San Antonio Eye & Face Institute

Patient Registration Form

Date: _____ /_____ /20____ **E-mail Address:**_____

Circle One: Dr. Mr. Mrs. Ms.

Last Name_____ **First Name**_____ **MI**_____

Address_____ City_____ St_____ Zip_____

Home Phone_____ Mobile Phone_____

Martial Status (Circle One): Single Married Divorced Widowed

Sex (Circle One): Male Female

Race: _____ Ethnicity: _____

Language Preference(circle one): English Spanish Other_____

Date of Birth _____ **Age** _____ **SSN#** _____-_____-_____

Employer (Job Title) & Employer's Address_____

_____

How did you learn about our office?_____

Primary Care Provider _____ **Pharmacy** _____

Date of Last Physical Exam:_____ **Referring Dr.**_____

HIPAA-Approved Emergency Contact _____

Relationship_____ Emergency Contact Phone #(s)_____

Primary Insurance_____ ID#_____ Group#_____

Insured's Name_____ Insured's DOB_____Relationship_____

Secondary Insurance_____ ID#_____Group#_____

Insured's Name_____ Insured's DOB_____Relationship_____

For Minors: Who will serve as the responsible party?

Full Name_____ Address_____

City_____ State_____Phone_____ DOB_____

Sex: Male Female

Employer (Job Title) & Employer's Address_____

_____

San Antonio Eye Institute, PLLC Policies

--PLEASE READ CAREFULLY AND SIGN--

Insurance

First and foremost, we are here to provide you with the best care possible. In order to remain a viable business and be here when you need us, it is critically important that we receive payment for services rendered.

Having medical insurance is no guarantee of payment for your medical care. **Co-Payments, Co-Insurance, Deductibles and Non-Covered Services are the responsibility of the patient and must be paid at the time service is rendered**.

We will attempt to determine if you are responsible for paying any part of the service you receive. However, there are times when we may receive incorrect, inaccurate, or incomplete information from your insurance company. If we learn that you are responsible for a charge that we did not collect during your visit, we will send you an Invoice for the amount due.

The invoice is **DUE UPON RECEIPT**. If we do not receive payment in a timely fashion, we may contact you by phone to collect payment. Failure to pay an outstanding invoice after 90 days will result in the account being turned over to a collection agency, which could have an adverse effect on your credit record.

If you have billing related questions, please do not hesitate contacting us. In most cases, your questions can be answered by first reviewing your insurance company's “Explanation of Benefits” or by contacting your insurance company's Member Services Department (the phone number is on your insurance card).

In situations pertaining to minors (regardless of custody arrangements or divorce decrees), the person bringing a dependent in for services is financially responsible and is expected to pay at the time service is rendered.

Cancellation & “No Show” Policy

Due to patient demand for appointments, you must provide us **more than 24-hours** notice to cancel an appointment. If you cancel an appointment with less than 24-hours notice or do not show up for a scheduled appointment, you will be **charged $35.00** for the missed appointment. You are responsible for this charge; your insurance company will not pay this LATE CANCELLATION/NO SHOW FEE.

NOTE: Y**ou are responsible for keeping track of your appointments.** We will make an attempt to notify you by text message or by phone one day prior to your appointment. We **CANNOT** *guarantee that you will always receive a reminder for various reasons* (i.e. some phone plans do not accept text messages from our reminder system) and therefore you are ultimately responsible for keeping track of your appointments.

***If you would like to receive text reminders, please provide us with:

1.) Cell Phone Number_____ and **2.) Cell Phone Co.**_____

We recommend that you request a “reminder text” test be performed today before you leave the office to be certain that your phone can receive the texts.

We reserve the right to dismiss patients who repeatedly miss scheduled appointments from the practice.

Patients who miss their appointments may put their general or ocular health at risk. **I understand that I am responsible for keeping my appointments to prevent poor medical outcomes. I hereby hold the San Antonio Eye Institute and its doctors/staff faultless for poor outcomes that result from me missing scheduled appointments.**

_____ _____

Patient Signature (Parent's Signature for minors) Date

Referrals & Insurance Claims

If your insurance is a HMO plan (or another plan that requires a referral), you are responsible for obtaining this referral from your primary care physician. It will typically be faxed to us by your primary physician's office.

As a courtesy to our patients, we will file your claim for your office visit or surgery with your insurance and allow 45 days for payment in full (if we are participating providers with your insurance). Should payment NOT be received within 45 days, the balance due will become the obligation of the patient (or parent/ guardian in the case of minors) and must be paid within 30 days.

If you do NOT have insurance, or we are NOT a participating provider with your insurance carrier, payment is expected the day services are provided.

Agreement to Pay

The undersigned responsible party does hereby agree to pay for all services provided. The undersigned excepts the fee charged as a lawful debt and promises to pay the fee, including all cost of collection, attorney fees, and court costs, if necessary, waving now and forever the right to claim exemption under the Constitution and laws of the state of Texas or any other state.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. Payment can be made in cash or with a major credit card (Discover, Master Card, VISA, or American Express) – we do NOT accept personal checks. All unpaid balances may be charged a 1.5% re-billing fee monthly.

Consent to Treat

I hereby consent to the treatment for myself or the above listed patient. I understand, that in case of an emergency, I may have to see a physician at an urgent care center or emergency room in San Antonio, Texas.

_____ _____

Patient Signature (Parent's Signature for minors) Date

Health Insurance Portability and Accountability Act (HIPPA)
Privacy Policy and Identity Theft Prevention

I consent to the use or disclosure of my protected health information (PHI) by San Antonio Eye and Face Institute for the purpose of diagnosing or providing treatment, obtaining payment for my health care bills or to conduct healthcare operations.

My PHI means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This PHI relates to my past, present or future physical or mental health or condition and identifies me, or there is a responsible basis to believe the information may identify me.

It is the policy of San Antonio Eye and Face Institute to follow all federal and state laws and reporting requirements regarding identity theft. You will be asked to provide proper identification along with your insurance card when seeking medical care.

The privacy policy describes the types of uses and disclosures of PHI that will occur in treatment, payment of bills or in the performance of healthcare operations. It also describes your rights and our duties with respect to PHI.

I understand I have a right to review the Company's Privacy Policy prior to signing this document. The Privacy Policy for the company are available at the practice and on our website at www.saeyeinstitute.com.

We reserve the right to change the practices that are described in the Privacy Policy. You may obtain revised policy documents by assessing our website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of your appointment.

By signing this form, you acknowledge that this Medical Practice has made available to you its Privacy Policy. I have received a copy of the policies (if requested). The Practice has given me the opportunity to ask any questions about these policies and all my questions have been answered.

_____ _____

Patient Signature (Parent's Signature for minors) Date

E-mail Communication

The San Antonio Eye and Face Institute uses electronic medical record and practice management systems to reduce the use of paper products. This is good for patient care and the environment. To make efficient use of these technologies, we ask patients to **provide a valid e-mail address**.

We may periodically send communication by e-mail. By providing us with your e-mail address, you consent to being contacted by e-mail if the need arises. Individuals may opt out of mass mailings at any time.

Patients periodically contact us via our online contact form or by e-mail. Please note that we CANNOT discuss topics of a medical nature, including your protected health information, or provide medical advice through the contact form on our website or by email. E-mail is used for scheduling purposes. If you have a medical question or concern, you understand that these issues must be handled over the phone or in person.

_____ _____

Patient Signature (Parent's Signature for minors) Date

Refraction Fees

What is a refraction?
A refraction is the test used to determine the best prescription needed to sharpen vision in glasses and/or contact lenses. You may recall being asked, “What’s better, one or two?”

Why is it sometimes necessary?
A refraction is sometimes necessary depending on the patient’s diagnosis and/or complaints. For example, if a patient is experiencing blurred vision or a decrease in vision a refraction would be needed to first determine if this is due to a change in refractive error. If the vision, does not improve, another cause is sought. A refraction is also performed to prove the need for cataract surgery. We must document that your vision cannot be improved with glasses before recommending surgery. As you can see a refraction is sometimes needed, however, Medicare and most insurances **DO NOT** consider it a part of a medical examination and **do not** cover it.

Will I be notified in advance if I need it?
Yes, a technician or doctor is qualified to tell you if this procedure is necessary. We do not charge for the refraction, unless a glasses prescription is dispensed. Likewise, we will not perform a refraction unless we deem it medically necessary.

How much does it cost?
We charge **$50** for the refraction. This is due at the time the glasses prescription is dispensed. We will bill your insurance according to the individual contracted fee schedules. If your insurance pays the fee we will refund the $50 back to your account.

Refraction Fee Acknowledgement

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service. The copay and deductible are separate from, and not included in, the refraction fee.

_____ _____

Patient Signature (Parent's Signature for minors) Date