Eye Muscle Specialist – **Everett A. Moody, MD**
Pediatric Ophthalmologist- **Monica Bratton, MD**
Optometrist – **David Willingham, OD**
Colleen Walters, OD

3200 N. MacArthur Blvd ste.200
Irving, TX 75062

Toll free: 1-888.511.2026

Patient Name:____ DOB:_______/______/________

Acknowledgement of Receipt of Notice of Privacy Practices

I have reviewed the Notice of Privacy Practices for Ophthalmology Consultants, PA. I acknowledge that I would be provided a copy for my records upon my request.

___________________________________ ___________________________________
Patient Signature Date

Access to Protected Health Information

I authorize the following individuals to receive access to the specified protected health information by phone or in person.

Name /DOB	Type of Information: Appointment	Billing	Treatment
____	☐	☐	☐
____	☐	☐	☐
____	☐	☐	☐
____	☐	☐	☐

I authorize Ophthalmology Consultants to leave medical information via voice mail at the following numbers:

____

____

___________________________________ ___________________________________
Patient Signature Date

Patient Information

Doctor of Record: EAM/ DW/ CW/MB

Ophthalmology Consultants, P.A.

Patient Name (as appears on insurance card)	DOB	Primary phone #	Alternate phone #
Address	SS#	Sex: M F	Marital Status: Married/ Single / Other
City, State,Zip			
Referring Doctor Name		Primary Care Doctor Name	

Responsible Party

Responsible Party Name(first, middle last)	Primary phone	Alt phone	Alt phone
address		DOB	SS#
City, State, Zip		Sex M F	Relation to patient
Employer	occupation		

Primary Insurance

Insurance Company Name		Insured's name	
Insurance Company address		Insured's address City, State, Zip	
Insurance company City, State, Zip			Insured's Date of Birth
Insurance company phone #s	Insured's SS#	Insured's sex M F	Patients relation to insured
Insured's policy #	Group #		Employer

Secondary Insurance

Insurance Company Name		Insured's name	
Insurance Company address		Insured's address City, State, Zip	
Insurance company City, State, Zip			Insured's Date of Birth
Insurance company phone #s	Insured's SS#	Insured's sex M F	Patients relation to insured
Insured's policy #	Group #		Employer

Authorization and Aknowledgement

I affirm that I, ____, am the [ ] Parent/ [ ] Legal Guardian (documentation must be provided) of the above named patient.

Signature:____ date:____________________

I hereby authorize Ophthalmology Consultants, P.A. to release any medical or incidental information that may be necessary for either medical care of insurance processing applications for financial benefit and authorize direct payment of any medical or surgical benefits to be made directly to Ophthalmology Consultants,P.A.

I hereby authorize the physicians and medical personnel of OCPA to provide medical treatment to my minor child/dependent.

Signature:____ date:____________________

WELCOME TO OUR OFFICE

NAME____SEX________________________

ADDRESS____BIRTHDATE____________________

CITY/STATE/ZIP____ AGE____________________

HOME PHONE:____EMPLOYER_____________________________

RESPONSIBLE PARTY____OCCUPATION________________________

ADDRESS,IF DIFFERENT____WORK PHONE:____________________________

Have you worn glasses? Yes No How are they used? For distance_______ Near __________ Constant __________

Approximate date of last eye exam?___________________________________ Recommended by?____

Your reasons for visit our office today (please check appropriate items):

__General check up (no specific problems)
__Lost or broken glasses
__Want new glasses
__Blurred distance vision
__Blurred near vision
__Headaches – When do you get them?
How often?
____
____

__Eye water
__Glare
__Eyes burn
__Eyes itch
__Eyes feel dry
__Eyes feel tired
__Pain in eyes
__see spots

__Want contact lenses
__soft____ extended wear
__gas permeable ____hard
__Bifocal contact lenses
__Contact lens check up
__Problems with present contact lenses
__Other – (please list
____
____

HOBBIES: ____

Your general health and ocular health: Past or Present (Please check appropriate items)

__High blood pressure
__Heart disease
__Diabetes
__Allergies
__Cancer
__Arthritis
__Respiratory problems
__Circulatory problems
__Multiple Sclerosis
__Other – (please list)
____

__Cataracts
__Strabismus
__Glaucoma
__Amblyopia
__Retinal disorders
__Eye injuries
__Eye surgery
__Other – (please list)
____
____

Has anyone in your family (blood relatives) had any of the above conditions? Yes No
If so, what relative and what condition(s)? Please list here. Do not check in the list above.

____
If you are presently taking any medications, hormones or birth control pills, please state what medication.

____

____ _____________________________________
Signature date

OCPA OFFICE POLICIES

The best medical care can be provided only on the basis of mutual understanding. We encourage you to discuss any questions you may have regarding our policies with our staff.

Insurance

We participate in a variety of insurance plans (list can be provided) and will directly bill your insurance under these plans. In this circumstance you are responsible only for applicable co-payments before the visit. If you have not met your deductible, you will be responsible for payment at the time of your visit. We cannot accept responsibility for negotiating claims with insurance companies. You are responsible for payment of your medical care within a reasonable time, regardless of status of a claim. Services not covered by your insurance are your responsibility.

Co-payments

When your insurance specifies a co-payment (usually indicated on the identification card), this payment must be made at check-in, prior to your exam.

Refraction Service and Fee

Refraction is the process of determining if there is a need for corrective eye glasses. It is an essential part of an eye examination and necessary to write a prescription for glasses. Our office fee for refraction is $57.00 if not covered by your insurance plan we will bill you for the amount in addition to any co-payment under your plan requirements. Medicare does not cover refractions.

Prior Authorization and Vision Care Forms

Some health maintenance organization (HMO) plans require you to obtain authorization for services from your primary care provider (internist, family practitioner, pediatrician, etc.). It is your responsibility to obtain authorization from your primary care provider. This is required by your insurance before you visit our office, even when the visit is for an urgent problem. Contact your insurer if you have questions, or contact the office of your primary care provider.

Contact Lenses

Payment in full is expected at the time of service for all contact lens exams, and before ordering contact lenses. Any questions regarding contact lenses should be directed to the doctor that is handling your contact lenses.

Credit Cards

For your convenience, we accept Visa, MasterCard, American Express, and Discover and Care Credit. Credit Card services are not always available at our satellite offices.

Billing

If billing is necessary, a statement will be mailed to you, which is due within 30 days. Charges and payments for services received during the last few days before your billing date may appear on the following month's statement.

Insurance Counseling

Before any surgical procedure which may entail greater expense, our office will provide insurance coverage information and estimate what, if any, balance may remain once insurance has paid. The Patient balance is due prior to the surgery. If you are unable to meet the financial requirements please ask your surgery coordinator about care credit.

For answers to further questions, please contact our office at 1-888-511-2026.

____ ____________________

Name of patient DOB

____ ____________________

Signature of patient or person acting on patient's behalf Date