KIRBY
EYE CENTER

10740 North Central Expressway Ste 250, Dallas, TX 75231

Doctor you are seeing today:

____ Judith A Kirby MD **____ Maheen Haque MD** **____ W Edward Culbertson OD**

Name: *First*	*Middle Initial*	*Last*	DOB:	Last 4 of SS:
Address: *Street*		*Apt/Ste/Unit*	*City, State and Zip*	

Phone (1st): _____ **Cell / Home / Work** Email: _____

Phone (2nd): _____ **Cell / Home / Work**

ER Contact Name: _____ Phone: _____ Relation: _____

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

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:	
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:	

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

Medication Allergies:
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_____ How many: _____ Date of most recent injection _____
☐ Eye Muscle Surgery Eye_____ Dates: _____
☐ Corneal Transplant Eye_____ Dates: _____
☐ Other_____

Medical Procedures:

_____

_____

_____

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 given _____
Covid-19 vaccine Yes or No Dates given (1st) _____ (2nd) _____
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 NO SHOW / CANCELLATION 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 $75. This fee is billed to all new patients and annually to all established patients or if multiple NEW glasses prescriptions are requested during a 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, 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

There is a $30.00 fee for all no-show or appointments cancelled same day. The fee must be paid prior to rescheduling your appointment. If you cannot make your appointment, please contact our office to cancel no later than the day before your appointment. **In addition, if you are a patient of Dr Judith Kirby and you cancel/no show for your appointment 3 or more times you will be required to see one of the other physicians in the practice.**

After Hour ER Services: There is an out of pocket fee of **$100** that will be charged to a patient who requires after hours emergency services. This fee will be due at the time of services along with any co-pay, co-insurance and deductible amount.

_____ _____
Patient's Name (print) Date

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

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MEDICAL VS. ROUTINE VISION

Patient:_____ Acct #:_____ Date:_____

Is this a **Routine** refractive or **Medical** eye examination?

Routine Vision (Refractive) Coverage: Your "vision" plan is intended to provide you with a baseline eye evaluation and update your glasses and contact lens prescription **only**. It does not cover medical exams. 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 wellness examination and return on a later date for the medical exam. *All routine only eye exams and contact lens fittings or evaluations will be scheduled with our optometrist.*

Medical Eye Examination Coverage: If you have an eye condition such as but not limited to diabetes; cataracts; macular degeneration; glaucoma; dry eyes; cornea problems; eye pain; etc., the examination will be billed to your medical insurance. Medicare and most medical plans do not pay for a refraction (See refraction policy). Medical plans do not cover materials (glasses or contact lenses).

Patient Responsibilities: Many medical insurance companies/plans do not pay for a routine wellness eye examination. 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, and Kirby Eye Center cannot be held responsible for knowing every plan.

I understand the information I've just read about the difference between vision and medical insurance and I authorize Kirby Eye Center to file my claim with the appropriate insurance based on the reason for my visit and the results of my examination.

- I am here for a: ☐ **Routine Eye Exam** *(claim filed on vision plan)* ☐ **Medical Eye Exam** *(claim filed on medical plan)*

_____ _____

Patient or Guardian Signature Date

_____

Relationship if not signed by 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:**	**Phone Number:**

☐ **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 patients to enroll into the MedFusion 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

- **Co-pay, Co-insurance and Deductibles.** It is the patient's responsibility to know what their co-pay, co-insurance and deductibles are. Payment is due when service is rendered.
- **Insurance Coverage**: All insurance cards (Medical and Vision) must be presented at each visit.
- **Non-covered Services** or **Denied Charges**: Some charges are non-covered services or are considered investigational, experimental or not medically necessary and will may be denied and not paid by the insurance carrier. Depending upon the exam findings or diagnosis the physician may feel these services are needed whether the insurance carrier deems them payable or not. It is the patient's responsibility to know what their insurance does or does not cover and understand that they are financially responsible for paying all non-covered services.
- **After Hour ER Services**: There is an out of pocket fee of $100 that will be charged to a patient who requires after hours emergency services. This fee will be due at the time of services along with any co-pay, co-insurance and deductible amount.
- **Refractions**: See refraction policy sheet
- **Participating Insurance Plans:** If the practice is not a participating provider on a patient's insurance plan, the patient will be responsible for filing their own claims and will be responsible for paying in full at the time of service. It is the patient's responsibility to know what providers are in network on their plan.
- **Returned Checks & Past Due Accounts:** Returned checks will be subject to collection charges, penalties and interest. The practice does not accept postdated checks.
- **Vision Plans**: The practice accepts VSP, Eyemed and Superior Vision. We cannot and will not bill an eye examination to a patient's medical and vision insurance for the same date of service. 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. It is a patient's responsibility to contact your carrier to verify your benefits and to see if the provider/office is in network for both your medical and vision plan. **We must know this prior to your eye examination.**
- **No Show Appointments:** There will be a $30.00 fee accessed for a no show appointment or same day cancelations. This $30.00 fee must be paid before we can reschedule your appointment.
- **Surgery Charges:** The practice will give a patient estimated physicians fee amount for surgery charges. Keep in mind that this is an estimate and is not a guarantee of payment by the insurance company. Please be aware that when surgery is performed, you may incur addition charges from the surgery facility, anesthesiologist, laboratory or radiologist. These facilities are separate facilities that have their own billing and billing procedures.
- **Authorizations/Referrals**: Some insurance plans require you receive a prior authorization from your primary care physician (PCP) 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. If not received, you may have to reschedule, or you will be completely responsible for all charges incurred.
- **Emailing**: Kirby Eye Center does not recommend communication by email due to the fact that it is unsecure. If you choose to communicate through unsecured email that has personal or medical information included, you must sign a release of responsibility form authorizing us to communicate with you through an unsecured email instead of a secured messaging portal which is provided.
- **Medical Record Copy Fee**: The office offers the use of secured patient portal for communication and record retrieval along with faxing. If a patient chooses to NOT use the patient portal and wants copies of records, there will be a copy and mailing fee for medical records. $25.00 fee for the first 20 pgs and $0.50 for each additional pg. This must be paid prior to the release of records.

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.