Patient Questionnaire

PLEASE PRINT AND FILL OUT COMPLETELY

Mr. Mrs. Miss. Ms. Dr. M F DOB_____ Age_____ Today's Date_____

_____ _____ _____

First Name Last Name Preferred Name

_____

Street Address City State Zip

Email Address _____

Please indicate your preferred number with a star

_____ _____ _____ Texting Ok ☐

Home Phone Day Phone Cell Phone

_____ _____

Primary Care Physician (First and Last Name) Phone Number

Social History

Do you currently use tobacco products? No Yes Have you used them in the past? No Yes_____

Do you drink alcohol? No Social Use Only If more, how many weekly? _____

Do you use illegal drugs? No Yes_____

What is your height? _____ Current Weight? _____

Medical History

Do you have any allergies to medications? No Yes _____

List any medications you are taking (including over the counter) _____

_____

List any changes in your medical history and surgeries you have had since your last visit _____

_____

List any eye symptoms you are having today _____

_____

iWellness Exam

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

Early detection of sight threatening diseases 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 Spots or Flashes of Light
Family History of Glaucoma/Macular Degeneration Strong Eyeglass Prescription History of Head Trauma

The results of this screening will become part of your permanent record and the procedure is not covered by insurance. 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

Visual Field Examination

The visual field instrument 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, allowing us to provide a more thorough medical evaluation of your eyes and assisting 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 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

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/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 _____