / AIDS
- Allergies
  - Chronic Seasonal
- Alzheimer's
- Anemia
- Arthritis / Rheumatoid
- Cancer: _____
- Chest Pains
- COPD (Chronic Obstructive Pulmonary Disease)
- Dementia
- Diabetes
  - Type 1 Type 2 Gestational
- Heart Attack
- Heart Condition: _____
- Heart Disease
- Hepatitis: A B C
- Herpes Virus
  - Cold Sores Shingles
- High Cholesterol
- High Blood Pressure
- Kidney Problems
  - Dialysis Disease Failure
- Liver Disease
- Long Term/ Current Steroid Use
- Lupus
- Melanoma
- Meningitis
- Migraine
- Multiple Sclerosis
- Pneumonia
- Pregnant
- Psychiatric Disorder
- Recent Chemotherapy Treatment
- Recent fall
- Radiotherapy Treatment
- Seizures
- Sickle Cell
- Sleep Apnea
- Stroke
- Syphilis
- Temporal Arteritis
- Terminal Illness: _____
- TIA (Transient Ischemic Attack)
- TB (Tuberculosis)
- Thyroid Disease

Surgical:

___ No Surgical History *(please list dates)*

- Amputation _____
- Angioplasty _____
- Back Surgery _____
- Blood Transfusion_____
- CABG (Coronary Artery Bypass Grafting)__
- Defibrillator_____
- Gastric Bypass_____
- Heart Bypass_____
- Heart Stent_____
- Mastectomy_____
- Pacemaker_____
- Thyroidectomy_____
- Transplant_____

Patient Name:_____ **Today's Date:**_____

PLEASE CIRCLE WHICH OF THE FOLLOWING APPLY TO YOU. YOU MAY CIRCLE MORE THAN ONE

☐Head Trauma: ***Date:***_____

☐Ocular Trauma: ***Date:***_____

☐Other Trauma: ***Date:***_____

SOCIAL HISTORY:

SMOKING STATUS:
oDAILY oOCCASIONAL oFORMER oNEVER

ALCOHOL STATUS:
oDAILY oOCCASIONAL oFORMER oNEVER

STREET DRUGS:
oNO oYES:_____

DO YOU LIVE ALONE?
oYES oNO

DO YOU DRIVE?
oYES oNO

Please list ALL of your current medications, or provide front office with an updated list

Name/dose/frequency/route

_____

_____

_____

_____

_____

_____

_____

_____

FAMILY HISTORY:

DIABETES
☐Mother☐Father☐Child☐Sibling☐Grandparent

CANCER
☐Mother☐Father☐Child☐Sibling☐Grandparent

STROKE
☐Mother☐Father☐Child☐Sibling☐Grandparent

HEART DISEASE
☐Mother☐Father☐Child☐Sibling☐Grandparent

GLAUCOMA
☐Mother☐Father☐Child☐Sibling☐Grandparent

MACULAR DEGENERATION
☐Mother☐Father☐Child☐Sibling☐Grandparent

RETINAL DETACHMENT
☐Mother☐Father☐Child☐Sibling☐Grandparent

CATARACTS
☐Mother☐Father☐Child☐Sibling☐Grandparent

ARTHRITIS
☐Mother☐Father☐Child☐Sibling☐Grandparent

HIGH BLOOD PRESSURE
☐Mother☐Father☐Child☐Sibling☐Grandparent

KIDNEY DIESEASE
☐Mother☐Father☐Child☐Sibling☐Grandparent

THYROID DISEASE
☐Mother☐Father☐Child☐Sibling☐Grandparent

Please list your allergies if any:

_____

_____

Patient Name:_____ **Today's Date:**_____

PLEASE CIRCLE WHICH OF THE FOLLOWING APPLY TO YOU. YOU MAY CIRCLE MORE THAN ONE

REVIEW OF SYSTEMS:

♦ALLERGY:

- None
- Autoimmune
- Seasonal

♦CARDIOVASCULAR:

- None
- Chest Pain
- Shortness of Breath
- Irregular Heart Beat/ Heart Palpitations
- Blood Pressure Stable
- Blood Pressure Uncontrolled
- Unsure of Blood Pressure Control
- Swelling of Extremities

♦CONSTITUTIONAL:

- None
- Intolerance to cold/heat
- Hair Loss
- Nervousness
- Fever Chills
- Weight Loss Loss of Appetite
- Fatigue
- Feels Sick/ Weak

♦ENDOCRINE:

- None
- Excessive Thirst
- Excessive Urination
- Intolerance of Cold/Heat
- Hair Loss
- Unsure of Blood Sugar Control
- Sarcoidosis
- Swollen Lymph Nodes

♦GASTROINTESTINAL:

- None
- Abdominal Pain
- Nausea Vomiting Diarrhea
- Bloody Stool
- Stomach Ulcer
- Trouble Swallowing

♦GENITOURINARY:

- None
- Bladder Trouble: _____
- Kidney Stones

♦HEMATOLOGY/ONCOLOGY:

- None
- Easy Bruising
- Prolonged Bleeding
- Swollen Lymph Nodes

♦HEAD/EARS/NOSE/THROAT:

- None
- Hearing Loss
- Sore Throat
- Runny Nose
- Dry Mouth
- Jaw Claudication
- Earache
- Stiff Neck

Patient Name:_____ **Today's Date:**_____

PLEASE CIRCLE WHICH OF THE FOLLOWING APPLY TO YOU. YOU MAY CIRCLE MORE THAN ONE

♦SKIN and BREAST:

- ☐None
- ☐Rash
- ☐Change in Mole
- ☐Skin Sores
- ☐Nail Changes

♦MUSCULOSKELETAL:

- ☐None
- ☐Muscle Aches
- ☐Joint Pain
- ☐Back Pain

♦NEUROLOGIC:

- ☐None
- ☐Weakness
- ☐Headaches
- ☐Scalp Tenderness
- ☐Dizziness
- ☐Paralysis of Extremities
- ☐Tremor
- ☐Stroke
- ☐Numbness
- ☐Seizures or Convulsions
- ☐Fainting

♦PSYCHIATRIC:

- ☐None
- ☐ADHD (Attention Deficit/Hyperactivity Disorder)
- ☐Bipolar Disorder
- ☐Depression ☐Anxiety
- ☐Panic Attack

♦RESPIRATORY:

- ☐None
- ☐Wheezing
- ☐Coughing Up Blood
- ☐Severe or Frequent Colds
- ☐Difficulty Breathing

Please list any other issues you think we may need to know:

_____

_____

_____

_____

_____

_____

_____

THANK YOU FOR YOUR HELP. FILLING OUT THIS INFORMATION WILL HELP US SPEED UP THE TIME OF YOUR VISIT!

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy Practices from this patient but it could not be obtained because:

The Patient refused to sign

Due to an emergency situation it was not possible to obtain an acknowledgment

We weren't able to communicate with the patient

Other (*please provide specific details*)

_____

_____

_____

_____ _____

Employee signature *Date*

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this Notice of Privacy Practices. This Notice will take effect on April 1, 2016 and will remain in effect until it is amended or replaced by us.

We reserve the right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and will be posted in waiting room, website and copies will be available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Office. Information on contacting us can be found at the end of this Notice.

We will keep your health information confidential, using it only for the following purposes:

Treatment: While we are providing you with health care services, we may share your protected health information (PHI) including electronic protected health information (ePHI) with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support or data analysis. These business associates and subcontractors through signed contracts are required by Federal law to protect your health information. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, insurance operations, health care clearinghouses and individuals performing similar activities.

Health Oversight: We may be required to disclose information to assist in investigations, audits, eligibility for government programs and similar activities

Appointment Reminders: We may use your health records to remind you of recommended services, treatment or scheduled appointments.

Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so. **Psychotherapy notes** will not be used or disclosed without your written authorization. Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

Death: we may report information regarding deaths to coroners, medical examiners, funeral directors and organ donation agencies

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request, judicial/administrative proceeding, law enforcement or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

National Security/Specialized Government Functions: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Workers' Compensation: We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so. Under the Omnibus Rule, we are required to obtain an authorization for

marketing purposes if communication about a product or service is provided and we receive financial remuneration (getting paid in exchange for making the communication). No authorization is required if communication is made face-to-face or for promotional gifts.

Fundraising: We may use certain information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money and you will have the right to opt out of receiving such communications with each solicitation. Under the Omnibus Rule, PHI that requires a written patient authorization prior to fundraising communication include: diagnosis, nature of services and treatment. If you have elected to opt out we are prohibited from making fundraising communication under the HIPAA Privacy Rule.

Research: We may use or disclose information for approved medical research

Sale of PHI: We are prohibited to disclose PHI without an authorization if it constitutes remuneration (getting paid in exchange for the PHI). "Sale of PHI" does not include disclosures for public health, certain research purposes, treatment and payment, and for any other purpose permitted by the Privacy Rule, where the only remuneration received is "a reasonable cost-based fee" to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by law. Corporate transactions (i.e., sale, transfer, merger, consolidation) are also excluded from the definition of "sale."

When it comes to your health information, you have certain rights

You have a right to obtain a copy of our Notice of Privacy Practices

Right to Request Restriction of PHI: If you pay in full out of pocket for your treatment, you can request us not to share information about your treatment with your health plan; if the request is not required by law. You have the right to restrict certain uses and disclosures of your PHI (family or friends) We are not required to agree, but if we do, we must abide by those restrictions

Confidential communication: you have the right to request routes or contact - phone, text or e-mail

Access: Upon WRITTEN request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) We will provide access to health information in a form / format requested by you. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested is $ **25**. If you want the copies mailed to you, postage may also be charged. Access to your health information in electronic form if (readily producible) may be obtained with your request. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. Please contact our Privacy Officer for an explanation of our fee structure.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer.

Right To Revoke Authorization: If you are asked to sign an authorization to use or disclose information, you can cancel that authorization at any time. You must make the request in writing. This will not affect any information that has already been released.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Breach Notification Requirements: It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps *required* by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

Complaints

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. **HOW TO CONTACT US:**

Practice Name: **Ophthalmology specialists of Texas** Privacy Officer: **Gwyneth Nafe COT**

Telephone: **325-673-9806** Fax:**325-673-9809**

Address: **5441 Health Center Dr, Abilene, Tx. 70606**

Revised May 10, 2016

Four payment terms you need to know

You will pay your share of health-care costs in the following ways:

• **Out-of-pocket limit:** This is the most you will have to spend from your own pocket for medical care in the policy year. Once you hit that limit, your health plan will pick up 100 percent of any additional costs until years end. The maximum allowable Out-of-pocket limit will depend on what insurance plan you have.

• **Deductible:** This is the amount you must pay for covered services each year before your insurance will start paying claims. Details may vary: One plan may have a single deductible for everything, while another may have a separate one for prescription drugs. Not all services are subject to the deductible with some plans.

• **Co-payment:** This is a relatively small fixed fee required by the health insurance company to be paid by the patient at the time of each visit.

• **Coinsurance:** This refers to money that an individual is required to pay for services after the deductible has been paid. For example, if the health insurance plans allowed amount for an office visit is $100 and you have met your deductible, your 20% coinsurance payment would be $20. The health insurance plan pays the rest.

EXAMPLE

Let's say that you are in a serious accident. You've accumulated $50,000 in covered medical expenses. A sample health insurance plan might offer:

- Deductible: $5,000
- Coinsurance: 20 percent
- Out-of-pocket maximum: $6,000
  - In the example above, you would be responsible for the first $5,000 (your deductible).
  - After you pay your deductible of $5,000, you would be responsible for 20 percent coinsurance until you reach your out-of-pocket maximum of $6,000 (in this case, you would be responsible for another $1,000).
  - Your health insurance plan would pay the rest of the covered medical expenses (in this case, 80 percent).
  - After you reach your out-of-pocket maximum, you would not pay anything for any additional covered medical expenses for the rest of the plan year.

Deductible: The amount you're responsible for paying for covered medical expenses before your health insurance plan begins to pay for covered medical expenses each year.
Coinsurance: Shared costs between you and the health insurance plan. For example, you pay 20 percent of costs and your plan pays 80 percent. These percentages may be different from plan to plan. Some plans may not have coinsurance.
Copayment: The payment you make, usually a fixed dollar amount such as $15, each time you visit the doctor or fill a prescription medication. Not all plans have copayments. These typically do not accumulate toward the deductible.
Out-of-pocket maximum: The most you will have to pay for covered medical expenses in a plan year through deductible and coinsurance before your insurance plan begins to pay 100 percent of covered medical expenses.