NORTH TEXAS EYE MD

PATIENT INFORMATION FORM

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security Number: _____

Telephone Numbers DOB: _____

Home: _____ Age: ____ Sex: M / F

Work: _____ Email: _____

Cell: _____

Marital Status:

☐ Single ☐ Married Spouse's Name: _____

☐ Widowed ☐ Divorced

Employment:

☐ Full-Time ☐ Retired Occupation: _____

☐ Part-Time ☐ Unemployed

☐ Student Employer/School: _____

Is this a workers compensation claim? ☐ YES ☐ NO

Emergency Contact:

Name: _____ Phone: _____ Relation: _____

How did you hear about us? _____

Who is your Primary Physician? _____

Does your insurance require a referral? ☐ YES ☐ NO

Payment to be made when services are rendered

Sign: _____ Date:_____

MEDICAL HISTORY QUESTIONNAIRE - *Adapted from the American Academy of Ophthalmology*

Name: _____

REVIEW OF SYSTEMS:

Primary reason for today's (first) visit: _____

Do you presently have any problems in the following areas? If "YES", give an explanation.

	YES	NO	EXPLANATION OF PROBLEM
Eyes			
Loss or blurred vision	[ ]	[ ]	_____
Loss of side vision, double vision	[ ]	[ ]	_____
Itching, burning, or discharge	[ ]	[ ]	_____
Redness	[ ]	[ ]	_____
Gritty feeling, dryness or tearing	[ ]	[ ]	_____
Glare/light sensitivity, or halos	[ ]	[ ]	_____
Eye pain or soreness	[ ]	[ ]	_____
Infection of eye lashes or lid, styes	[ ]	[ ]	_____
Ears, nose, mouth, throat	[ ]	[ ]	_____
Cardiovascular, (heart, blood vessels)	[ ]	[ ]	_____
Respiratory (lungs/breathing)	[ ]	[ ]	_____
Gastrointestinal (stomach/intestines)	[ ]	[ ]	_____
Genitourinary (genitals/kidney/bladder)	[ ]	[ ]	_____
Musculoskeletal (muscles/joints)	[ ]	[ ]	_____
Integument (skin/breast)	[ ]	[ ]	_____
Neurological	[ ]	[ ]	_____
Psychiatric	[ ]	[ ]	_____
Endocrine (hormones, glands)	[ ]	[ ]	_____
Hematologic/Immunologic (blood)	[ ]	[ ]	_____
Seasonal allergies (hay fever, etc.)	[ ]	[ ]	_____

PAST HISTORY (EYE)

	YES	NO	
Eye drops currently in use: (list)	[ ]	[ ]	
_____			
_____			
_____			
_____			
Allergies to eye drops	[ ]	[ ]	List drops you are allergic to:
History of cataract, glaucoma	[ ]	[ ]	_____
History of cross/lazy eye	[ ]	[ ]	_____
Eye injury or other disease	[ ]	[ ]	_____
Eye surgery	[ ]	[ ]	_____

PAST HISTORY (MEDICAL)

List any medications (other than eyedrops) that you are currently using: _____

_____

_____

List all major illnesses: Diabetes _____ Hypertension _____

Other: _____

_____

List any major surgical procedures: _____

_____

Do you have any medication allergies? [ ] NO [ ] YES Penicillin Sulfa

List other medication allergies: _____

_____

FAMILY HISTORY

	YES	NO	EXPLANATION/RELATIONSHIP
OCULAR			
Blindness	[ ]	[ ]	_____
Cataract	[ ]	[ ]	_____
Glaucoma	[ ]	[ ]	_____
Macular degeneration	[ ]	[ ]	_____
Retinal detachment	[ ]	[ ]	_____
MEDICAL			
Diabetes	[ ]	[ ]	_____
Arthritis, lupus, etc.	[ ]	[ ]	_____
Other (list)	[ ]	[ ]	_____

SOCIAL HISTORY

	YES	NO	EXPLANATION
OCULAR			
Have you ever tried to wear contacts?	[ ]	[ ]	_____
Did you have problems with contacts?	[ ]	[ ]	_____
Vision causes problems with:			
❑ Driving ❑ Night vision ❑ Reading ❑ Sports/Outdoor activities			
GENERAL			
Do you drink alcohol?	[ ]	[ ]	How much per day? _____
Do you smoke?	[ ]	[ ]	
Have you ever had a blood transfusion?	[ ]	[ ]	
Have you ever had contact with a person who had a sexually transmitted disease?	[ ]	[ ]	

Patient's signature: _____ Date: _____

History reviewed [ ] No changes [ ] Additions as noted

Physician's signature: _____ Date: _____

NORTH TEXAS EYE MD

NAME: _____

DATE: _____

FUNCTIONAL VISION EVALUATION

Do you have difficulty, even with glasses….		**If Yes, how much difficulty do you have?**
Reading small print such as labels on medicine bottles, a telephone book or food labels?	[ ] YES [ ] NO [ ] Not Applicable	[ ] A little. [ ] A moderate amount. [ ] A great deal. [ ] I am unable to do this activity.
Reading a newspaper or book?	[ ] YES [ ] NO [ ] Not Applicable	[ ] A little. [ ] A moderate amount. [ ] A great deal. [ ] I am unable to do this activity.
Seeing steps, stairs, or curbs?	[ ] YES [ ] NO [ ] Not Applicable	[ ] A little. [ ] A moderate amount. [ ] A great deal. [ ] I am unable to do this activity.
Reading traffic signs, street signs, or store signs?	[ ] YES [ ] NO [ ] Not Applicable	[ ] A little. [ ] A moderate amount. [ ] A great deal. [ ] I am unable to do this activity.
Doing fine handwork like sewing, knitting, crocheting, or carpentry?	[ ] YES [ ] NO [ ] Not Applicable	[ ] A little. [ ] A moderate amount. [ ] A great deal. [ ] I am unable to do this activity.
Writing checks or filling out forms?	[ ] YES [ ] NO [ ] Not Applicable	[ ] A little. [ ] A moderate amount. [ ] A great deal. [ ] I am unable to do this activity.
Playing games such as bingo, dominos, card games, or mahjong?	[ ] YES [ ] NO [ ] Not Applicable	[ ] A little. [ ] A moderate amount. [ ] A great deal. [ ] I am unable to do this activity.
Watching television?	[ ] YES [ ] NO [ ] Not Applicable	[ ] A little. [ ] A moderate amount. [ ] A great deal. [ ] I am unable to do this activity.

Do you have any of the following symptoms?

[ ] Glare, Halos, rings around lights?
[ ] Difficulty with color perception?
[ ] Difficulty with depth perception?
[ ] Double or distorted vision?
[ ] Worsening/Blurred vision?

_____

Patient Signature

Dennis H. Goldsberry, MD, PE, FACS
5225 Independence Pkwy, Suite 100
Frisco, Texas 75035
(972) 215-7500

PATIENT FINANCIAL AGREEMENT

☐ INSURANCE ASSIGNMENT AND PATIENT RESPONSIBILITY

The person signing below agrees, whether he/she signs a patient or representative of the patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of North Texas EyeMD at the regular rates and terms of North Texas EyeMD. Should the account be referred to an attorney for collection, the person signing below shall pay reasonable attorney's fees and collection expenses.

"I assign payment for the unpaid charges for certain medical treatment and/or supplies furnished by the physicians and staff of North Texas EyeMD for whom North Texas EyeMD is authorized to bill. I understand that I am responsible for any health insurance deductibles, coinsurance, and noncovered services at the time services are rendered.

☐ MEDICARE AND/OR MEDICAID CERTIFICATION

The person signing below certifies that he/she has read this document, and is the patient, or is duly authorized by the patient as the patient's representative, to execute the above and accepts its terms.

"I certifiy that the information given by me is applying for payment under Title XVIII and/or Title XIX of the Social Security Administration is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries/carriers any information needed for this or related Medicare claim. I request that payment of authorized benefits be made on my behalf."

Relationship to Patient: ☐Self ☐Child ☐Dependent ☐Other_____

_____ _____ _____
Printed Name Signature Date

ASSIGNMENT OF BENEFITS:

In consideration of services rendered, I hereby assign North Texas EyeMD and/or any physician who as treated me, all rights, title, and interest in any payment due for services described herein as provided in the policy or policies of insurance. I agree to pay the charges of North Texas EyeMD, which are greater than the amount paid by the insurance company or companies.

_____ _____ _____
Printed Name Signature Date

NORTH TEXAS EYE MD

Dennis H. Goldsberry, MD, PE, FACS
5225 Independence Pkwy, Suite 100
Frisco, Texas 75035
(972) 215-7500

Refraction and Contact Lens Policies

Refraction Policy

During your visit, a refraction may be performed to determine your need for glasses or to evaluate if any further visual improvement can be achieved. This is a necessary and essential portion of your eye exam and in some cases, it is the sole reason for the appointment.

Medicare and almost all insurance companies treat refraction (CPT 92015) as a separately billed procedure from the examination. The refraction is considered a NON-COVERED service by Medicare and some insurance companies.

Please be aware it is the responsibility of the patient to pay for the refraction. Our office charges $85 for this procedure, but we offer a prompt pay price of $50 to the patient when paid at the time of service. This fee is in addition to the fee for the eye exam and is in addition to the patient's insurance copay.

We appreciate your cooperation in paying this fee at the time services are rendered.

I have read the above information and understand I may be charged a prompt pay price of $50 at the time of service. If billing is required, the full charge of $85 will be billed.

Contact Lens Policy

The glasses prescription you receive is NOT a contact lens prescription. Contact lenses are a medical device that must be fit properly to your eyes. An improperly fit contact lens can lead to long-term complications including corneal scarring and loss of vision. Fitting of contact lenses is also a separate service from the eye exam. The fee for this service may vary depending on many factors, including the type of lenses fitted, whether you have worn lenses before, and other individual factors.

I have read and understood the above refraction and contact lens policy.

_____

Patient or Guardian's Signature Date

Dennis H. Goldsberry, MD, PE, FACS
5225 Independence Pkwy, Suite 100
Frisco, Texas 75035
(972) 215-7500 office
(972) 432-5164 fax
www.ntxeye.com

ACKNOWLEDGMENT OF RECEIPT OF
NOTICE OF HEALTH INFORMATION PRACTICES

The *Health Insurance Portability and Accountability Act (HIPAA)* is a federal government regulation designed to ensure that you are aware of your privacy rights and how your medical information can be used by our staff in providing and arranging your medical care.

North Texas EyeMD is furnishing you with the attached notice, which provides information about how we may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law.

HIPAA Privacy Act Information Release Form

Please mark below for release of information concerning your healthcare:

Release Information ONLY to me: ___ **Yes** ___ **No**

Release of Information to Spouse: ___ **Yes** ___ **No**

Spouse's Name: _____

Release of Information to Other Individuals: ___ **Yes** ___ **No**

Name & Relationship: _____ Phone #: _____

Name & Relationship: _____ Phone #: _____

Name & Relationship: _____ Phone #: _____

Name & Relationship: _____ Phone #: _____

May we leave detailed information on your cell phone? ___ **Yes** ___ **No**

May we leave detailed information on your home answering machine? ___ **Yes** ___ **No**

May we send appointment reminders via email? ___ **Yes** ___ **No**

Email Address: _____

By signing this form, you acknowledge that you have received a copy of North Texas EyeMD's Notice of Health Information Practices and have provided instructions regarding release of your individual healthcare information.

_____ X_____ _____
Patient Name Signature of Patient, Parent or Legal Guardian Date

NORTH TEXAS EYE MD

Dennis H. Goldsberry, MD, PE, FACS
5225 Independence Pkwy, Suite 100
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(972) 215-7500 office
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Notice of Privacy Practices

The notice of privacy practices is required by the Privacy Regulations created as a result of Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how health information about you or your legal dependent (as a patient of this practice) may be used and disclosed, and how you can access to your individually identifiable health information.

Our Practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information: How we may use and disclose your IIHI, Your privacy rights in your IIH, Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all or your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

The following categories describe the different ways in which we may use and disclose your IIHI.

Treatment. Our practice may use your IIHI to treat you. For example we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice—including but not limited to, our doctors and nurses—may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such service costs, such as family members. Also, we may use your IIHI to bill you directly for service and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the way in which we may use and disclose your information for operations, our practice may use your IIHI to evaluate the quality of care you receive from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.

Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

Treatment Options. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

Health-Related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatricians' office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

Disclosures Required by Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state, or local law.

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of: 1. Maintaining vital records, such as births and deaths. 2. Reporting child abuse or neglect. 3. Notifying a person regarding potential exposure to a communicable disease. 4. Notifying a person regarding a potential risk for spreading or contracting a disease or condition. 5. Reporting reactions to drugs or problems with products or devices. 6. Notifying individuals if a product or device they may be using has been recalled. 7. Notifying appropriate governmental agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information. 8. Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

Law Enforcement. We may release IIHI if asked to do so by a law enforcement official: Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement. Concerning a death we believe has resulted from criminal conduct. Regarding criminal conduct at our offices. In response to a warrant, summons, court order, subpoena or similar legal process. To identify/locate a suspect, material witness, fugitive or missing person. In an emergency, to report a crime (including the location or victim[s] of the crime, or the description, identity or location of the perpetrator).

Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

Organ and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain written authorization to use your IIHI for research purposes except when Internal Review Board of Privacy Board has determined that the waiver of your authorization satisfies the following: The use or disclosure involves no more than a minimal risk to your privacy based on the following: An adequate plan to protect the identifiers from improper use and disclosure; An adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and Adequate written assurances that the IIHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; the research could not practicably be conducted without the waiver; and the research could not practicably be conducted without access to and use of the IIHI.
Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.
Workers' Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

You have the following rights regarding the IIHI that we maintain about you:
Confidential Communication. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written to the Privacy Officer at our office specifying the requested method of contact and/or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.
Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to our office. Your request must describe in a clear and concise fashion: the information you wish restricted; whether you are requesting to limit our practice's use, disclosure or both; and to whom you want the limits to apply.
Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to our office in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor, and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.
Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to our office. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion (a) accurate and correct; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment or non-operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented (for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim). In order to obtain an accounting of disclosures, you must submit your request in writing to our office. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 1, 2010. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of other costs involved with additional requests, and you may withdraw your request before you incur any costs.
Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact the front desk in our office.
Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our office. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note we are required to retain records of your care.

If you have any questions regarding this notice or our health information privacy policies, please contact our Privacy Officer at 972-215-7500.

Dennis H. Goldsberry, MD, PE, FACS
5225 Independence Pkwy, Suite 100
Frisco, Texas 75035
(972) 215-7500

Authorization for the Release and/or Discussion of Protected Health Information

Patient Name:_____ Birth Date: ___/____/_____

Authorization

1. I, _____, hereby authorize
(Name of Patient or Patient's Legally Authorized Representative)

2. Name of person or organization:_____

Street Address: _____

City, state, zip:_____ Telephone: ( )

3. To release and/or discuss the following information:

[ ] Complete Record [ ] Outpatient Care [ ] Inpatient Care

[ ] Laboratory Results [ ] Treatment Plan [ ] Last Office Visit

Other: _____

If my record contains the following information, it is also released if CHECKED in boxes below:
[ ] *Substance Abuse* [ ] *Mental Health Treatment* [ ] *HIV Testing or Treatment*

4. To: **North Texas EyeMD, 5225 Independence Pkwy, Suite 100, Frisco, Texas 75035.**
Office Phone: 972-215-7500 Office Fax: 972-432-5164
This information release is at my request for the purpose of continued medical care.

5 Signature:
I have carefully read and understand the above information, and do herein consent to its disclosure. I am aware that information regarding my medical condition will be released to those persons or agencies named above. I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

I understand that this consent is subject to revocation, in writing, at any time, unless action based on it has already begun.

This authorization expires _____6 months _____one year from today's date, or upon the following specified event: _____.

I authorize the use of a copy of this form for the disclosure of the information described above.

Signed _____ Relationship_____ Date: ____/____/____