Welcome to EyeCare Associates of Texas, P.A. Serving the Best Southwest Area of Dallas since 1979

Trang D. Le, MD, FACS
Gowri Pachigolla, MD
Beverly B. Bishop, MD
Silus P. Motamarry, MD, FACS

New Patient Registration

Demographics

Name: _____ **Birthdate:** _____ **SSN:** _____

Sex: M / F **Preferred Language:** _____ **Race:** _____

Address: _____ **City/State/Zip:** _____

Home #: _____ **Cell#:** _____ **Email:** _____

Pharmacy Name: _____ **Phone #:** _____

Emergency Contact: _____ **Relation:** _____

Phone #: _____

Primary Care Physician: _____

Is the patient in hospice or a skilled nursing facility? Y / N

Primary Insurance : _____ **ID#** _____

Policy Holder's Name: _____ DOB: _____

Secondary Insurance: _____ **ID#** _____

Policy Holder's Name: _____ DOB: _____

CONSENT TO TREATMENT: I voluntarily consent to receive medical and health care services provided by EyeCare Associates of Texas, P.A. physicians, employees and such associates, assistants, and other health care providers as my physicians deem necessary. I understand that such services may include diagnostic procedures, 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 EyeCare Associates of Texas, P.A.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 payable to me, payable to the providers of EyeCare Associates of Texas, P.A.. I also authorize direct payments to be made by Medicare/Medicaid and/or my insurance company or other third party payer, up to the total amount of my medical and health care charges, to the providers of EyeCare Associates of Texas, P.A. 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 payor and agree to make payment as requested by EyeCare Associates of Texas, P.A..

_____

Patient/Other Legally Authorized Signee

_____ _____

Printed Name and Relationship to Patient **Date**

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POLICY REGARDING REFRACTION AND ROUTINE EYE EXAMS

Refraction is the process of measuring the eye's need for glasses or other corrective lenses (also called the eye's refractive error). **Medicare and most health insurance plans do not cover this service and therefore, the patient is responsible for this charge, in addition to any co-pays or deductibles.** The refraction is performed during a complete exam and this portion of the exam is billed separately. If performed, the for the refraction is **$50**. In the absence of a medical condition, Medicare and most health insurance plans consider an eye exam to be routine and not a covered service. Charges for routine eye exams are the responsibility of the patient and should be paid in full at the time of service.

If you want an updated glasses or contact lens prescription we must perform a refraction today.

_____ Yes, I wish to have a refraction performed today and understand I will owe $50

_____No, I do not want to have the refraction performed today.

_____ _____
Signature **Date**

Are you currently wearing contact lenses? Y / N

- ******If yes please be prepared to pay an additional $25 Fee to update your contact lens prescription******

RELEASE OF MEDICAL INFORMATION AUTHORIZATION

Please list any persons who you give permission to EyeCare Associates of Texas to disclose protected health information, appointment scheduling, or financial account information (i.e. spouse, child, friend, parent)

Name: _____Relationship:_____

Name: _____Relationship:_____

May we leave you a message at your residence? **YES NO**

In order to facilitate and coordinate care with your physicians, EyeCare Associates will electronically access your medication history.

I have been given the opportunity to read and review EyeCare Associates Notices of Privacy Practices.

_____ _____
Signature **Date**

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Payment and Treatment Policies

Our office files your insurance as a courtesy. Your copay and/or deductible are due at the time of your visit.

Insurance – Insurance card and driver's license must be presented prior to each office visit in order to utilize benefits. Please notify our office if there is a change in your insurance plan or coverage. We file claims as a courtesy to our patients and are only responsible for filing claims to contracted insurance carriers. Any dispute for unpaid charges from the insurance company will be billed directly to the patient and due upon receipt of a statement from our office.

If your insurance company requires you to have a referral for your visit you must contact your primary care doctor at least 7 days in advance of your appointment and call our office 1 day prior to your appointment to be sure we have received the necessary documentation.

Paperwork - You are required to update paperwork annually. If you have not been seen by one of our physicians within the last 6 months, or come in with a new problem, you will be asked to update your information. This allows us to keep your medical record up to date so that we may provide quality care.

Payment – Full payment is due at the time services are rendered unless other payment arrangements have been made with our billing department prior to your visit.

Medication Refills – Prescription refill requests are required to be called into your pharmacy at least 5 days prior to running out of your medication to allow adequate time for approval. Refills will only be handled during normal business hours Monday through Friday. Please contact your pharmacy for refill requests.

Appointment Reminders – You will receive a reminder call/text from our office 2 days prior to your scheduled appointment and an email confirmation one week prior if your email is on file. Please confirm your appointment with this system if you are able to do so.

After Hours – Our phone message will provide you with instructions to reach the physician on call. This service is to be utilized in emergency situations only. Refill requests or routine requests for appointments will not be returned until the next business day by a staff member.

NSF Checks – A $25 fee will be added to your account for all returned checks.

Minor Patients - For all services rendered to patients age 17 or younger we will look to the adult accompanying the patient for payment. All minors must have written consent from the parent/guardian in order for us to provide treatment.

Thank you for your business and we look forward to providing you quality eye care.