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:	Last 4 of SS:
Address:		

Phone: _____ **Cell / Home / Work** Email: _____

Alternate Phone: _____ **Cell / Home / Work**

How do you prefer to be contacted for appointment reminders and recalls? ☐ Voice calls ☐ Text ☐ Email ☐ All

Primary Doctor:	Address:	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:	Last 4 of SS:
Secondary Insurance	Policy #:	Group #:
Medical Claims Address:		Phone:
Vision Insurance	Policy #:	Group #:
Policy holder name:	DOB:	Last 4 of SS:
Medical Claims Address:		Phone:

HMO, POS & EPO Insurance Carriers: May require a referral or authorization from your primary care physician. If not received, you may have to reschedule, or you will be completely responsible for all charges incurred.
The patient is financially responsible for any co-payment, coinsurance and uncovered medical expenses not covered by their insurance.

Pt Name: ***(please print)*** **_____**

Medication Alergies:
Current Medications:

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 A1c _____ Date _____ ☐ 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

Flu vaccine Yes or No Date vaccine given _____

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 AND CANCELATION & NO SHOW FEE

Refraction

A refraction *(CPT – 92015)* 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. Due to not being a covered service for most plans we charge separately for that portion of the examination.
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 or if multiple NEW glasses prescriptions are requested during that years' time. 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.

_____ _____
Patient's Name (print) Date

_____ _____
Patient Signature (Legally responsible applicable) Relationship to patient

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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Is this a **Routine** (Refractive) or **Medical** eye examination?

Routine Vision (Refractive) Coverage: Your "vision" insurance is intended to provide you with a baseline eye evaluation and update your glasses prescription **only**. If the doctor discovers a medical eye problem during a routine exam, the doctor will inform you that your visit is now a medical exam and will be billed to your medical insurance. You can choose to finish the routine examination and return at a later date for the medical exam.

Medical Eye Examination Coverage: If you have an eye condition such as but not limited to: cataracts; macular degeneration; glaucoma; dry eyes; cornea problems, this examination will be billed to your medical insurance. Please note that the refraction (CPT 92015 - a test done to prescribe glasses and/or contact lens) fee is not always covered by you medical insurance and will be the patients responsibility.

Patient Responsibilities: Many medical insurance companies do not pay for a routine eye examination. We cannot and will not bill an eye examination to a patient's medical insurance and vision insurance companies for the same date of service. It is your responsibility to check with your insurance carrier for proper coverage and to let us know before your eye examination. Please understand that each patient's insurance coverage varies. The Kirby Eye Center staff verifies each patient's insurance to the best of their ability and cannot be held responsible for knowing every patients' coverage.

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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 _____**

☐ _____

We strongly urge all patients to enroll into the NextMD patient portal for secured communication.

*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

FINANCIAL POLICY AND BILLING PROCESSES

- **Payment Due**: I understand that payment is due when service is rendered.
- **Co-pay, Co-insurance and Deductibles.** It is my responsibility to know what my co-pay, co-insurance and deductibles are, and my obligation to pay this at the time of service.
- **Insurance Coverage**: I acknowledge that the insurance cards I have presented are current and accurate.
- **Non-covered Services**: I understand that some services may be considered non-covered services by my insurance plan. I understand that it is my responsibility to know what my insurance does or does not cover and I understand that I am financially responsible for paying all non-covered services.
- **Denied Charges**: I understand that some charges may be denied by my insurance carrier as investigational, experimental or not medically necessary and will not be paid by my insurance carrier. I understand that depending upon my exam findings or diagnosis my physician may feel these services are needed whether my insurance carriers deems them payable or not and that I am obligated to pay for these services in full.
- **Refractions**: Refraction is the process of determining if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and necessary in order to write a prescription for glasses or contact lens. Medicare and most medical insurance do not cover the fee for refractions. I understand that I am responsible for this fee and it is payable at the time of service. We can, at your request, file your refraction charge with your insurance plan. If your insurance policy pays this fee. We will then refund your payment or you may choose to leave a credit for your next visit.
- **Participating Insurance Plans:** If the practice is not a participating provider in my insurance plan, I will be responsible for filing my own claims and I will be responsible for paying in full at the time of service.
- **Returned Checks & Past Due Accounts;** Returned checks will be subject to collection charges, penalties and interest. The practice does not accept post dated checks.
- **Vision Plans**: The practice does not participates in any vision plans and I will be responsible for filing my own claims and I will be responsible for paying in full at the time of service. Please be advised that some medical plans do have routine vision benefits; however, sometimes these vision benefits are with a different carrier than your medical plan. We may be participating providers with your medical plan but not your vision plan. Please contact your carrier to verify your benefits and whether the practice is a provider for both your medical and vision plan.
- **No Show Appointments:** all appointments that are not cancelled within 24 hours of appointment time are subject to a $30.00 no show fee. This $30.00 fee must be paid before we can reschedule your appointment.
- **Surgery Charges:** The practice will give you estimated physicians fee amount for surgery charges, please keep in mind that this is just an estimate and is not a guarantee of payment by your insurance company. Please be aware that when surgery is performed, you may incur addition charges (in addition to the surgeon's fees) from the surgery facility, anesthesiologist, laboratory or radiologist. These facilities are completely separate facilities that have their own billing and billing procedures.
- **Authorizations/Referrals**: Some insurance plan require you receive a prior authorization for services by a specialist, please review your policy to see if there is such a requirement and obtain this authorization prior to your visit with our clinic.
- **Emailing**: Kirby Eye Center does not allow communication with patients by email due to the fact that it is unsecure and is a HIPAA violation.

If you would like a printed copy of the financial policy please inform the receptionist.

Patient Authorization for Use and Disclosure of Protected Health Information

For Treatment: Your health information may be used with medical treatment and services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in your health care. We may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work or diagnostic testing. This may include family members. We may also release medical information about you for workers' compensation or similar programs. The release of such information is controlled by state and/or federal law. We may also give information to someone who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in disaster relief efforts so that your family can be notified about your condition, status and location.

For Payment: We may use and disclose medical information about you so that treatment and services you receive may be billed to and payment collected from you, an insurance company or a third party. We may also tell your health plan information about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

Appointment Reminders: We may use and disclose medical information to contact you as a reminder that you are due for an appointment or have an appointment scheduled for treatment or medical care.

Treatment Alternatives: We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health Related Benefits and Services: We may use and disclose medical information to tell you about health related benefits or services that may be of interest to you.

Research: Under certain circumstances, we may use and disclose medical information about you for research purposes. Before we use or disclose medical information about you to people preparing to conduct a research project, the project will have been approved through a research approval process. We may however, disclose your medical information to people preparing to conduct a research project to help them look for patients with specific medical needs. We will ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care.

As Required By Law: We will disclose medical information about you when required to do so by federal, state or local law. If you are involved in a lawsuit or dispute, we may disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request to obtain an order protecting the information requested.

To Avert A Serious Threat to Health or Safety: We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety of the public or another person. Any disclosure, however, would only be to help prevent the threat.

Special Situations: If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation. If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information to foreign military authority. We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law. We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for our office to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Your Rights Regarding Medical Information About You: You have the right to inspect and copy medical information that may be used to make decisions about your care. To inspect and copy medical information that may be used to make decisions about your care, you must submit your request to the office manager. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.