

EYE CENTER OF MIDLAND AND THE SURGICAL CENTER OF MIDLAND
2706 W. Cuthbert Ave., Building A Midland, TX 79701 (432) 694-0999

Date: _____

Name: _____ Age: _____ Date Of Birth: _____

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

Home Phone: _____ Cell: _____ Email: _____

Race: _____ Ethnicity: _____ Language: _____

Sex: ☐ M ☐ F Weight: _____ Height: _____ Social Security: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed *Occupation: _____

Responsible Party: _____ Phone: _____

(Self, Spouse, Parent)

Emergency Contact: _____ Relation: _____ Phone: _____

Name of Family Physician: _____ Phone: _____

Referred By: _____

Pharmacy: _____

Address: _____

1. Is the patient in a skilled nursing facility: ☐ YES ☐ NO

2. Does the patient have an advanced directive: ☐ YES ☐ NO

3. Are you allergic to any food, medications, or chemicals? ☐ YES ☐ NO

If yes, please list: _____

4. Have you had any major surgeries? ☐ YES ☐ NO

If yes, please list and provide year:

5. Have you ever taken any prostate medication such as FLOMAX, JALYN, or TAMSULOSIN?

If yes, when and for how long? _____

6. Do you have any medical conditions of the liver? ☐ YES ☐ NO

7. Please list below, or provide a list of medications you are currently taking:

☐ Not currently taking any medications

☐ Providing a list, (please attach list)

☐ I am currently taking the following medications:

If you currently are taking drops for glaucoma, for how long? : _____

8. Tobacco Status ☐ Never smoked ☐ Current every day smoker ☐ Current someday smoker

☐ History of smoking, but stopped year _____.

***Occupation is requested for surgery restrictions.**

Patient name: _____

Date: _____

General Medical History:

Yes:

Anemia	
Anxiety	
Arthritis	
Asthma	
Bleeding disorder	
Cancer (specify)	
Congestive heart failure	
COPD	
Dementia	
Depression	
Dialysis	
Diabetes Type I	
Diabetes Type II	
Elevated Cholesterol	
Heart Attack	
Hepatitis	
HIV	
Hypertension (high blood pressure)	
Kidney disease	
Liver (cirrhosis)	
Liver Failure	
MRSA	
Other	
Pacemaker	
Pregnancy	
Stroke	
Thyroid	
Tuberculosis	
Patient denies all history of medical conditions	

If you have ever had any past eye surgeries, please list them with completed year:

Past Ocular History:

Yes:

Amblyopic	
Astigmatism	
Blepharitis	
Cancer	
Cataract	
Chalazion	
Contact lenses	
Corneal abrasion	
Corneal ulcer	
Diabetic retinopathy	
Diplopia (double vision)	
Dry Eyes	
Ectropion	
Entropion	
Epiretinal membrane	
Eyelid lesion	
Glaucoma	
Herpes simplex or Herpes zoster	
Hyperopia (far-sighted)	
Keratoconus	
Macular degeneration	
Macular hole	
Monovision	
Myopia (near-sighted)	
Ocular trauma	
Posterior vitreous detachment	
Pterygium	
Ptosis (droopy eyelid)	
Retinal detachment	
Strabismus	
Uveitis	

MEDICARE

We are a participating MEDICARE provider. We submit all Texas claims. Medicare pays 80% of their allowable charge after you have met your plan year deductible. You or your secondary insurance carrier will be responsible for the remaining 20%.

SURGERY

Surgery usually involves a larger fee than office procedures. Prior to any surgery, we will provide you with a financial estimate of your responsibility, also known as a facesheet. Therefore, payment will be required prior to surgery. Please remember that financial estimates are solely based on information provided to us from your insurance plan. Therefore, it is NOT a guarantee of payment from them.

VISION INSURANCE

We accept a variety of medical insurance plans for medically necessary eye care, treatment, and comprehensive eye exams. Please note that we do not accept vision insurance plans.

REFUNDS

In the event of overpayment, a refund in the amount of the credit can be issued to the patient upon request. Refunds can be issued by check if paid by cash or check or credited back to the original form of payment made by credit card. Please allow us up to one week for a refund to be issued upon request. To ensure patients receive their refunds, we do not send refund checks through the mail; we ask that patients please pick up their checks from the facility.

MEDICAL RECORD REQUEST

To release or request your personal health information, you will need a HIPAA-compliant Authorization to Release Medical Information form. This document grants your healthcare provider explicit consent to share your records with another doctor, specialist, insurance company, for personal use, or to a third party.

We can provide you with this form upon request. Please note that if we are releasing records to the patient, we do charge a \$25.00 fee for the first twenty pages and \$.50 per page for every copy after that. The requested copies of medical and/or billing records or a summary or narrative of the records shall be furnished by the physician within 15 business days after the date of receipt of the request and reasonable fees for furnishing the information. We appreciate your patience.

I ACCEPT THE POLICIES OF EYE CENTER OF MIDLAND AND SURGICAL CENTER OF MIDLAND

Signature of Patient or Responsible Party

Date

AUTHORIZATION TO RELEASE INFORMATION TO THE EYE CENTER OF MIDLAND AND SURGICAL CENTER OF MIDLAND

I authorize the release of medical information necessary to process insurance.

Signature of Patient or Responsible Party

Date

AUTHORIZATION OF BENEFITS TO PHYSICIAN

I authorize payment of medical and surgical benefits to Eye Center of Midland and Surgical Center of Midland for services rendered. I understand I am financially responsible to the physician for charges not covered by insurance.

Signature of Patient or Responsible Party

Date

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices (posted), which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Responsible Party

Date

Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority

APPOINTMENT CANCELLATION AND NO-SHOW POLICY

When patients schedule an appointment, we set enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment, please contact our office within 24 hours of your scheduled appointment at our clinic and 48 hours for scheduled surgery in the Surgical Center of Midland. This gives us time to schedule other patients who may be waiting for an appointment.

Please see our appointment and no-show policy below:

- Effective May 1, 2018, any patient who **no show, cancels, or reschedules an appointment** and has not contacted our office within 24 hours before their scheduled appointment, will be considered a no-show and be charged a \$25.00 fee.
- **Failure to show, cancel, or reschedule a surgery appointment**, without contacting our office within 48 hours before the scheduled surgery will result in a \$100.00 fee. If your surgery is scheduled on Tuesday, it's the patient's responsibility to contact our office by 8:30 A.M. on Monday, the day before your surgery or leave a voicemail.
- After three NCNS and/or failing to cancel your surgery/office visit, you will receive a letter from our facility informing you that we will no longer be able to provide health services due to your failure to comply with the appointment cancellation and no-show policy. We will gladly provide patients with emergency services for 30 days upon notice.

We understand there may be times when an unforeseen emergency may occur and you may not be able to attend your scheduled appointment. If you should experience an emergency circumstance, please contact our office as soon as possible.

Eye Center of Midland: (432)-694-0999

Surgical Center of Midland: (432)-694-6517

I have read and understand the appointment cancellation and no-show policy and agree to the following terms.

Signature of Patient: _____ Date: _____

Printed name of Patient: _____