You can use your computer to enter the information on the following pages, or you can print the form and fill it out by hand. If you fill out the form with your computer, click the Submit by E-mail button on the last page to e-mail the form to our office using your default e-mail editor. You can review your information with our office staff on the day of your scheduled appointment.

Welcome to Our Office.

As a new patient, we would like to know how you found us and whom to thank for your visit today.

Mark the checkbox below that applies to your visit.

☐ Referred by Patient Patient's Name: ____________________

☐ Dr. Referral Doctor's Name: ____________________

☐ Internet: Website: ____________________

Website with Special Offer: ____________________

Banner on Different Website: ____________________

☐ Facebook ☐ Twitter Other Social Network: __________

☐ Magazine/Newspaper Name of Publication: ____________________

☐ Radio What Station: ____________________

☐ TV What Channel: ____________________

☐ LASIK Flyer

☐ Drove by Clinic

☐ Sign Location: ____________________

☐ Phone Book Which One: ____________________

☐ Word of Mouth

☐ Other Please Specify: ____________________

Avery Eye Clinic

400 South Loop 336 West
Conroe, TX 77304
(936) 539-4500 (800) 346-6162

Dear Patient: Most Insurance Companies will not pay for a Complete Eye Exam with an OPHTHALMOLOGIST (Eye M.D.) unless it is due to a medical illness or an injury. (**Querido Paciente:** Por lo regular muchas de las seguranzas no pagan el examen rutinario de ojos. Si el resultado es un diagnostico medico o accidente su seguranza si lo cubre)

Date: ____________________
(Fecha)

Patient's Name: ______________________ Age: _____ Date of Birth: ______________
(Nombre de paciente) (Edad) (Fecha de nacimiento)

Mailing Address: ______________ City: ______________ State: ____________ Zip: ________
(Direccion de envio) (Ciudad) (Estado) (Codigo)

E-mail Address: ______________ Home Phone #: ______________ Cell #: ______________
(el correco electronico) (Telefono de casa) (Telefono de celular)

Patient's Social Security #: ______________ ◯ Male ◯ Female
(Numero social de paciente) (Masculino) (Femenina)

Spouse's Name: ______________________ Date of Birth: ______________
(Nombre de su pareja) (Fecha de nacimiento)

Patient's Family Doctor: ______________________ Phone #: ______________
(Doctor de paciente) (Telefono)

Referring Doctor: ______________________ Phone #: ______________
(Referir al doctor) (Telefono)

Relative's Name (not living with you): ______________________ Phone #: ______________
(Nombre de un familiar cercano pero que no viva con usted) (Telefono)

PRIMARY INSURANCE: ______________________ Insurance ID #: ______________
(Seguro primario) (Numero de seguro)

Insured's Name: ______________________ Date of Birth: ______________
(Nombre de asegurado) (Fecha de nacimiento)

Employer's Name: ______________________ Phone #: ______________
(Nombre de empleo) (Telefono)

SECONDARY INSURANCE: ______________________ Insurance ID #: ______________
(Seguro secundario) (Numero de seguro)

Insured's Name: ______________________ Date of Birth: ______________
(Nombre de asegurado) (Fecha de nacimiento)

IF PATIENT IS A MINOR: List the parent's or guardian's name below (si el paciente es menor de edad por favor de poner su pariente o guardian)

Parent/Guardian Name: ______________________ Address: ______________________
(Nombre de paciente/guardian) (Direccion)

Parent/Guardian Phone #: ______________________
(Telefono de paciente/guardian)

Avery Eye Clinic

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Conroe, TX 77304
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WE REQUIRE A COPY OF YOUR INSURANCE CARD AND PHOTO ID FOR PROOF OF INSURANCE.
(Tiene que presentar su licencia de manejar o una ID que tenga foto.)

WE DO NOT ACCEPT WORKER'S COMP.
(NO aceptamos Worker's Comp)

IT IS OUR POLICY THAT PAYMENT BE MADE AT THE TIME SERVICES ARE RENDERED.
(Es necasario pagar su consulta despues de cada visita.)

WE DO NOT LOOK TO A THIRD PARTY TO BILL.
(Nosotros no mandamos el bill a una persona tercera.)

A PARENT/GUARDIAN IS RESPONSIBLE FOR ALL CHARGES FOR A MINOR CHILD.
(El pariente/guardian es responsable por un paciente que es menor de edad.)

BY SIGNING BELOW, I HEREBY AUTHORIZE:
(Al firmar en la linea de abajo, yo autorizo)

1. My consent for medical treatment by the doctor/Avery Eye Clinic Staff & acknowledge no guarantees have been made RE: The results of treatment/exam.
   (Yo autorizo el tratamiento por el doctor/Avery Eye Clinic y reconosco que no hay garantias en referencia al los resultados de tratamiento/examen.)
2. Payment from my insurance company to Avery Eye Clinic for medical treatment.
   (Pago de mi aseguranza a Avery Eye Clinic por recibir tratamiento medico.)
3. **I UNDERSTAND I'LL BE RESPONSIBLE FOR ALL CHARGES NOT PAID BY MY INSURANCE.**
   (Yo soy responsable de los cargos que no page mi aseguranza.)
4. The release of any medical records when necessary to/from another physician, hospital, or other medical facility.
   (Mi records pueden ser consultados con oto doctor ques sea relacionado a mi enfermedad, hospital u otro centro medico.)
5. Release of medical information to/from the insurance for claims processing.
   (Mandar/recibir la informacion medica de la compania de aseguranza.)
6. **I WILL BE RESPONSIBLE FOR CHARGES IF I DID NOT OBTAIN A REFERRAL OR AUTHORIZATION FROM MY INSURANCE COMPANY OR PRIMARY CARE PHYSICIAN.**
   (Yo soy responsable de obtener una referencia o autorizacion de mi compania de aseguranza o de mi doctor primario.)
7. List names of people we may give your PRIVATE HEALTH INFORMATION to:
   (Por favor de poner 3 personas que puedan dar su informacion privada:)

   1. ______________________________
   2. ______________________________
   3. ______________________________

8. Permission to leave reminder for appointment on answering machine.
   (Permiso de dejar mensaje en su maquina contestador en su casa.)

xx____
Patient's/Guardian's Signature
(Firma de Paciente/Guardian)

HISTORY FORM

CHART # ______________

NAME: ____________________________ DATE: ______________

Family Physician: ____________________________ Referral Source: ______________

REVIEW OF SYSTEMS - Are you currently experiencing any of the following symptoms? Check all that apply:

Constitutional

- ☐ Fever
- ☐ Fatigue
- ☐ Poor Appetite
- ☐ Night Sweats
- ☐ Chills

Eye

- ☐ Blurry
- ☐ Foggy
- ☐ Glare
- ☐ Blindness
- ☐ Tunnel Vision

Ear, Nose, Throat

- ☐ Congestion
- ☐ Sore Throat
- ☐ Hearing Trouble
- ☐ Ear Ringing
- ☐ Nose Bleed
- ☐ Hoarseness

Cardiovascular

- ☐ Chest Pain/Pressure
- ☐ Racing Heart
- ☐ Ankle Swelling

Respiratory

- ☐ Short of Breath
- ☐ Cough
- ☐ Wheezing

Gastrointestinal

- ☐ Indigestion
- ☐ Nausea/Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Tarry/Bloody Stool

Genitourinary

- ☐ Difficult Urination
- ☐ Frequent Urination
- ☐ Burning
- ☐ Pain

Musculoskeletal

- ☐ Weakness
- ☐ Aches
- ☐ Muscle Cramps

Skin/Breast

- ☐ Hives
- ☐ Rash
- ☐ Sores
- ☐ Lump
- ☐ Pain

Neurological

- ☐ Dizziness
- ☐ Severe Headache
- ☐ Neck Pain
- ☐ Back Pain
- ☐ Numbness

Psychiatric

- ☐ Confusion
- ☐ Poor Memory
- ☐ Depressed
- ☐ Poor Sleep
- ☐ Nervous/Tense

Endocrine

- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Poor Energy

Heme/Lymph

- ☐ Bruising
- ☐ Nose Bleed
- ☐ Lymph Nodes

Allergy/Immune

- ☐ Sinus
- ☐ Sneezing
- ☐ Hay Fever
- ☐ Frequent Infection

Other:

PAST MEDICAL HISTORY:

Check any of the following conditions that the patient has had:

☐ Cataracts	☐ Ulcer	☐ Heart Disease	☐ Paralysis	☐ Cancer (type):
☐ Glaucoma	☐ Jaundice	☐ Kidney Stone	☐ Drug Addiction	☐ High Blood Pressure
☐ Hay Fever	☐ Gallstone	☐ Bladder Trouble	☐ Prostate Trouble	☐ Tuberculosis
☐ Asthma	☐ Liver Disease	☐ Thyroid Disease	☐ Nerve Disease	☐ Anemia
☐ Diabetes	☐ Hepatitis	☐ Stroke	☐ Muscle Disease	☐ Bleeding Disorder
☐ Pneumonia	☐ Colitis	☐ Infections	☐ Seizure	☐ Macular Degeneration

(continued on next page)

PAST MEDICAL HISTORY *(continued)*:

Other Eye or Medical Problems: **Date:**

PREVIOUS SURGERIES:

Surgery: **Date:**

FAMILY HISTORY:

Do any of the following illnesses run in the patient's family? (Check all that apply)

- ☐ Diabetes
- ☐ Glaucoma
- ☐ Seizures
- ☐ Heart Disease
- ☐ Stroke
- ☐ Macular Disease
- ☐ Arthritis
- ☐ Asthma
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ Migraine Headache
- ☐ Goiter

Other Illness: **Relation:**

CURRENT MEDICATIONS: (Including: Prescription, Over the Counter, Herbal and Dietary Supplements)

DRUG ALLERGIES:

SOCIAL HISTORY:

Do you currently use tobacco? ◯Yes ◯No Have you used it in the past? ◯Yes ◯No

Type: ______________ How much each day? ______________________ How long? ___________________________

Do you use alcohol? ◯Yes ◯No Type: ____________________ How much? ___________________________

Do you have a history of drug use or addiction? ◯Yes ◯No Type: ____________________________________

For office use only. **ROS AND PFSH updated:**

Date Updated	Initial	Date Updated	Initial	Date Updated	Initial

Avery Eye Clinic
Phone: 936-539-4500 Fax: 936-539-1216
P.O. Box 2648
Conroe, Texas 77305

Authorization to Disclose Private Health Information "PHI"

From:
- ☐ Patient
- ☐ Entity
- ☐ Family Member
- ☐ Facility
- ☐ Physician
- ☐ Representative

Phone #: ______________________________

Fax #: ______________________________

Release To:
- ☐ Patient
- ☐ Entity
- ☐ Family Member
- ☐ Facility
- ☐ Physician
- ☐ Representative

Phone #: ______________________________

Fax #: ______________________________

Patient's Name: ______________________________ Date of Birth: ________________ CHART # ______________

By signing below, I hereby authorize the disclosure or use of the above named individual's health information in accordance of the Medical Privacy Act of Texas from the Individual or organization described below for the disclosure and use of Avery Eye Clinic.

MAPLE AVERY, M.D. BAPTISTE DEJEAN, M.D. CRAIG KUGLEN, M.D. LINDA LIN, M.D. GURPREET SINGH, M.D.

Reason or purpose of disclosure or release:

- ☐ Patient and or authorized representatives request
- ☐ Continuance of Medical care
- ☐ Other: ______________________________

Items to be disclosed are as follows:

- ☐ Entire Chart
- ☐ Medical records dated from: ______________
- ☐ Correspondence
- ☐ Insurance Notes
- ☐ Financial Information
- ☐ Diagnostics
- ☐ Surgical Notes
- ☐ Contact Lens RX / Glasses RX / Notes
- ☐ Other: ____

☐ I understand that the information disclosed may contain information regarding HIV or sexually transmitted disease and or mental / behavioral health services information and / or drug/alcohol use.

Right To revoke PHI after the date of April 14, 2003: I understand that if I decide to revoke this authorization to release PHI, I have to send a written request to the Avery Eye Clinic Privacy Officer to the following address.******Privacy Officer, P.O. Box 2648, Conroe, Texas 77305.

I understand that a revocation is not effective to the extent that Avery Eye Clinic has relied on this authorization for its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself. I understand that information pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by Federal HIPPA Privacy regulations. Avery Eye Clinic will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use of disclosure.

Unless revoked, this authorization will be in force and until the following date: 6 years or event occurs (describe event or write “not applicable”). ____

____
Signature of Patient/Guardian/Legal Representative

____
Print Name of Patient/Guardian/Legal Rep.

____
Date

____
Description of Representative (e.g. court order, lawyer)

☐ FOR MARKETING PURPOSES - I understand that the person I am authorizing to use and / or disclose information for marketing purposes will receive either direct or indirect compensation for doing so.

Avery Eye Clinic Financial Policy

DEFINITIONS

IN NETWORK

Are insurance companies with whom we have a contractual agreement. If we are "in network", we have agreed to a pay scale/discounted rate with the insurance company for members of the insurance carrier.

OUT OF NETWORK/NONPARTICIPATING INSURANCE

If we are not in network with your insurance carrier, we will not bill your carrier. Payment is due at the time of service. We will be happy to give you something so that you can file the claim yourself with the insurance company.

ACCEPT ASSIGNMENT

We agree to accept check payment from your insurance company for services rendered.

FINANCIAL POLICIES AND PROCEDURES

At Avery Eye Clinic, we believe that all patients who come to this office deserve the best medical care and services available. For us to provide you with the highest quality eye care with current technology, we must meet the expenses necessary to operate this facility. To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

PAYMENT AT TIME OF SERVICE

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. As a courtesy, we bill your insurance company for office visits. However, we ask that you pay any portion not covered by your insurance company, such as DEDUCTIBLES or CO-PAYMENTS, on the day of service. IF YOU DID NOT OBTAIN A REQUIRED REFERRAL OR AUTHORIZATION FROM YOUR INSURANCE COMPANY OR PRIMARY CARE PHYSICIAN, YOU WILL BE RESPONSIBLE FOR ALL CHARGES.

SUBMISSION OF CLAIMS

We will submit your insurance claims. However, it is important to remember that YOUR INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. Although we file insurance claims as a courtesy to you, YOU ARE STILL RESPONSIBLE FOR ALL CHARGES NOT PAID BY YOUR INSURANCE, SUCH AS DEDUCTIBLES, CO-PAYMENTS, AND NON-COVERED SERVICES.

Your medical insurance plan will only pay for services that it defines as "reasonable and necessary". If your carrier determines that a particular service does not meet its criteria under program standards, your plan will deny payment for this service. In the event that your insurance carrier determines a service is "not covered", you will be responsible for the complete charge for that service.

BALANCES DUE AFTER INSURANCE PAYS

If a balance remains due after your insurance carrier pays, payment is due upon receipt of a statement from our office. Payment arrangements can be made for special circumstances by contacting the billing manager within 30 days of receipt of the invoice. IT IS YOUR RESPONSIBILITY TO CONTACT OUR OFFICE TO MAKE SPECIAL ARRANGEMENTS.

OUTSTANDING BALANCES
We urge you to keep your account current to avoid misunderstandings with our office.

PAYMENT OPTIONS
Our office accepts cash, check, Visa, MasterCard, Discover, American Express, and Diners Club. There will be a $30 fee for all returned checks.

MEDICARE PATIENTS
If you have Medicare as your primary insurance but no secondary insurance, you are responsible for the 20 percent not covered by Medicare at the time of service.

BILLING PROCEDURE
You will receive a statement with your remainder balance once a reply is received from your insurance company.

MEDICAL RECORDS
A copy of your medical records is available to you at your discretion. A medical records release form must be filled out and signed by the patient. One set of records is provided to the patient at no charge.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time to time.

____

Patient Name

____ ________________

Signature of Patient or Responsible Party If a Minor **Date**

Avery Eye Clinic

Conroe
400 South Loop 336 W.
Conroe, TX 77304
(936) 539-4500
(800) 346-6162

Huntsville
3361 Montgomery Rd.
Huntsville, TX 77340
(936) 294-0218

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed Avery Eye Clinic's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

______________________________	________________	________________
Signature of Patient or Responsible Party If a Minor	**Date**	**Chart #**

______________________________	______________________________
Name of Patient or Personal Representative	**Description of Personal Representative's Authority**

☐ **Patient declines to sign at this time** **Staff Initials** _________ **Date**______________

SUMMARY OF NOTICE OF PRIVACY PRACTICES

Avery Eye Clinic cares about protecting all patients' privacy. In the process of providing services requested, we will collect, use, and share certain information provided by the patient. The "Notice of Privacy Practices" explains in detail what information is collected and how that information may be used.

TREATMENT - We are permitted to use and disclose your medical information to those involved in your treatment, including, but not limited to, hospital staff, primary care physicians, and specialists.

PAYMENT - We are permitted to use and disclose your medical information to bill and collect payment for services provided to you.

HEALTH CARE OPERATIONS - We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support Avery Eye Clinic and ensure that quality care is delivered.

DISCLOSURES WITHOUT PATIENT AUTHORIZATION - There are situations in which we are permitted by law to disclose or use your medical information without written authorization or opportunity to object. These include, but are not limited to: Public Health Activities, abuse/neglect, health oversight, legal proceeding, law enforcement, workers compensation, military, or as otherwise required by law.

RESTRICTION - You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or health care operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency situations.

INSPECTION/AMENDMENT OF MEDICAL INFORMATION - You may inspect and/or copy health information that is within the designated record set. You may request an amendment of your medical information in the designated record set. Any such request must be submitted in writing to the Avery Eye Clinic Privacy Officer.

Avery Eye Clinic is required by law and regulation to protect the privacy of patients' medical information to provide notice of our privacy practices with respect to protecting health information and to abide by the terms of the
notice of privacy practices in effect. This notice is subject to change at any time. If changes are made, a new notice will be posted in the office where it can be seen.