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

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

3050 S. Center St.
Arlington, TX 76014 **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 or guarantor 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 (print) DOB

X____ ____________________

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

Please fill out… and add any additional information that you think might be helpful.

Name: ______________________ ____ ___________________________ **Physician:** **Kartik Kumar, M.D.**
(FIRST) (M.I.) (LAST)

DOB ___/___/____ **PCP:** ____________________________ **Fax #:** _______________________________
DOS:

Chief Complaint & Present Illness: ____
(WHAT IS THE MAIN PROBLEM THAT LED TO THIS VISIT?)

Past Medical Hx:

☐ NONE **Allergies to medications:** or… ____

☐ NONE **Known Allergies:** ____

☐ UP TO DATE **Immunizations:** ☐ PARTIAL ☐ NONE

☐ NONE **Medical Conditions:** or… ____

☐ NONE **Previous Hospitalizations:** or… ____

☐ NONE **Previous Eye Surgeries: x** ___. Last one __/__/__.

☐ NONE **Previous Other Surgeries:** or… ____

☐ NONE **Medications:** or… ____

☐ NORMAL **Developmentally…** or… ____

☐ NO **Premature:** _______WEEKS EARLY. (BW: ____# ___ oz.)

Family Hx: ____ STRABISMUS _____ TROUBLE WITH ANESTHESIA (LIKE HIGH FEVER), OTHER ____________________________

Social Hx: Speaks ____ENGLISH, or____ ESL , or SPANISH ONLY, or_______________________________,

Does the patient use: (circle all that apply)

Cigarettes Chewing Tobacco Alcohol Recreational Drugs None

Is the patient exposed to: (circle all that apply)

Cigarette smoke Recreational drugs None

Custody: ___PARENT(S)… OR OTHER ___________________ ___CUSTODIAL PAPERS? ________________________________

☐ ***ALL NEGATIVE*** **or…**

__ HEART	__ LUNGS	__ EAR-NOSE-THROAT (AIRWAY)	__BRAIN—NERVOUS SYSTEM	__ RASH
__BLOOD or BLEEDING	__ IMMUNOLOGIC	__ GASTROINTESTINAL	__ GENITO-URINARY	__HEPATO-RENAL
__ MUSCULOSKELETAL	__ PSYCHIATRIC	__ TROUBLE IN SCHOOL	__ DDD-ADHD	__ SUSTEMIC

Details:____

____

Patient Information

Doctor of Record: EAM/ DW/ CW/KK

Ophthalmology Consulatants, 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:__________________________