Patient Information

Morris Neel, O.D. P.A. 8329 Whitley Rd, Watauga, TX 76148 817-431-2020 Tiffaney Tregellas, O.D.
Emily Horn, O.D.

PLEASE FILL OUT COMPLETELY

□ Mr. □ Dr. □ Mrs. □ Ms. □ Miss Name____ Date ______________________

Nickname ___________________________________ Birth Date _________________________ Age _____________________

Preferred Language ______________________________________ Race ____

Address _________________________________ City _____________________________ State _____ Zip ________________

***Please indicate your preferred contact number with a star** *

____________________________ ________________________________ _________________________ Texting OK □
Home Phone Day Phone Cell Phone

Email address ____ Preferred Method of Contact ______________________

Patient Status □ Single □ Married Other _____________ Employment Status □ F/T □ P/T Other _________________

Occupation:____ Referred by:_____________________________________

Primary Care Physician ____ Phone_____________________________________

If you have any questions regarding your insurance or fees for today's visit please speak with office staff.

Please check all that apply:

□ Allergies
□ Anemia
□ Arthritis
□ Asthma
□ Bleeding Problems
□ Cancer
□ Chronic Bronchitis
□ Chronic Cough
□ Constipation
□ Diabetes
□ Diarrhea
□ Dry Throat/Mouth
□ Emphysema
□ Fever
□ Genitals/Kidney/Bladder
□ Headaches
□ Heart Disease
□ High Cholesterol
□ High Blood pressure
□ Joint Pain
□ Kidney Disease
□ Lupus
□ Migraines
□ Muscle Pain
□ Post-Nasal Drip
□ Rheumatoid Arthritis
□ Runny Nose
□ Seizures
□ Sinus Congestion
□ Stroke
□ Thyroid
□ Vascular Disease
□ Weight Loss/Gain

□ Blindness
□ Blurred Vision
□ Burning
□ Cataract
□ Chronic Infection of Eyelid
□ Crossed Eyes
□ Distorted Vision/Halos
□ Double Vision
□ Dryness
□ Excess Tearing/Watering
□ Eye Pain or Soreness
□ Flashes of Light
□ Floaters in Vision
□ Foreign Body Sensation
□ Glare/Light Sensitivity
□ Glaucoma
□ Itching
□ Loss of Side Vision
□ Loss of Vision
□ Macular Degeneration
□ Mucous Discharge
□ Redness
□ Retinal Detachment
□ Sandy or Gritty Feeling
□ Sties or Chalazion
□ Tired Eyes

List all major surgeries you have had ______________________________

List ***any*** medications you take (including over the counter): ______________________________

____

Do you have any allergies to medications? □ No □ Yes ______________________________

Do you have any other allergies? □ No □ Yes ______________________________

Please list any eye conditions you may have: ______________________________

Do you drive? □ No □ Yes If yes, do you have difficulty when driving? □ No □ Yes

Do you wear glasses? □ No □ Yes If yes, how old is your current pair of lenses? ______________________________

Do you wear contacts? □ No □ Yes If yes, how old is your present pair of lenses? ______________________________

Type of contact lenses: □ Rigid □ Soft □ Extended Wear Are they comfortable? □ No □ Yes

Are you interested in Lasik through this office? □ Yes □ No

Have you had: □ Lasik Surgery □ PRK Surgery □ RK Surgery □ Cataract Surgery

Family History

Please mark any family history (living or deceased) for the following conditions:

	Mother	Father	Sister	Brother	Grandmother		Grandfather		Aunt	Uncle
					Mat. /	Pat.	Mat. /	Pat.		
Disease/Condition										
Blindness										
Cataract										
Crossed Eyes										
Glaucoma										
Macular Degeneration										
Retinal Detachment/Disease										
Arthritis										
Cancer										
Diabetes										
Heart Disease										
High Blood Pressure										
Kidney Disease										
Lupus										
Thyroid Disease										
Other										

What is your height? ______________________ Current Weight? ______________________

Do you use tobacco products? □ No □ Yes Have you in the past? □ No □ Yes If yes, how long ago? ____________

Do you drink alcohol? □ No □ Social Use Only If more how many weekly?__________________

Do you use illegal drugs? □ No □ Yes _______________

iWellness Exam

Dr. Neel, Dr. Tregellas and Dr. Horn have incorporated the iWellness Exam TM SD-OCT as a supplement to their comprehensive eye exam.

As part of your pre-examination work up, our technician will perform the iWellness Exam, which your doctor will review with you during your examination today. The results of this screening will become part of your permanent record. Early detection of sight threatening diseases such as glaucoma, macular degeneration, and diabetes is crucial as there are no outward signs of symptoms in early stages. We highly recommend this Scanning Laser be performed if you have any of the following:

Headaches Diabetes High Blood Pressure Circulatory Problems
Family History of Glaucoma/Macular Degeneration Strong Eyeglass Prescription
History of Head Trauma Spots or Flashes of Light

This procedure is typically not covered by your medical or vision insurance unless being used to actively follow disease. This cost will be added into the price of your visit today. Any questions you have about these tests can be discussed with your doctor. The iWellness Exam is an eligible expense for Flexible Spending Accounts.

The fee for this routine screening is $39.

_______Discuss with doctor _______Yes, I want this screening ___________No, I do not want this screening

Date:_______________________

Visual Field Examination

A visual field instrument is a sophisticated machine that uses a computer to electronically test the functioning of the retina, optic nerve and the part of the brain used for seeing. It provides additional information we have no other way of obtaining. This allows us to provide a more thorough medical evaluation of your eyes and can assist in the detection of many disorders. We strongly recommend that all patients receive the “screening” version of this exam, especially those with any of the following:

Family history of high cholesterol, high blood pressure, diabetes, retinal detachment/tear, glaucoma, brain tumors, floaters, flashes of light and macular degeneration.

The fee for this routine screening is $29.

_______Discuss with doctor _______Yes, I want this screening ___________No, I do not want this screening

Date:_______________________

*If both of these screeners are done there is a discounted fee of $54.

**Be aware these are for screening purposes only. If there is a medical reason to perform a more detailed test we *may* be able to file on your medical insurance.

We provide both vision and medical services. If you have any questions regarding INSURANCE, DIABETIC EXAMS, MEDICAL ISSUES and/or TESTING, CONTACT LENS EXAM and FITTING FEES; PLEASE ASK NOW.
Any of the above may require additional fees or for us to file on your medical insurance.

Morris Neel O.D. and Associates

Financial Agreement / Signature on File

* In signing this statement I agree to be financially responsible for all charges for this and all subsequent office visits.

* $30 will be billed for returned checks.

* Accounts will be considered past due 60 days from the date a service is billed. In the event that your account is turned over to collections, a fee equal to the amount charged by the collections agency will be assessed.

* If you must cancel, please provide 24 hour notice. Cancellations with less than 24 hour notice or "no show" appointments are subject to a $25 fee. These charges will be billed to you, not your insurance.

INSURANCE

* I hereby authorize payment directly to Morris Neel O.D. and Associates for services and materials.

* I authorize the release of medical information to the appropriate agencies, for the purpose of billing, any information acquired during the course of my examination.

* Insurance is a contract between you, your employer, and the insurance company. We are not a party to this contract. It is your responsibility to be aware of plan benefits and your rights to appeal claims.

* Insurance contracts vary greatly; in-network and out-of-network providers are often covered at different levels. It is your responsibility to know your benefits; we recommend you contact your employer or insurance company directly for the most accurate information. However, we will do our best to assist with your insurance coverage information and questions.

* If your insurance is through the Texas Health Marketplace and your insurance does not pay at the end of the three month grace period, you are responsible for payment in full.

* If you have an HMO or plan that requires a referral, you are responsible for bringing a current referral to each visit.

* As a courtesy we will electronically file your primary insurance claim on your behalf. If you are covered by a secondary plan, we will be happy to provide forms to enable you to file your secondary insurance.

* In the event insurance denies a claim, it is your responsibility to pursue action with the carrier.

* I understand the fees quoted for services rendered are an ***ESTIMATE ONLY*** AND NOT A GUARANTEE OF PAYMENT BY MY INSURANCE COMPANY.

Patient Name Printed: ____

Patient/Guardian Signature: ____________________ Date: ________________

Patient Acknowledgment of Receipt of Privacy Practices Notice

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities and heath care operations. Upon request, we can issue a copy of this policy.
By signing this form, you will consent to our use and disclosure of your protected health information to only carry out treatment, payment activities and submission of insurance.
Due to the Privacy Laws please list family members we can disclose your private health information to:

____ ____

____ ____

I hereby acknowledge that I have reviewed and received a copy of this office's *Notice of Privacy Practices* explaining:

- How this office will use and disclose my protected health information.
- My privacy rights with regard to my protect health information.
- This office's obligations concerning the use and disclosure of my protected health information.

I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of any revised *Notice of Privacy Practices* upon request.

I also understand that if I have any complaints, I may contact: **Morris Neel, O.D. & Associates 817-431-2020**

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

Patient or Personal Representative

Signature ____ Date __________________________

Name:____
Please Print

Relationship to Patient:____

*****For Office Use Only*****

We made a good-faith effort to obtain an acknowledgement of ___________________________________'s receipt of our Notice of Privacy Practices. In spite of these efforts, our office has been unable to obtain a signed acknowledgement of receipt for the following reasons:

❑Patient refused to sign on _______________________
❑Communication barriers prohibited obtaining an acknowledgement.
❑An emergency situation prevented us from obtaining an acknowledgement.

Attempt was made by ____ Date _________________________