Cornea Associates of Texas

Celebrating 30 Years
www.corneatexas.com

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Dear Patient,

Thank you for choosing Cornea Associates of Texas. With over 30 years of service in the DFW area, our practice specializes in providing corneal treatment options, vision correction services and a commitment to quality patient care. As part of our commitment, we want to provide you with a few suggestions to enhance the productivity of your first visit to our practice.

- **Please complete the paperwork enclosed in this packet.**
- **Bring a current list of all medications you are taking, including systemic.** Please identify the condition for which you are taking each medication.
- **Bring all insurance cards.** We must have an actual copy of all insurance card(s), in order to bill your visit to insurance; including Medicare, Medicaid, Medicare Replacement Plans and/or commercial insurance cards such as PPO or HMO plans.
- **Bring any necessary insurance referrals.** If you are on an HMO plan or another plan which requires a referral, please request that referral from your primary care provider. To ensure that your appointment is not delayed, contact our insurance department directly at 214.692.0146 and confirm that we have received your referral.
- **Please bring prior medical records related to your current eye care needs**.
- **Potential Surgical Candidates:** Some of the tests we perform require you to remove your contact lenses for two weeks in order to obtain the most accurate results. If you are able to function in your glasses, it is preferable that you remove contacts for two weeks prior to your appointment. It is also likely that you will be dilated at your office visit. Please arrange for transportation if you are not comfortable driving after dilation. **If your surgery is scheduled more than 90 days after your exam, you will need to return for a repeat exam and testing**
- **Translators:** We are proud of the fact that we have team members fluent in both English and Spanish at both locations. However we still recommend that you invite someone to attend your appointment to ensure you receive and understand all of the information you are given. We are unable to guarantee the presence of a bilingual team member at each visit.

The Health Insurance Portability Accountability Act (HIPAA) requires our practice to notify all patients of our protected health information practices. This enclosed notice describes how your medical information may be disclosed and how you can gain access to your medical information. You will be asked to sign an acknowledgement (also enclosed) stating that you have had an opportunity to review our HIPAA policy.

To assist in your appointment planning, please be aware that our New Patient evaluation can last 1½ to 2½ hours. This is particularly common for a potential surgical candidate. We allow time for a thorough evaluation by our physician, time for necessary testing and we allow time for a meeting with one of our surgical counselors.

We look forward to your initial evaluation and by taking the steps listed above we will be able to address your needs more effectively.

Thank you for choosing Cornea Associates of Texas.

Cornea Associates of Texas

Refractive Patient Information Form

First Name: _____ MI: _____ Last Name: _____

Date of Birth: _____ Age: _____ Sex: ☐ M ☐ F Marital Status: _____

Social Security #: _____ E-mail_ _____

Mailing Address: _____
City State Zip

Home #:_____ Cell #: _____ Work #: _____

Preferred Contact Method: ☐ Home Phone ☐ Other _____

Preferred Language: ☐ English ☐ Other _____ Ethnicity*: ☐ Hispanic/Latino ☐ Other

Race*: _____

Employers Name: _____ Position: _____

Complete Address: _____

Emergency Contact: _____ Relationship: _____

Home #:_____ Cell #: _____ Work #: _____

Please describe your contact lens use (if any): ☐ Currently wearing ☐ Discontinued x _____ weeks

Type of Lenses Worn: ☐ Soft Contacts ☐ Gas Permeable/Hard Contacts ☐ Other _____

If applicable, are you currently pregnant or nursing: ☐ Yes ☐ No

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Referred By: _____ Primary Eye Doctor: _____

PLEASE READ AND SIGN BELOW

I hereby authorize the physicians and staff of **Cornea Associates of Texas** to perform or procedures necessary to assess and diagnose my condition properly and such treatments as may be prescribed by my attending physician during any and all visits to **Cornea Associates of Texas**. I understand that I am financially responsible for all charges from services rendered to me by **Cornea Associates of Texas.**

Signature: _____ Date: _____

*For more information regarding Race and Ethnicity, see Supplemental Handout.

Patient Authorization To Release Protected Health Information

I authorize Cornea Associates of Texas to release protected health information to the individual (s) listed below for the purpose of assisting with my care and /or payment.

_____	_____
Name	Relation
_____	_____
Name	Relation
_____	_____
Name	Relation

Description of the information to be used or disclosed:

- Patient's demographic information
- Patient's medical information
- Patient's billing information

I understand that this authorization will be in effect during the time period I am a patient at Cornea Associates of Texas.

I further understand that this authorization is voluntary and that my health care and the payments of my healthcare will not be affected if I do not sign this form.

I further understand that if the recipient authorized to receive the information is not a covered entity. E.g. insurance company or non-health care provider; the released information may no longer be protected by federal and state privacy regulations.

I further understand that I may revoke this authorization at any time by notifying Cornea Associates of Texas in writing at 10740 *N. Central Expressway Suite 350, Dallas, Texas 75231*. I also understand written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

_____	_____
Signature of Patient or Patient's Representative	Today's Date

CONSENT

TO THE USE AND /OR DISCLOSURE OF PROTECTED INFORMATION HEALTH INFORMATION FOR TREATMENT, PAYMENT, HEALTH CARE OPERATIONS, AND AS OTHERWISE ALLOWED BY LAW

Cornea Associates of Texas (hereinafter referred to as "Cornea Associates") will maintain a record of the care and services you receive at Cornea Associates. This consent only covers your protected health information created while you are a patient of Cornea Associates. Your protected health information pertains to your diagnosis and/or treatment at Cornea Associates, including, but not limited to information concerning mental illness (except for psychotherapy notes), use of alcohol or drugs or communicable diseases such as Human Immunodeficiency Virus ("HIV"), and Acquired Immune Deficiency Syndrome ("AIDS"), laboratory test results, medical history, treatment progress or any other such related information.

By signing this form, you consent Cornea Associates' use and/or disclosure of protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. Our *Notice of Protected Health Information Practices,* provides information about how Cornea Associates and its physicians may use and/or disclose protected health information about you for treatment, payment, healthcare operations and as otherwise allowed by law. **By signing this form, you also acknowledge that you have received a copy Cornea Associates' Notice of Protected Health Information Practices and an opportunity to review it before signing this consent.**

_____ _____

Signature of Patient or Legal Representative Witness

_____

Date

Cornea Associates of Texas

Date _____ Patient Name _____ DOB _____

Preferred pharmacy: _____ Address: _____

Preferred pharmacy phone number: _____

Eye: ☐ Right ☐ Left ☐ Both

Reason for exam (symptoms): _____

Do you normally wear: Glasses ☐ Yes ☐ No If yes, how old are your current glasses? _____

Do you normally wear: Contact Lenses ☐ Yes ☐ No If yes, are you wearing them today? ☐ Yes ☐ No

Drug Allergies/Reactions: ☐ Check here if you have no known drug allergies or reactions

☐ Acetaminophen ☐ Aspirin ☐ Cipro ☐ Codeine ☐ Ibuprofen ☐ Penicillin ☐ Sulfa ☐ Tramadol

☐ Other (please list) _____

LATEX allergy or reaction? ☐ Yes ☐ No If yes, please explain reaction _____

Past/Present Eye Conditions: ☐ Check here if you have no known eye conditions

Name of eye condition/diagnosis	Eye	Date Diagnosed	Treating Doctor

Prior Eye Surgeries or Procedures: ☐ Check here if you have never had any eye surgeries or procedures

Type of eye surgery/procedure	Eye	Date	Doctor

Eye Medications (include prescription and over the counter): ☐ Check here if you are not currently taking any eye medications

Eye Medication Name	Dosage	Eye	Date Started

Non Eye Medications: (include prescription, over-the-counter and vitamins) ☐ Check here if you are not currently taking any medications

Medication Name	Reason Using

Medication Name	Reason Using

Patient Name_____ DOB _____

Medical History: Have you EVER been diagnosed with any of the following?

☐Yes ☐No Hearing Loss	☐Yes ☐No Urinary Incontinence	☐Yes ☐No Depression
☐Yes ☐No High Blood Pressure	☐Yes ☐No Arthritis	☐Yes ☐No Diabetes
☐Yes ☐No High Cholesterol	☐Yes ☐No Rheumatoid Arthritis	☐Yes ☐No Thyroid Disorder
☐Yes ☐No Congestive Heart Failure	☐Yes ☐No Osteoporosis	☐Yes ☐No Anemia
☐Yes ☐No Heart Attack	☐Yes ☐No Rosacea	☐Yes ☐No Allergies
☐Yes ☐No Irregular/Fast Heartbeat	☐Yes ☐No Eczema	☐Yes ☐No Lupus
☐Yes ☐No Atrial fibrillation	☐Yes ☐No Migraine Headaches	☐Yes ☐No Sjogrens
☐Yes ☐No Asthma	☐Yes ☐No Multiple Sclerosis	☐Yes ☐No Tuberculosis
☐Yes ☐No Emphysema	☐Yes ☐No Parkinson's	☐Yes ☐No HIV
☐Yes ☐No Acid Reflux	☐Yes ☐No Alzheimer's	☐Yes ☐No Cancer; Type:
☐Yes ☐No Stomach Ulcers	☐Yes ☐No Stroke/paralysis	☐Yes ☐No Currently Pregnant or Nursing
☐Yes ☐No Hiatal Hernia	☐Yes ☐No Seizure Disorder	☐Other:
☐Yes ☐No Prostate Disorder	☐Yes ☐No Anxiety	

Past Surgical History: please list all prior surgeries (other than eye) ☐ Check here if you have not had any previous surgeries

_____

_____

Review Of Systems: Do you CURRENTLY have any problems in the following areas?

Constitutional Symptoms	Metabolic/Endocrine	Neurological
☐Yes ☐No Fatigue	☐Yes ☐No Cold intolerance	☐Yes ☐No Dizziness
☐Yes ☐No Fever	☐Yes ☐No Heat intolerance	☐Yes ☐No Headaches
☐Yes ☐No Night Sweats	☐Yes ☐No Polydipsia (excessive thirst)	Other
Other	☐Yes ☐No Polyphagia (excessive hunger)	Hematologic/Lymphatic
Head, Ears, Nose and Throat	☐Yes ☐No Polyuria (frequent urination)	☐Yes ☐No Bleeding
☐Yes ☐No Hearing loss	Other	☐Yes ☐No Bruising
Other	Integumentary (Skin)	Other
Respiratory (Lungs/Breathing)	☐Yes ☐No Rash	Allergic/Immunologic
☐Yes ☐No Cough	Other	☐Yes ☐No Environmental allergies
☐Yes ☐No Wheezing	Gastrointestinal (Stomach/Intestines)	☐Yes ☐No Food allergies
Other	☐Yes ☐No Constipation	☐Yes ☐No Recurrent infections
Cardiovascular	☐Yes ☐No Diarrhea	Other
☐Yes ☐No Chest pressure or discomfort	☐Yes ☐No Vomiting	Musculoskeletal
☐Yes ☐No Irregular heartbeat/palpitations	Other	☐Yes ☐No Arthralgia (joint pain)
Other	Psychiatric	☐Yes ☐No Joint swelling
Genitourinary (Genitals/Kidney/Bladder)	☐Yes ☐No Emotional changes	☐Yes ☐No Muscle weakness
☐Yes ☐No Dysuria (painful urination)	☐Yes ☐No Disorientation	Other
☐Yes ☐No Hematuria (blood in urine)	Other	
Other		

Family History: ☐ Check here if you do not have any relevant family history

Eye Diseases	Relationship To Patient	Medical Conditions	Relationship To Patient	Medical Conditions	Relationship To Patient
☐ Amblyopia		☐ Arthritis		☐ Cancer	
☐ Fuch's Dystrophy		☐ Asthma		Type of cancer:	
☐ Keratoconus		☐ Diabetes			
☐ Glaucoma		☐ Heart Attack			
☐ Macular Degeneration		☐ High Blood Pressure			
☐ Retinal Detachment		☐ Stroke			

Patient Name_____ DOB _____

Social History:

Smoking/Tobacco Use (please mark one)
☐ Never smoked/used tobacco ☐ Current some day smoker ☐ Current every day smoker ☐ Current heavy smoker ☐ Former Smoker ☐ Unknown
Alcohol Use (please mark yes or no)
Do you drink alcohol? ☐ Yes ☐ No If yes, how often? ☐ Occasional ☐ 1 drink/day ☐ 2-3 drinks/day ☐ 4+ drinks/day
Recreational Drug Use (please mark yes or no)
Do you use recreational drugs? ☐ Yes ☐ No If yes, what type? How often?
Caffeine Use (please mark yes or no)
Do you use caffeine? ☐ Yes ☐ No If yes, how often? ☐ Occasional ☐ 1/day ☐ 2-3/day ☐ 4+/day

Height/Weight: what is your current height and weight? Height ____ft _____in Weight _____lbs

Lifestyle:

The following questions will help us provide you with a customized treatment solution based on your visual needs and lifestyle

Current Living Arrangements (please mark one)
☐ Alone ☐ With Family ☐ Assisted Living ☐ Nursing Home ☐ Other
Fall History
Have you fallen in the past year? ☐ Yes ☐ No If yes, how many times? Did any fall result in an injury? ☐ Yes ☐ No
Occupation
What is your current occupation?
If you work, what are some of your daily work-related tasks?
Vision Correction
If you currently wear glasses for which activities to you need them? ☐ Near (Reading) ☐ Intermediate (Computer) ☐ Distance (TV)
If you currently wear contacts for which activities to you need them? ☐ Near (Reading) ☐ Intermediate (Computer) ☐ Distance (TV)
Motivation
Please explain why are you considering having a refractive procedure?
Expectations
Please list what you are hoping to achieve by having a refractive procedure?
Hobbies (please list some of your favorite hobbies)
Personality
Which selection best describes your personality? ☐ Easy Going ☐ In Between ☐ Perfectionist

Name of person completing this form:(if other than patient) _____

Relationship to patient: ☐ Parent/Guardian ☐ Spouse ☐ Technician ☐ Other _____

Patient Signature_____ Date_____

CORNEA ASSOCIATES OF TEXAS

PATIENT FINANCIAL AGREEMENT

☐ INSURANCE ASSIGNMENT AND PATIENT RESPONSIBILITY

The person signing below agrees, whether he/she signs as 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 the Cornea Associates of Texas at the regular rates and terms of Cornea Associates of Texas. 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 Cornea Associates of Texas for whom Cornea Associates of Texas is authorized to bill. I understand that I am responsible for any health insurance deductibles, coinsurance and non-covered 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 certify that the information given by me in 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 any information needed, for this or related Medicare claims. I request that payment of authorized benefits be made on my behalf."

ASSIGNMENT OF BENEFITS:

In consideration of services rendered, I hereby assign to Cornea Associates of Texas, and/or any physician who has 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 any balance due, including co-insurance and co-payment amounts, not paid by the insurance company or companies.

Relationship to Patient: ☐ Self ☐ Child ☐ Dependent ☐ Other _____

_____	_____	_____
Printed Name	Signature	Date
_____	_____	_____
Printed Name of Witness	Signature of Witness	Date

Cornea Associates of Texas

Cornea Associates of Texas is currently implementing processes to comply with the new federal Electronic Medical Records, meaningful use requirements. The purpose of collecting this information is to ensure that all patients receive high-quality healthcare. We would like for you to provide us with your race and ethnic background. We will only use this information to ensure all patients receive the best care available and to comply with current and future federal requirements.

Ethnicity: There are two ethnic groups as define by the US. Census, list the option that best describes your Ethnicity.

- Hispanic/Latino
- Not Hispanic/Latino

Race: Following are the standard choices, list the choice that best describes your Race.

- American Indian or Alaska Native
- Black or African American
- White
- Multiracial
- Asian (Includes Pakistan or Indian origins)
- Native Hawaiian or Other Pacific Islander
- Decline

Language: What language do you feel most comfortable speaking with your doctor or nurse?

- English
- Spanish
- Vietnamese
- Chinese
- German
- French
- Hindi
- Korean
- Tagalog
- Sign Language or other Auxillary Aid/Service
- Do Not Know
- Decline
- Other

CORNEA ASSOCIATES OF TEXAS
NOTICE OF PROTECTED HEALTH INFORMATION PRACTICES

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.

Understanding Your Health Record/ Information

This notice describes the practices of Cornea Associates of Texas (hereinafter "Cornea Associates") and that of its physicians with respect to your protected health information created while you are a patient at Cornea Associates. Physicians and personnel of Cornea Associates authorized to have access to your medical chart are subject to this notice. In addition, physicians of Cornea Associates may share medical information with each other for treatment, payment or health care operations described in this notice.

We create a record of the care and services you receive at Cornea Associates. We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. This notice applies to all of the records of your care at Cornea Associates.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

Your Health Information Rights

Although your health record is the physical property of Cornea Associates, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information for treatment, payment, health care operations and as to disclosures permitted to persons, including family members involved with your care and as provided by law. However, we are not required by law to agree to a requested restriction;
- Obtain a paper copy of this notice of protected health information practices;
- Inspect and request a copy of your health record as provided by law;
- Request that we amend your health record as provided by law. We will notify you if we are unable to grant your request to amend your health record;
- Obtain an accounting of disclosures of your health information as provided by law;
- Request communication of your health information by alternative means or at alternative locations. We will accommodate reasonable requests; and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken in reliance on your authorization.

You may exercise your rights set forth in this notice by providing a written request, except for requests to obtain a paper copy of the notice, to the Cornea Associates' Privacy Officer at 10740 N. Central Expressway, Suite 350; Dallas, Texas 75231.

Our Responsibilities

In addition to the responsibilities set forth above, we are also required to:

- Maintain the privacy of your health information;
- Provide you with a notice as to our legal duties and privacy practices with respect to information we maintain about you;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction on certain uses and disclosures;
- We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain, including information created or received before the change. Should our information practices change we are not required to notify you, but we will have the revised notice available for you to request at any Cornea Associates' location. The revised notice will also be posted at our offices and on the Cornea Associates' web page at www.CorneaTexas.com; and
- We will not use or disclose your health information without your written authorization, except as described in this notice.

Examples of Disclosures for Treatment, Payment, Health Care Operations and As Otherwise Allowed By Law.

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information should fall within one of the categories.

We will use your health information for treatment.

For example: We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at Cornea Associates. We may share medical information about you in order to coordinate different treatments, such as prescriptions, lab work and x-rays. We may also provide your physician or a subsequent health-care provider with copies of various reports to assist in treating you once you are discharged from care at Cornea Associates.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health care operations.

For example: We may use the information in your health record to assess the care and outcome in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and services we provide.

We will use your health information as otherwise allowed by law. The following are some examples of how we may use or disclose medical information about you.

Business associates: There are some services provided in our organization through agreements with business associates. Examples include answering services and copy services. To protect your health information, however, we require business associates to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to protect the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Communications for treatment and health care operations: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, medications, devices, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Worker's compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse, neglect or domestic violence: As required by law, we may disclose health information to a governmental authority authorized by law to receive reports of abuse, neglect, or domestic violence.

Judicial, administrative and law enforcement purposes: Consistent with applicable law, we may disclose health information about you for judicial, administrative and law enforcement purposes.

Required or allowed by law: We will disclose medical information about you when required or allowed to do so by federal, state or local law.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact Cornea Associates' Privacy Officer at Metro (214) 692-0146.

If you believe your privacy rights have been violated, you can file a complaint with Cornea Associates' Privacy Officer or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

EFFECTIVE DATE: 04/01/03
VERSION: 1

Print Document