

New Patient Registration Packet



**2709 Virginia Parkway, #200
McKinney, TX 75070**

**8380 Warren Parkway, #101
Frisco, TX 75034**

Phone: 972-548-2015

Fax: 972-548-2014

www.TexasVisionAndLaser.com

Welcome to the Texas Vision & Laser Center! Please print and fill out all forms completely and **FAX the first SIX PAGES (including this cover sheet) back to us at 972-548-2014.** Please be confident that we keep all patient information strictly confidential. We will prepare your medical record before you arrive, to expedite your visit, and to minimize your wait. If you are unable to fax these forms to us please complete them at home and bring them with you on your appointment day. If you are unable to print out the forms, please arrive at your appointment thirty minutes early to complete the Pre-registration process. Be sure and bring your medicine list, and all pertinent insurance and health related information with you.

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Patient Registration Form

Welcome to the Texas Vision & Laser Center. Please fill out this form **completely**. Your Insurance Company may not pay if we cannot provide all of this information. If a question is not applicable, please enter "n/a".

Name: _____ <input type="checkbox"/> Dr. Home Phone: _____ <input type="checkbox"/> Mr. Work Phone: _____ <input type="checkbox"/> Mrs. Cell Phone: _____ <input type="checkbox"/> Ms. Mailing Address: _____ City: _____ State: _____ Zip: _____ E-mail: _____ Are you a veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you in a wheelchair? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you in a Skilled Nursing Facility? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you a student? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicate: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Race: <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Other <input type="checkbox"/> African-American Date of Birth: _____ SSN #: _____ Drivers Lic #: _____ State: _____
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Primary Care Physician: _____ Phone: _____

Referring Doctor: _____ Phone: _____

How did you hear about us? Family Physician Ophthalmologist Optometrist Newspaper TV
 Radio Yellow Pages Friend _____ Other _____

Employment Status: Full-Time Part-Time Retired Self-Employed Unemployed Active Military

Employer: _____ Occupation: _____

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

Spouse, Parent/Legal Guardian Information

Name: _____ Work Phone: _____

Employment Status: Full-Time Part-Time Retired Self-Employed Unemployed Active Military

Employer: _____ Occupation: _____

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

Emergency Contact (relative, friend, or neighbor not living with you)

Name: _____ Relationship: _____ Phone: _____

Insurance Information (Please list policyholder if other than the patient. List your primary company first.)

Primary Insurance Name of Insurance: _____ Policy #: _____
 Address: _____ Group #: _____
 Policy Holder: _____ Relationship to Patient: _____
 Date of Birth: _____ SSN#: _____

Other Insurance Name of Insurance: _____ Policy #: _____
 Address: _____ Group #: _____
 Policy Holder: _____ Relationship to Patient: _____
 Date of Birth: _____ SSN#: _____

CONSENT TO TREATMENT

I voluntarily consent to receive medical and health care services provided by the Texas Vision & Laser Center physicians, employees and such associates, assistants, and other health care providers as my physicians deem necessary. I understand that such services may include diagnostic procedure examinations, and treatment. I acknowledge that no warranty or guarantee has been made to me as to result or cure. I understand that this consent to treatment will be valid and remain in effect as long as I attend the Texas Vision & Laser Center clinics unless revoked by me in writing.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

In consideration for receiving medical or health care services, I hereby assign my right, title and interest in all insurance, Medicare/Medicaid, or other third party payer benefits for medical or health care services other payable to me to the providers of the Texas Vision & Laser Center. I also authorize direct payments to be made by Medicare/Medicaid and/or my insurance company or other third party payer upon the total amount of my medical and health care charges, to the providers of the Texas Vision & Laser Center. I certify that the information I have provided in connection with any application for payment by third party payers, including Medicare/Medicaid, is correct. I agree to pay all charges for medical and health care services not covered by or which exceed the estimated amount to be paid or actually paid by Medicare/Medicaid, my insurance company, or other third party payer and agree to make payment as requested by the Texas Vision & Laser Center. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance that insures the patient, or any other party liable to the patient, is hereby assigned to the Texas Vision & Laser Center. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to the Texas Vision & Laser Center. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

REFRACTION AND OTHER NON-COVERED SERVICES

I understand that refraction (measurement of eyes for glasses/contacts) is a non-covered service. I accept full financial responsibility for the cost of this service. The co-pay is separate from and not included in the refraction fee. I understand that the Texas Vision & Laser Center's contracts with health care service plans (i.e. HMOs, PPOs) relate only to items and services that are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans *not* to be covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health service plan. The undersigned agrees to cooperate with the Texas Vision & Laser Center to obtain necessary health care service plan authorizations.

RELEASE OF INFORMATION

The Texas Vision & Laser Center may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to the Texas Vision & Laser Center for reimbursement for services rendered, (2) any health care provider for continued patient care. The Texas Vision & Laser Center may also disclose on an anonymous basis, any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute, or regulation. A copy of this authorization may be used in place of the original.

Date

Time

Signature of Patient/Legally Authorized Person

Witness/Translator

Print Name and Relation to the Patient

Print Name and Translated Language



Medical History Information Form

(Please fill out completely)

Name: _____

Family Physician: _____

Date: _____

Past Medical History (Please indicate if you have any of the following conditions, or are being treated for any of the following conditions)

- | | | |
|---|--|---|
| <input type="checkbox"/> Asthma/Emphysema | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Cancer (type) | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Other _____ |

Past Surgical History (Please list any surgery you may have had)

Past Ocular History (Please list any eye problems/conditions you have or have had)

Medication Allergies (Please indicate in parentheses the kind of reaction you had to the medicine)

Family History (Please indicate which **family member** has any of the listed conditions)

- | | |
|--------------------------|----------------------------|
| Cancer (Type) _____ | Macular Degeneration _____ |
| Cataracts _____ | Diabetes _____ |
| Glaucoma _____ | High Blood Pressure _____ |
| Lazy/Crossed Eyes _____ | Heart Disease _____ |
| Retinal Detachment _____ | Other _____ |

Social History

- Alcohol _____ Tobacco _____ Drugs _____ Caffeine _____
- Do you live with Spouse Alone Other _____

Medications (Please list ALL of your medications that you currently take; include herbs/vitamins)

Review of Systems (Please indicate if you have any active problems in the following areas)

Normal

- 1. General Health
 - Fever
 - Weight loss
 - Other _____
- 2. Eyes
 - Blurred vision
 - Doubled vision
 - Pain
 - Other _____
- 3. Ears, Nose, Throat, Mouth
 - Pain
 - Mass
 - Hearing loss
 - Other _____
- 4. Cardiovascular
 - Chest pain
 - Shortness of breath
 - Irregular heart beat
 - Other _____
- 5. Respiratory
 - Shortness of breath
 - Cough
 - Asthma
 - Other _____
- 6. Gastrointestinal
 - Constipation
 - Diarrhea
 - Stomach pain
 - Others _____
- 7. Blood/Lymphatics
 - Anemia
 - Bleeding disorder
 - Swollen lymph nodes
 - Other _____
- 8. Musculoskeletal
 - Weakness
 - Joint pain
 - Decreased range of motion
 - Other _____
- 9. Skin/Breast
 - Masses/tumors
 - Pigmented lesions
 - Rash
 - Other _____
- 10. Neurologic
 - Weakness
 - Tingling
 - Numbness
 - Other _____



Acknowledgement of Receipt of Notice of Privacy Practices

Texas Vision & Laser Center, PLLC

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of the Texas Vision & Laser Center. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy of the revised notice by accessing our website at www.texasvisionandlaser.com or by calling the Texas Vision & Laser Center at 972-548-2015. If you have any questions about our *Notice of Privacy Practices*, please inquire at the Texas Vision & Laser Center.

I acknowledge receipt of the *Notice of Privacy Practices* of the Texas Vision & Laser Center.

Print Name of Patient: _____

Signature of Patient or Representative: _____

If Representative, give relationship: _____

Date: _____

Inability To Acknowledge Receipt of Notice of Privacy Practices

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

- Patient is unresponsive
- Patient is injured
- Other (specify) _____

Signature of Representative: _____

Date: _____



Authorization To Disclose Private Healthcare Information

I, _____, do authorize Texas Vision & Laser Center to release information including the diagnosis, records; examination rendered to me, and claims information. Information may be release to:

My Spouse, _____

On my answering machine, _____

My child, _____

My friend, _____

Other, _____

Patient Signature

Date of Birth

Witness Signature

Date



Notice of Privacy Practices

Texas Vision & Laser Center, PLLC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THIS NOTICE APPLIES TO ALL OF THE RECORDS OF YOUR CARE GENERATED BY THE PRACTICE, WHETHER MADE BY THE PRACTICE OR AN ASSOCIATED FACILITY.

This notice describes our Practice's policies, which extend to:

- Any health care professional authorized to enter information into your chart (including physicians, PAs, RNs, etc.);
- All areas of the Practice (front desk, administration, billing and collection, etc.);
- All employees, staff and other personnel that work for or with our Practice;
- Our business associates (including a billing service, or facilities to which we refer patients), on-call physicians, and so on.
- The Practice provides this Notice to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health
- Insurance Portability and Accountability Act of 1996 (HIPAA).

OUR THOUGHTS ABOUT YOUR PROTECTED HEALTH INFORMATION

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create paper and electronic medical records about your health, our care for you, and the services and/or items we provide to you as our patient. We need this record to provide for your care and to comply with certain legal requirements.

We are required by law to:

- make sure that the protected health information about you is kept private;
- provide you with a Notice of our Privacy Practices and your legal rights with respect to protected health information about you; and
- follow the conditions of the Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose protected health information that we have and share with others. Each category of uses or disclosures provides a general explanation and provides some examples of uses. Not every use or disclosure in a category is either listed or actually in place. The explanation is provided for your general information only.

- **Medical Treatment.** We use previously given medical information about you to provide you with current or prospective medical treatment or services. Therefore we may, and most likely will, disclose medical information about you to doctors, nurses, technicians, medical students, or hospital personnel who are involved in taking care of you. For example, a doctor to whom we refer you for ongoing or further care may need your medical record. Different areas of the Practice also may share medical information about you including your record(s), prescriptions, requests of lab work and x-rays. We may also discuss your medical information with you to recommend possible treatment options or alternatives that may be of interest to you. We also may disclose medical information about you to people outside the Practice who may be involved in your medical care after you leave the Practice; this may include your family members, or other personal representatives authorized by you or by a legal mandate (a guardian or other person who has been named to handle your medical decisions, should you become incompetent).
- **Payment.** We may use and disclose medical information about you for services and procedures so they may be billed and collected from you, an insurance company, or any other third party. For example, we may need to give your health care information, about treatment you received at the Practice, to obtain payment or reimbursement for the care. We may also tell your health plan and/or referring physician about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment, to facilitate payment of a referring physician, or the like.
- **Health Care Operations.** We may use and disclose medical information about you so that we can run our Practice more efficiently and make sure that all of our patients receive quality care. These uses may include reviewing our treatment and services to evaluate the performance of our staff, deciding what additional services to offer and where, deciding what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other personnel for review

and learning purposes. We may also combine the medical information we have with medical information from other Practices to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are. We may also use or disclose information about you for internal or external utilization review and/or quality assurance, to business associates for purposes of helping us to comply with our legal requirements, to auditors to verify our records, to billing companies to aid us in this process and the like. We shall endeavor, at all times when business associates are used, to advise them of their continued obligation to maintain the privacy of your medical records.

- **Appointment and Patient Recall Reminders.** We may use and disclose medical information to contact you as a reminder that you have an appointment for medical care with the Practice or that you are due to receive periodic care from the Practice. This contact may be by phone, in writing, e-mail, or otherwise and may involve the leaving an e-mail, a message on an answering machines, or otherwise which could (potentially) be received or intercepted by others.
- **Disclosure Relevant to Health Care or Payment to Person Assisting with Health Care or Payment.** If you do not object, we may disclose the medical information about you to the following persons if they are involved in your health care or payment or health care, provided that the information is relevant to the person's involvement with you:
 - Family
 - Relative
 - Close personal friend
 - Other person identified by you as being involved in your health care or payment of health care
- **Emergency Situations.** In addition, we may disclose medical information about you to an organization assisting in a disaster relief effort or in an emergency situation so that your family can be notified about your condition, status and location.
- **Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes regarding medications, efficiency of treatment protocols and the like. All research projects are subject to an approval process, which evaluates a proposed research project and its use of medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process. We will obtain an Authorization from you before using or disclosing your individually identifiable health information unless the authorization requirement has been waived. If possible, we will make the information non-identifiable to a specific patient. If the information has been sufficiently de-identified, an authorization for the use or disclosure is not required.
- **Required by Law.** We will disclose medical information about you when required to do so by federal, state or local law.
- **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 either to your specific health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.
- **Organ and Tissue Donation.** 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.
- **Workers' Compensation.** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Public Health Risks.** Law or public policy may require us to disclose medical information about you for public health activities. These activities generally include the following:
 - to prevent or control disease, injury or disability;
 - to report births and deaths;
 - to report child abuse or neglect;
 - to report reactions to medications or problems with products;
 - to notify people of recalls of products they may be using;
 - to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
 - to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- **Investigation and Government Activities.** We may disclose medical information to a local, state or federal agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the payor, the government and other regulatory agencies to monitor the health care system, government programs, and compliance with civil rights laws.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. This is particularly true if you make your health an issue. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute. We shall attempt in these cases to tell you about the request so that you may obtain an order protecting the information requested if you so desire. We may also use such information to defend ourselves or any member of our Practice in any actual or threatened action.

- **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official:
 - In response to a court order, subpoena, warrant, summons or similar process;
 - To identify or locate a suspect, fugitive, material witness, or missing person;
 - About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
 - About a death we believe may be the result of criminal conduct;
 - About criminal conduct at the Practice; and
 - In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.
- **Coroners, Medical Examiners and Funeral Directors.** We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the Practice to funeral directors as necessary to carry out their duties.
- **Inmates.** 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 the institution 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.

CHANGES TO THIS NOTICE

We reserve the right to change this notice at any time. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we may receive from you in the future. We will post a copy of the current notice in the Practice. The notice will contain on the first page, in the top right-hand corner, the date of last revision and effective date. In addition, each time you visit the Practice for treatment or health care services you may request a copy of the current notice in effect. Our current notice will always be posted on our Web site @ www.TexasVisionAndLaser.com.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, write us directly @ Texas Vision & Laser Center, HIPAA Privacy Officer, 2709 Virginia Pkwy, #200, McKinney, TX 75070. All complaints must be submitted in writing, and all complaints shall be investigated, without repercussion to you.

You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission, unless those uses can be reasonably inferred from the intended uses above. If you have provided us with your permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

PATIENT RIGHTS

THIS SECTION DESCRIBES YOUR RIGHTS AND THE OBLIGATIONS OF THIS PRACTICE REGARDING THE USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION.

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. This includes your own medical and billing records, but does not include psychotherapy notes. Upon proof of an appropriate legal relationship, records of others related to you or under your care (guardian or custodial) may also be disclosed.

To inspect and copy your medical record, you must submit your request in writing to our Compliance Officer. Ask the front desk person for the name of the Compliance Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies (tapes, disks, etc.) associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that our Compliance Committee review the denial. Another licensed health care professional chosen by the Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome and recommendations from that review.

Right to Amend. If you feel that the medical information we have about you in your record is incorrect or incomplete, then you may ask us to amend the information, following the procedure below. You have the right to request an amendment for as long as the Practice maintains your medical record.

To request an amendment, your request must be submitted in writing, along with your intended amendment and a reason that supports your request to amend. The amendment must be dated and signed by you and notarized.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for the Practice;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is inaccurate and incomplete.
- Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you, to others.

To request this list, you must submit your request in writing. Your request must state a time period not longer than six (6) years back and may not include dates before April 14, 2003 (or the actual implementation date of the HIPAA Privacy Regulations). Your request should indicate in what form you want the list (for example, on paper, electronically). We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care (a family member or friend). For example, you could ask that we not use or disclose information about a particular treatment you received.

We are not required to agree to your request and we may not be able to comply with your request. If we do agree, we will comply with your request except that we shall not comply, even with a written request, if the information is excepted from the consent requirement or we are otherwise required to disclose the information by law.

To request restrictions, you must make your request in writing. In your request, you indicate:

- what information you want to limit;
- whether you want to limit our use, disclosure or both; and to whom you want the limits to apply, (e.g., disclosures to your children, parents, spouse, etc.)
- Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail, that we not leave voice mail or e-mail, or the like.

To request confidential communications, you must make your request in writing. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish us to contact you.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

This information is made available on request by a patient.

End of Document