Date: _____ Doctor: _____ Chart#: _____

Welcome to Houston Eye Associates. So that we can most effectively meet your needs, please complete all the information below.

HOW DID YOU LEARN ABOUT HOUSTON EYE ASSOCIATES?

Referral was by:

Physician _____

Optometrist _____

Patient _____

Other _____

Please provide their name & address so we can thank them:

_____
Name

_____
Address Phone

_____
City State Zip

PATIENT INFORMATION

Mr.___ Mrs.___ Other___

Name _____
First Middle Last

Address _____
Street City State Zip

Home Phone_____ Work Phone_____ Cell Phone _____

Soc Sec#_____Date of Birth_____/_____/_____Sex Male /Female

Marital Status__ Single__ Married__ Divorced __Widowed _____

Family doctor Name/Address _____ Phone _____

E-mail address:_____

In the future may we confidentially communicate with you through this email address? _ Y _ N

Emergency Contact Name_____Phone_____

PARENT / GUARDIAN INFORMATION (if patient is a MINOR)

Parent / Guardian's Name _____
First Middle Last

Address _____
Street City State Zip

Home Phone_____ Work Phone_____ Cell Phone _____

Soc Sec# _____ DOB_____Relationship to Patient:Child _____ Other _____

Other Parent / Guardian's Name _____
First Middle Last

Address _____
Street City State Zip

Home Phone_____Work Phone_____Cell Phone_____

RESPONSIBLE PARTY (if different from above)

Contact Person_____
First Middle Last

Address _____
Street City State Zip

Employer/Company/Agency Name_____ Phone_____

Houston Eye Associates

Notice of Payment Policies and Procedures

PAYMENT POLICY: It is customary to pay for professional services when rendered. For your convenience we accept major credit cards, checks or cash.

INSURANCE: Please read and sign below if you have insurance with: Medicare, Medicaid, an HMO/PPO/POS or State Agency or Worker's Comp, and the Physician is contracted with your carrier. Present your insurance card along with any required referrals/authorizations to the Receptionist/Registrar.

MEDICAL / SURGICAL BENEFITS ASSIGNMENT AND RELEASE OF MEDICAL BENEFITS INFORMATION AGREEMENT: I request payment of my authorized insurance benefits be made for charges on my behalf to Houston Eye Associates for any unpaid medical / surgical procedures performed now or in the future. I also authorize Houston Eye Associate to release medical information to my insurance company (ies) or agent, now or in the future, for claim consideration purposes. I understand that payment for services does ultimately remain my responsibility.

NON-COVERED SERVICES: The filing of a claim for any service rendered DOES NOT GUARANTEE PAYMENT from your insurance company. You will be financially responsible for these services. Also, having more than one insurer DOES NOT necessarily mean that your services are covered 100%. Secondary insurers will pay as a function of what your primary carrier pays. We may bill your secondary as a courtesy. You are responsible for any balances after your insurance(s) has cleared.

DIVORCE DECREES: This office is NOT a party to your divorce decree. Adult patients are responsible for their bill at the time of service. The responsibility for minors rests with the accompanying adult.

MINOR PATIENTS: For unaccompanied minors,non-emergency treatment will be denied unless charges have been pre-authorized to an approved Credit Card, or payment by cash or check at the time of service has been verified.

EYE EXAM: I agree to and understand that my eye(s) must be dilated in order for the doctor to thoroughly check the retina of the eye. I agree to and understand that my eye may need to be patched as part of the treatment of my condition. I understand that if my pupils are dilated or my eye is patched after the exam, I may not be able to safely operate a motor vehicle and that the staff and doctors of Houston Eye Associates suggest that I evaluate my need for alternative transportation and the decision is solely mine, therefore I will not hold Houston Eye Associates responsible.

The contents of this document will remain in effect unless revoked by me in writing.

Name of Patient (Print)	Name of Witness (Print)
Signature of Patient	Signature of Witness
Date	Date
Signature of Patient Representative	
Relationship of Patient Representative to Patient	

HOUSTON EYE ASSOCIATES
NOTICE OF PRIVACY PRACTICES

1. **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.** This page briefly summarizes how we handle your health information, and the pamphlet provides further details of our privacy policies and procedures.

2. **How we may use and disclose your health information.** We use health information about you for treatment, to get paid for treatment, for administrative purposes, and to evaluate the quality of care that you receive. For example, your health information may be shared with other providers to whom you are referred. Information may be shared by paper, mail, electronic mail, fax, or other methods. We may use or disclose your health information without your authorization for several reasons. If you sign an authorization to disclose information, you can later revoke it to stop any future disclosures.

3. **Your rights.** In most cases, you have the right to look at or get a copy of your health information that we use to make decisions about you. You may request that we limit disclosure to family members, other relatives, caregivers, or close personal friends who may or may not be involved in your care. If you request copies, we may charge you a cost-based fee. You also have the right to request a list of certain types of disclosures of your information that we have made. If you believe that your health information is incorrect or information is missing, you have the right to request that we correct the existing information or add the missing information.

4. **Our legal duty.** We are required by law to protect the privacy of your health information, provide this notice about our privacy practices, follow the privacy practices that are described in this notice, and seek your acknowledgement of receipt of this notice. We may change our privacy policies any time. Before we make a significant change in our policies, we will change our notice. The notice will be prominently displayed at all HEA locations and on our website. You can also request a copy of our notice at any time. For more information about our privacy policies, contact our privacy officer.

5. **Privacy complaints.** If you are concerned that we have violated your privacy rights, our privacy policies, or if you disagree with a decision we made about access to your health information, you may contact our privacy officer. You may send a written complaint to the U.S. Department of Health and Human Services. Our privacy officer can provide you with the appropriate address upon request.

If **you have any questions or complaints, please contact:** Houston Eye Associates, Privacy Officer, 7155 Old Katy Rd., Suite# NlO0, Houston, Texas 77024. Phone number: (713) 558-8755.

Acknowledgement of receipt of Notice of Privacy Practices: Please sign and print your name and provide the date below to acknowledge that you have received the Notice of Privacy Practices.

Signature:_____

Printed Name: _____ Date: _____

HOUSTON EYE ASSOCIATES PATIENT HISTORY RECORD

Name: _____ Date: _____ No.: _____

MEDICAL HISTORY: Please answer the following questions; (Circle NO or YES)

1. Have you ever had any eye disease (e.g. glaucoma, cataract, retinal detachment, "lazy" eye, etc.)?
NO YES IF YES, please list:

_____

_____

2. Have you ever had any EYE surgery (including injections and lasers)? NO YES IF YES, please list:

_____

_____

3. Have you ever been treated for any medical conditions (e.g. diabetes, high blood pressure, arthritis, infections, etc.)?
NO YES IF YES, please list:

_____

_____

4. Have you ever had any OTHER surgery? NO YES IF YES, please list:

_____

_____

5. Have you ever been hospitalized?
NO YES IF YES, please provide date and reason:

_____

_____

6. Do you take any EYE medications? NO YES IF YES, please list with dosage:

_____

7. Do you take any OTHER medications? NO YES IF YES, please list with dosage:

_____

_____

_____

_____

8. Do you have any drug or food allergies or sensitivities? NO YES IF YES, please list:

_____

_____

FAMILY HISTORY:

Do any medical or eye diseases run in your family (e.g. diabetes, high blood pressure, cancer, glaucoma, macular degeneration, etc.)? NO YES IF YES, please list:

_____

SOCIAL HISTORY:

_____

Do you smoke? NO YES IF YES, how much? _____

Do you drink alcohol? NO YES IF YES, how much? _____

What is your occupation? _____

Continue next page

HOUSTON EYE ASSOCIATES PATIENT HISTORY RECORD

Name: _____ Date: _____ No.: _____

REVIEW OF SYSTEMS:

Do you currently have any of the following problems: (Circle NO or YES)

Chronic fever, unexpected weight loss/gain, fatigue, night sweats?
NO YES PLEASE EXPLAIN: _____

Skin problems (e.g. rashes, excessive dryness, etc.)?
NO YES PLEASE EXPLAIN: _____

Ear/nose/throat problems (e.g. hearing loss, sinus problems, sore throat, etc.)?
NO YES PLEASE EXPLAIN: _____

Respiratory problems (e.g. shortness of breath, wheezing, coughing, etc.)?
NO YES PLEASE EXPLAIN: _____

Heart problems (e.g. chest pain, irregular heart beat, etc.)?
NO YES PLEASE EXPLAIN: _____

Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea, vomiting)?
NO YES PLEASE EXPLAIN: _____

Urinary problems (e.g. pain or discomfort, blood in urine)? _____
NO YES Do you take Flomax? NO YES PLEASE EXPLAIN: _____

Musculoskeletal problems (e.g. muscle aches, joint pain, swollen joints, etc.)?
NO YES PLEASE EXPLAIN: _____

Neurological problems (e.g. numbness, weakness, headaches, dizziness, etc.)?
NO YES PLEASE EXPLAIN: _____

Bleeding or bruising problems?
NO YES PLEASE EXPLAIN: _____

Psychiatric problems (e.g. depression, anxiety, etc.)?
NO YES PLEASE EXPLAIN: _____

Other: PLEASE LIST: _____

I verify that the information provided is complete and accurate.

PATIENT SIGNATURE: _____ DATE: _____

DATE: NAME: AGE: CHART NO:

HISTORY

Refractive surgery procedures are designed to reduce your dependence on contacts or glasses.

What are your expectations of laser surgery for vision correction? _____

Referred by? _____

Do you wear contacts? YES or NO TYPE: Gas Permeable Hard Soft

How long have you been in contacts? _____ Extended wear Daily Wear

How long have you been out of your contact lenses prior to this appointment? _____

How many hours a day are you able to wear your contacts comfortably? _____

Do you have monovision contact lenses? YES or NO

Have you had a change in your prescription in the last year? YES or NO

List any eye injuries or surgeries: _____

Do you ever wake up with eye pain?:

For Office Use Only

Allergies: IOP: OD:_____ OS: _____

VA sc OD 20/____N_____ Tear Lab: OD:_____ OS: _____

VA sc OS 20/____N _____

AR OD:_____=20/_____ OS:_____=20/_____

CAR OD:_____=20/_____ OS:_____=20/_____

Present Glasses OD:_____=20/_____ OS:_____=20/_____

Age Rx:_____

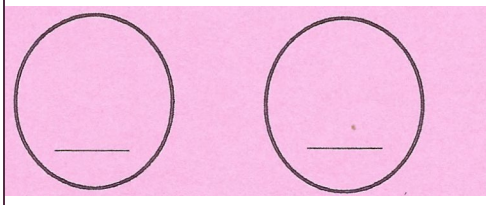
Manifest Refraction OD:_____=20/_____ OS:_____=20/_____

Time Dilated: _____

Cyclo Refraction OD: =20/_____ OS:_____=20/_____

Dominant Eye: OD or OS

Pachymetry Pupil Size OD:_____OS:_____



Slit Lamp: _____

Fundus: _____

Was Monovision discussed if patient is over 40 years? YES or No Which eye near? OD or OS

PLAN: _____

Flap Thickness:_____ FS200_____ Moria_____

Target OD:_____OS:_____ Initials _____

John Goosey, MD

Dr. Goosey provides a free LASIK Screening. During this Screening, we will check your vision prescription for stability, perform corneal topography (mapping), and pachymetry for corneal thickness. You will meet with Dr. Goosey to discuss testing results and determine your LASIK candidacy. Dr. Goosey will discuss potential risks or complications and provide a realistic assessment of how LASIK may or may not benefit you.

After your LASIK Screening, if it is determined that you are a candidate, Dr. Goosey will need to perform a Dilated eye exam before proceeding with surgery. The Dilated eye exam can be done on the same day as your Screening exam, or it can be done on another day. The cost for the Dilated exam is $200.00. Payment is expected at time of service. We will apply the Dilated exam fee towards the cost of your procedure.

Please be aware that Dr. Goosey does not file insurance for services that are not medically necessary. Dr. Goosey may be a contracted provider with your medical insurance for medical evaluations - but this does not apply to non-medically necessary services such as LASIK, PRK or LRI procedures.

I have read and accept these terms.

(Print Name) _____

(Signature) _____

(Date) _____

(Witness) _____

Office of Dr. John Goosey
Authorization and Acknowledgement
Effective January 1, 2014

Insurance Services:

- Payment of your estimated patient liability is expected at the time services are rendered. This payment will include known deductibles, copays, and coinsurance due for this visit. While we may estimate your financial responsibility, it is your insurance company that makes the final determination regarding your eligibility and benefits.
- Please be aware that certain office procedures or services may not be covered, or may be considered "not medically necessary", "experimental", or "cosmetic" by your health plan. You are responsible for payment of these services. Please also be aware that many health plans limit preventative / annual coverage. In the event your care exceeds a plan limitation, you will be responsible for the balance. It is your responsibility to know the benefits and limitations of your current health care coverage. Dr. Goosey will provide medically necessary care based on a patient's medical needs, not a patient's insurance coverage. Your physician is not responsible for knowing your plan's specific benefit and coverage limitations. Additional charges may be incurred during the course of an exam when addressing, diagnosing or treating a problem focused concern.
- Please be advised that Dr. Goosey is NOT enrolled in any vision plans.

Past Due Accounts:
If your account becomes past due we will take necessary steps to collect this debt. Accounts turned over to collection agencies may result in you being dismissed for non-payment as a patient from Dr. John Goosey's practice.

Referrals:
If you are enrolled in a managed care plan (HMO), it is your responsibility to obtain authorization from your primary care physician. Referrals must be received by our office at least 3 business days before your scheduled appointment.

Test Results:
In the event we need to relay test results to you, do you authorize our staff to leave a voice mail message at your contact numbers on file? **CIRCLE ONE:** YES or NO

Do you authorize us to discuss your test results and treatment recommendations with a family member? **CIRCLE ONE:** YES or NO

If YES, - name of authorized individual: _____

I have read and agree to the above policies.

PATIENT SIGNATURE: _____ DATE: _____

PATIENT NAME: _____ DOB: _____

Office of Dr. John Goosey
Authorization and Acknowledgement
Effective January 1, 2014

Refraction Policy Addendum:

- During your visit a refraction may be performed to determine your need for glasses or to evaluate if any further visual improvement can be achieved. This is a necessary and essential portion of your eye exam and in some cases it is the sole reason for the appointment.
- The Centers for Medicare and Medicaid Services (CMS) use a system - the Resource Based Relative Value Scale (RBRVS) - to determine the fees for all Medicare services, including the refraction. Most other insurance companies use this same system to set their payment schedules. However, the refraction is considered a NON-COVERED service by Medicare and some insurance companies.
- Please be aware it is the responsibility of the patient to pay for the refraction. Effective January 16, 2012 our office charges $98.00 for this procedure, but provides a prompt pay price of $59.00 to the patient when paid at the time of service. The refraction fee (based on the RBRVS) is in addition to both the fee for the eye exam and the patient's co-pay.
- It is Dr. Goosey's policy to perform a refraction at all yearly eye exams. Refractions are performed for a variety of reasons (other than for a glasses prescription). Refractions are also necessary to determine the health of the eye and evaluate various ophthalmic and systemic medical conditions. These factors are taken into account at each office visit and refractions are performed when necessary.
- I have read the above information and understand I may be charged a prompt pay price of $59.00 at the time of service. If billing is required, the full charge of $98.00 will be billed.

Contact Lens Policy:
The glasses prescription you receive from Houston Eye Associates is NOT a contact lens prescription. A qualified contact lens fitter must fit the contact lenses. Our Optical Department or one of your choice may fit the contact lenses. There is a fee for this service, which varies greatly depending on the type of contact lenses that are right for you, if you have been fitted before, and other individual factors. After your contact lens fitting is completed and services incurred are paid for, you will receive a copy of your contact lens specification.

Forms & Letters:
A fee of $25.00 may be incurred within this office separate from the standard fees for an office visit for the following: FMLA or other work related forms, Personal disability (non federal), and Leave of Absence forms or letters.

PATIENT SIGNATURE: _____ DATE: _____

PATIENT NAME: _____ DOB: _____