Jane H. Leidlein M.D

Gulf Coast Eye Center

PATIENT INFORMATION					
Patient's name (first and last):			Marital Status:		
Is this your legal name?	If not, what is your legal name?	Former Name:	Birth Date:	Age:	Gender
Address:					
Social Security #:	Home Phone:	Cell Phone:			
Employer:	Work Phone:				
Email:					

Race: (required by federal HIPAA regulations)

☐ American Indian or Alaskan Native ☐ Black or African American ☐ Native Hawaiian or Pacific Islander
☐ Asian ☐ Hispanic ☐ White
☐ Unknown

IN CASE OF EMERGENCY			
Name of local friend or relative:	Relationship to patient:	Home Phone:	Cell Phone:

PREFERRED PHARMACY	
Name:	Phone:
Address:	Fax:

REFERRING PHYSICIAN		
Name:	City:	Phone:

PRIMARY CARE PHYSICIAN		
Name:	City:	Phone:

PRIMARY INSURANCE INFORMATION		
(please bring your insurance card to your appointment and give it to the receptionist)		
Primary Insurance Company:		Effective Date:
Subscriber's Name:	Subscriber's SSN:	Date of Birth:
Patient Relationship to Subscriber:	Group #:	Policy #:

SECONDARY INSURANCE INFORMATION		
Primary Insurance Company:		Effective Date:
Subscriber's Name:	Subscriber's SSN:	Date of Birth:
Patient Relationship to Subscriber:	Group #:	Policy #:

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Patient's name (first and last):	Date:

MEDICAL HISTORY QUESTIONNAIRE

The Health Care Financing Administration requires we obtain the following information from you to be in compliance with their patient history guidelines for billing services. If you have any questions regarding this form or need assistance, please let our staff know.

What symptoms or complaints do you have with your vision (please be specific, including dates if necessary)?

List all major illnesses and injuries that you have had in the past:

List any surgeries (including on your eyes) that you have had in the past:

List any medication (including any eye medications) that you take:

List any allergies you have (including medication allergies):

Do you presently have any problems with the following areas?

Integumentary (skin)	☐ Yes	☐ No	☐ Yes	☐ No	Neurological
Ears, Nose, Mouth, Throat	☐ Yes	☐ No	☐ Yes	☐ No	Lymph Nodes
Respitory (lungs)	☐ Yes	☐ No	☐ Yes	☐ No	Hematopoietic (blood)
Cardiovascular (heart)	☐ Yes	☐ No	☐ Yes	☐ No	Allergic/Immunologic
Gastrointestinal (stomach)	☐ Yes	☐ No	☐ Yes	☐ No	Genitourinary
Bones, Joints, Muscles	☐ Yes	☐ No			

Do you drink alcohol? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

Are you taking blood thinners ☐ Yes ☐ No If so what are you taking? _____

Do you think you may have been exposed to HIV? ☐ Yes ☐ No

_____

Patient/Guardian Signature

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Patient Authorization for Personal Representative	Form 7.30
Please print all information, then sign and date form at bottom.	
Name of Practice: **GULF COAST EYE CENTER, P.A.**	
Patient Name:	
Social Security Number:	Date of Birth:
Purpose of request: I authorize the practice to disclose or provide my protected health information to the following individual who is authorized to act as my personal representative for the purposes of receiving all protected health information about myself. As my designated personal representative, he/she may exercise my right to inspect, copy, and request amendments to my protected health information. He/she may also consent or authorize the use or disclosure of my protected health information:	
Name of Personal Representative:	Phone
Address:	
City:	State: / Zip:

Description of information to be disclosed:

- I authorize the practice to disclose all of my protected health information to my designated personal representative.

Expirations or termination of authorization:

- This authorization will remain in effect until terminated by you, your personal representative or another individual(s) of legal entity authorized to do so by court order or law.

Right to revoke or terminate:

- As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in-person or by mailing a request to:
- **Gulf Coast Eye Center, P.A.**
  117 Circle Way Street
  Lake Jackson, TX 77566
  Attention: Privacy Manager

Redisclosure: We have no control over the person(s) you have listed as your personal representative. Therefore, your protected health information disclosed under this authorization, will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of this practice.

_____ _____

Patient/Guardian Signature Date

Copies of signed authorizations are available upon request.

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT OF RECEIPT

*** You may refuse to sign this acknowledgment ***

GULF COAST EYE CENTER, P.A.'s Notice of Privacy Practices provides information about how we may use and disclose medical information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may request a revised copy. I have received a copy of GULF COAST EYE CENTER, P.A.'s Notice of Privacy Practices. I have had an opportunity to read the Notice of Privacy Practices. I understand that I may ask questions of the Privacy Officer if I do not understand any information contained in the Notice of Privacy Practices.

Patient/Guardian Signature:	Date:
Patient/Guardian Printed Name:	Date:

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining the acknowledgment
- ☐ Other (Please Specify):

CONSENT TO OBTAIN MEDICATION HISTORY

GULF COAST EYE CENTER, P.A. has adopted an electronic medical record system in order to improve the quality of our services. This system also allows us to collect and review your "medication history". A medication history is a list of prescription medicines that we or other doctors have recently prescribed for you. This list is collected from a variety of sources, including your pharmacy and your health insurer. An accurate medication history is very important to helping us treat you properly and in avoiding potentially dangerous drug interactions. By signing this consent form you give us permission to collect, and give your pharmacy and your health plan permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This information will become part of your medical record. The medication history is a useful guide, but may not be completely accurate. It is still very important for us to take the time to discuss all medication you are taking including over the counter medicines, supplements or herbal remedies.

☐ Yes I give permission for you to obtain my medication history from Surescripts. ☐ No I do not give permission.

Patient/Guardian Signature:	Date:

REFRACTION POLICY

Refraction is the process of determining the eye's refractive error, or need for corrective spectacle and/or contact lenses. It is an essential part of an eye examination, but is NOT a covered service by Medicare or most insurance companies. Our office fee for refraction is $50.00 and this fee is collected in addition to the patient's co-pay, if paid on the date of service our discounted fee is $35.00. If filed to insurance you will be responsible for entire fee of $50.00. I have read the above information and understand that the refraction 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.

Patient/Guardian Signature:	Date:

CONTACT LENS FITTING POLICY

This is an acknowledgment of the fee associated with the fitting of contact lenses. The fees are as stated below:

New monovision fit:	$160.00	Monovision refit:	$85.00
New Contact Lens fit:	$85.00	Refit (every year)	$60.00

By signing this acknowledgment you are stating that you understand the price and agree to pay prior to the service being rendered. This fee is not approved by most insurance companies and is your responsibility.

Patient/Guardian Signature:	Date:

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FINACIAL POLICY

GULF COAST EYE CENTER, P.A. is committed to providing you with the highest quality services available. Please read and sign the following financial policy summary. If you have questions about this Financial Policy please contact our office at 979-297-4042.

Payment is due in full at the time services are rendered. We accept cash, check, Visa, MasterCard and Discover credit cards. Post-dated checks will not be accepted by our office.

Please be prepared to provide our office with a copy of your insurance card(s) and picture identification every time you visit our practice. Each time you visit our office you may be required to update your personal information such as home address, contact phone numbers, and emergency contact phone numbers. If there are any changes in your insurance, it is your responsibility to notify our office prior to your visit. If the information is not provided prior to the visit, you could be responsible for charges incurred for any dates of service prior to the new information being given.

Physician surgical fees owed are due prior to any surgery performed. This would include any deductible, copay, or coinsurance. Fees quoted by our office for surgery are for the surgeon only. The facility where the operation is performed is responsible for quoting and collecting payment for their fees.

Financial responsibility for a minor is the responsibility of the accompanying adult unless arrangements have been made prior to the visit.

Any PAST DUE BALANCE is required to be paid either by the statement received from our billing office or at the time of your next visit. In the event your account is past due, we will take the necessary steps to collect the debt, and possible referral to a collection agency which could affect your credit record.

SELF PAY/CASH PAY POLICY: For patients who are not using insurance for their office visit, payment is due in full at the time of service. We will collect at check-in.

A $25.00 return check fee will be assessed if your check is returned by your bank.

Patient/Guardian Signature:	Date:
Patient/Guardian Printed Name:	Date: