KIRBY
EYE CENTER

9301 North Central Expressway Ste 180, Tower 2, Dallas, TX 75231

Doctor you are seeing today: ____Judith A. Kirby MD ____ Maheen Haque MD

____ G. Stephon Payseur MD ___Idean Nikrooyan MD ____W. Edward Culbertson OD

Name:		DOB:	
Address:			
How do you prefer to be contacted for appointment reminders and recalls? ☐ **Voice calls** ☐ **Text** Phone: _____ **Cell / Home / Work** Alternate Phone: _____ **Cell / Home / Work**			
Address:	Primary Doctor:	Phone:	
Referred by:	Phone:		
Preferred Pharmacy:	Street Address:	City/State/Zip:	Phone:
Reason for exam:			
Employer Name & Address:			
Occupation:	Marital Status:	Spouse:	
Emergency Contact:	Phone:	Relation:	
Primary Insurance:	Policy #:	Group #:	
Medical Claims Address:		Phone:	
Primary policy holder Name:		DOB:	
Secondary Insurance	Policy #:	Group #:	
Medical Claims Address:		Phone:	
Medication Allergies:			
Current Medications:			

Pt Name: *(please print)* _____

Past Ocular History: ☐ Cataracts ☐ Glaucoma ☐ Iritis Macular Degeneration: ☐*Dry* *or* ☐*Wet*

☐ Diabetic Retinopathy ☐ Floaters ☐ Flashes ☐ Retinal Tear ☐ Retinal Detachment

☐ Amblyopia (Lazy eye) ☐ Eye Muscle Disorder ☐ Dry Eyes / Tearing

Other_____

Past Ocular Procedures:

☐ Cataract Surgery Eye_____ Dates_____

☐ Refractive Surgery ☐Lasik ☐RK Eye_____ Dates: _____

☐ Laser Eye_____ Dates: _____

Reason for laser: ☐ Diabetes ☐ Retinal Tear/Detachment ☐ Wet Macular Degeneration

☐ Eye Injections Eye_____ Dates: _____

☐ Eye Muscle Surgery Eye_____ Dates: _____

☐ Corneal Transplant Eye_____ Dates: _____

☐ Other_____

Medical History:

☐ Diabetes ☐ Rheumatoid Arthritis ☐ Sjogren's ☐ Lupus ☐ Aids/HIV ☐ Cholesterol ☐ Psychological disorder

☐ Hepatitis ☐ Asthma ☐ COPD ☐ High Blood Pressure ☐ Heart disease ☐ Cancer *Type*_____

☐ Stroke ☐ Thyroid disorder ☐ Migraines or Headaches

Other_____

Family History (Ocular):

☐ Cataracts ☐ Glaucoma ☐ Iritis Macular Degeneration: ☐*Dry* *or* ☐*Wet* ☐ Diabetes ☐ Diabetic Retinopathy

☐ Floaters ☐ Flashes ☐ Retinal Tear ☐ Retinal Detachment ☐ Amblyopia (Lazy eye) ☐ Eye Muscle Disorder

☐ Blindness ☐ High Blood Pressure ☐ Heart Disease

Other_____

Social History:

Tobacco History (if yes) Type: Cigarettes Cigar Pipe Chew/Snuff Vapor

How long: _____ Amount per day: _____ If you have stopped, when: _____

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REFRACTION SERVICES AND FEES

Refraction

A refraction is the process and measurement of the lens power to determine your best corrected vision and if there is a need for corrective eyeglasses or contact lenses. It is an essential part of the eye exam and is necessary to write a prescription for glasses or contact lenses.

A refraction is NOT a covered service by Medicare and most medical insurance plans. These plans consider a refraction a "vision" service not a "medical" service and insist that we charge separately for that portion of the examination, since it is not a covered service.
Routine vision plans DO cover the refraction and we will NOT collect the refraction fee.

Our office fee for a refraction is $50. This fee is billed to all new patients and annually to all established patients. It is collected at the time of service in addition to any co-payment, deductible and co-insurance your plan may deem as your responsibility. Should your plan pay us for the refraction, we will reimburse you accordingly.

In accordance with our contract with your insurance provider, we are responsible for collecting, and you are responsible for paying, non-covered charges, co-payments, deductibles or coinsurance at the time of service.
We cannot file claims on both the medical and routine vision plan for the same date of service.

No Show or Cancellation Policy

Due to an increase in patient no shows and last-minute cancellations the office has implemented a no show/cancellation fee of $30. If you cannot make your appointment you must contact our office and cancel 24 hours or more in advance or you will be charged a fee of $30.

_____ _____

Patient's Name (print) Date

_____ _____

Patient Signature (Legally responsible applicable) Relationship to patient

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AUTHORIZATION FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION:

I authorize my physician and/or administrative and clinical staff of Kirby Eye Center to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices.

Name and relationship of person(s) you wish to allow access: *(e.g., your spouse, son, daughter, sibling, caretaker, friend)*

Name of Person or Entity: **Relationship:**

_____

_____

_____

☐ **It is OK to leave detailed information at ( ) _____-_____**

☐ **ONLY leave a call back number at ( ) _____-_____**

☐ **It is OK to mail detailed information to _____**

☐ _____

*I have been provided a **copy of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)** to read and understand and consent to use and disclosure of protected health information about myself for treatment, payment and health care operations.

*I have been provided a **copy of the Financial Policy** to read. I understand, that I, the patient or the patient's representative, am/is responsible for payment of all charges for service rendered. I also acknowledge that non-payment of my account may result in collections proceedings and dismissal from the practice.

*I authorize the release of any medical information necessary to process all claims and I authorize the release of payment for medical benefits to my insurance company(s).

My signature below confirms that I have been given appropriate information, read, understand and agree to the statements above.

_____ _____

Patient's Name (Print) Date

_____

Signature of the Patient or Patient Representative