CONFIDENTIAL **Welcome! Please take few minutes to fill out this form as completely as you can. If you have any questions we will be glad to assist you.**

Please fill out your intake form, download it, and send it to the correct practice location email address:

meyerland@rizeye.com | sugarland@rizeye.com | wharton@rizeye.com | woodlands@rizeye.com | northshore@rizeye.com

Date: _____

_____ |_____| |_____| | N/A |

Last name First name Date of Birth Age Sex

Address: _____ Email: _____

APT#_____ Cell No. _____Home No._____

City _____ST_____ Zip_____ Occupation _____

Parent's or Guardian's name if patient under 18 years of age, and in case of emergency, who we should contact:

Name_____ Relationship_____ Phone_____

How will you be paying for your visit today? ____ Medical Insurance ____ Vision Insurance ____ Self-pay

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WHAT IS THE PURPOSE OF YOUR VISIT TODAY? ____Wellness Check/Glasses ____ Wellness Check/Contact lenses ____Both _____Other

Medical and Ocular History (please CHECK all that apply)

Self (ocular)

___healthy, no complaints
___blurred vision without correction
___lazy eye
___headaches/eye strain
___double vision
___eye injury
___eye surgery
___flashes of light
___floaters
___other: please explain

_____

Self (medical)

___healthy, no medical conditions
___heart disease
___diabetes
___glaucoma
___asthma
___high blood pressure
___thyroid
___other: Please list

_____

List all drug allergies: _____

List all medications being taken:_____

Family: **List: (Who Mom/Dad etc.)**

___healthy, no medical conditions
___heart disease _____
___high blood pressure _____
___diabetes _____
___glaucoma _____
___cataracts _____
___others: please list _____

_____

_____

Are you pregnant? YES NO Are you nursing? YES NO Tobacco Use? YES NO Alcohol Use? YES NO

How did you hear about us?

____ Friend ____ Vision Center ____ Banner/Sign ____ Newspaper _____Other

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PLEASE READ CAREFULLY

Dilation:

Dilation is the opening of the pupils by using medicated eye drops. This allows a better view of the retina and helps the doctor to detect many eye conditions that may be missed during a routine eye exam. Dilation is strongly recommended for patients with a history of cataracts, high blood pressure, high prescriptions, and patients older than 40. However, dilation is mandatory for all diabetic patients, patients with a history of glaucoma, and children 12 and under. After being dilated, you may experience blurred near vision and light sensitivity. These side effects can last from 3-6 hours. **There are no additional fees for the test.**

____ **Yes, I would like to be dilated today.**

____ **No, I do not want dilation.** *By signing below, I understand and release **Riz Eye Care/ Meyerland Family Eye Care/ North Shore Eye Care** and their doctors from all liability to treat or diagnose any eye condition due to lack of diagnostic information that could have been obtained from dilation.*

Patient/Guardian: _____ ***Date:*** _____

Visual Field:

ADDITIONAL TESTS – PLEASE READ CAREFULLY

Computerized device used to test your peripheral vision. This test helps detect vision loss caused by glaucoma, retinal disease, stroke, injuries to the head, in addition to certain medications such as Chloroquine, Seizure medications, Antidepressants etc. that cannot be detected with a comprehensive dilated exam. With early detections, this test can prevent many blindness-causing diseases before it is too late. This test does not require eye drops and takes 3-5 minutes to perform.
The cost of this procedure is an additional $20 (If using insurance the cost of the VF will be $20)

___Yes, I would like to have it done today ___No, I decline

Patient/Guardian: _____ ***Date:*** _____

OFFICE POLICY

- All visits to the office are due and payable at the time of service
- All fees are for professional services and therefore are non-refundable
- Contact lens exam fees include up to 2 follow up visits within 30 days from the date of initial examination
- I have received and read the Notice of Privacy Practices (HIPAA)
- I agree to all of the terms mentioned above

Patient/Guardian: _____ ***Date:*** _____

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT, HIPAA NOTICE

_____

Patient Name (PRINT)

1. **HIPAA NOTICE OF PRIVACY PRACTICES:** I acknowledge that I have received availability of Notice of Privacy Practices issued by Riz Eye Care/ Meyerland Family Eye Care/ North Shore Eye Care that was effective April 1, 2005. Available at www.rizeye.com Hard copies available upon request.

2. **RELEASE OF INFORMATION:** Riz Eye Care/ Meyerland Family Eye Care/ North Shore Eye Care may disclose all or part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Riz Eye Care/ Meyerland Family Eye Care/ North Shore Eye Care for reimbursement for services rendered, and (2) any health care provider for continued patient care. A copy of this authorization may be used in place of original.

3. **NON-COVERED SERVICES:** I understand that Riz Eye Care/ Meyerland Family Eye Care/ North Shore Eye Care contracts with health care service plans (i.e., HMO's, PPO's) relate only to items and services which are 'covered" by health care service plans. **Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care, service plans not to be covered, including refraction fee (which is not covered by Medicare).** I agree to cooperate with Riz Eye Care/ Meyerland Family Eye Care/ North Shore Eye Care to obtain necessary health care service plan authorizations.

4. **MEDICAL RECORDS REQUEST:** Request for medical records must be made in writing by the patient. Records will be reviewed and released for a **FEE of $20.00**, it may take up to 30 days for records to be reviewed and released to patients.

5. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to me by Riz Eye Care/ Meyerland Family Eye Care/ North Shore Eye Care, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Riz Eye Care/ Meyerland Family Eye Care/ North Shore Eye Care for payment. IF my account is sent to an agency for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance are hereby assigned to Riz Eye Care/ Meyerland Family Eye Care/ North Shore Eye Care. If my insurance company or health plan designates co-payments and/ or deductibles, I agree to pay them to Riz Eye Care/ Meyerland Family Eye Care/ North Shore Eye Care. However, I understand that I am primarily responsible for the payment of my bill.

6. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Riz Eye Care/ Meyerland Family Eye Care/ North Shore Eye Care , for services furnished to me by Riz Eye Care/ Meyerland Family Eye Care/ North Shore Eye Care . I authorize any holder of medical information about me to release the centers for Medicare and Medicaid services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorized release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFS 1500 form or elsewhere on other approved claim forms, my signature authorized releasing the information to the insurer or agency shown. Riz Eye Care/ Meyerland Family Eye Care/ North Shore Eye Care accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

7. **MEDIGAP:** I understand that if a Medigap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurance or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Riz Eye Care/ Meyerland Family Eye Care/ North Shore Eye Care, if possible, or otherwise to me.

8. **OTHER INSURANCE:** I authorize payment of my medical and surgical insurance benefits to Riz Eye Care/ Meyerland Family Eye Care/ North Shore Eye Care, I understand that I am financially responsible for any charges whether paid by said insurance. If my insurance company or health plan designates co-payments and/or deductibles, I agree to pay them to Riz Eye Care/ Meyerland Family Eye Care/ North Shore Eye Care.

9. **MEDICAL PHOTOGRAPHY:** May be taken at the time of your visit using a phone or iPad assigned to our office. The photographs taken are used strictly for diagnostic purposes and will be placed in your medical record. Refusal to consent to photographs will not affect the medical care you receive but could affect medical decisions making. If you have any questions, please contact our office.

10. **OTHER PROVIDERS:** You may be scheduled with one of our highly qualified Physician Assistants. All screening and tests are evaluated by our state licensed Optometrist who will assess your eye health and create your prescription. If you wish to speak with our state-licensed Optometrist, we offer telehealth visit before you leave the office. Additional Information can be located at www.rizeye.com

Patient/Guardian Signature: _____ ***Date:*** _____

By signing above you confirm you have read and understand all policies of Riz Eye Care/ Meyerland Family Eye Care/ North Shore Eye Care, and give consent to treatment.

The Difference in Vision Care Fees & Medical Care Fees

To avoid misunderstanding and confusion about our professional fees for Vision Care vs. Medical Care, please read and sign the following:

No Insurance Coverage

If you are healthy and have healthy eyes, wellness eye exam fees will be charged for your eye exam and/or contact lens exam to correct your nearsightedness or farsightedness or astigmatism or presbyopia.

If you have a general health problem or an eye disease then medical eye exam fees will be charged for your medical eye care. (Further explanation under Medical Insurance below)

Vision Plan and/or Medical Insurance

Many Patients have vision plans and many have medical insurance coverage for their eye care, some have both. Your eye care problem will determine which Insurance Carrier we will file with for your eye care visit. Often, there is no way to know before your examination which type of insurance we file. If you have questions about your insurance coverage and/or your eye care fees, please feel free to discuss them with our staff or doctors.

A Vision Plan

A Vision Plan will pay for your wellness eye exam if you are healthy and have healthy eyes.

The results of your wellness eye exam are used to correct vision problems such as; myopia, hyperopia, astigmatism and/or presbyopia.

A Vision Plan usually (but not always) requires a co-pay if you are examined for contact lenses.

A Vision Plan **does not** pay for your examination if the examination requires medical decision-making and/or the treatment of a medical eye problem.

Medical Insurance

Medical Insurance will pay for your eye care if your examination requires testing and medical decision-making because you have:

- Systemic health problems (diabetes, high blood pressure, thyroid, etc.)
- An eye disease (cataracts, glaucoma, diabetic retinopathy, allergic conjunctivitis, ocular surface disease, etc.)
- A medical condition that requires taking a high-risk medication (plaquenil, etc.).

If you have a medical problem or we discover a medical eye problem during the exam, we are required to furnish a Medical-level eye examination that is determined by your Medical Insurance Carrier. The complexity of your medical condition and the level of medical decision-making required to treat the problem are factors used to determine the exam fee level and co-pay amount. We did not set these fees your Insurance carrier did.

Also, depending on your medical problem, certain Supplemental Tests may be necessary. The fees for these Tests are usually paid by your Insurance Carrier but often they will also require you to pay an additional co-pay amount. Medical Insurance Carriers have very specific guidelines regarding every aspect of your medical eye care testing and documentation which they require us as a provider by signed contract to follow.

Our office did not make these Insurance rules; they were made by the Insurance carriers.

In the event we do not take your major medical or vision plan, we will provide you with an itemized statement that you can file with your carrier.

Please sign one of the applicable lines below:

I DO have insurance and I authorize RIZ EYE CARE / MEYERLAND FAMILY EYE CARE / NORTH SHORE EYE CARE to file my vision plan and/or Medical insurance claims.

Patient's Signature (or Guardian if minor) _____ **Date** _____/_____/_____

I DO NOT have insurance

Patient's Signature (or Guardian if minor) _____ **Date** _____/_____/_____