Name:	**Physician:**
DOB:	
DOS:	**PCP:**

COVID-19 Patient Screening Form

Due to the COVID-19 global pandemic we have taken steps to minimize exposure in our office. We ask that if the patient or anyone in the household has had **fever, significant cough** or if children have had **discolored toes** in the last week or if you suspect you have been exposed to COVID-19, please reschedule your appointment.

Please complete this form before your appointment.

1. Do you or anyone in your household have any of the following symptoms:
   sore throat, cough, chills, body aches for unknown reasons, shortness of breath loss of smell, loss of taste, fever over 100°
   If the answer is None, have you had them anytime in the last 14 days? ☐ **Yes** ☐ **No**
2. Have you or anyone in your household been tested for COVID-19? ☐ **Yes** ☐ **No**
   If yes, what was the result? _____
3. Have you or anyone in your household visited or received treatment in a hospital, nursing home? ☐ **Yes** ☐ **No**
4. Have you or anyone in your household traveled in the U.S. or on a cruise ship in the past 21 days? ☐ **Yes** ☐ **No**
5. Are you or anyone in your family a health care provider or emergency responder? ☐ **Yes** ☐ **No**
6. Have you or anyone in your household cared for someone with COVID-19? ☐ **Yes** ☐ **No**
7. Do you have any reason to believe you or anyone in your household has been exposed to or been in close proximity to someone with COVID-19? ☐ **Yes** ☐ **No**

If you have answered yes to any of these questions, we will review your answers and let you know if it is safe to keep your appointment or if it should be postponed.

Eye Muscle Specialist **Everett Moody, MD**
Pediatric Ophthalmologist **Kartik Kumar, MD**
Optometrist **Colleen Walters**

3200 N MacArthur Dr
Suite 200
Irving, TX 75062

10150 Legacy
Suite 300
Frisco, TX 75034

3050 S Center St, Suite 110
Arlington, TX 76014

526 N Locust St
Denton, TX 76201

Acknowledgement of Receipt of Notice of Privacy Practices

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

_____

_____

Patient / Parent Signature Date

Access to Protected Health Information

Starting with your name, please list the name, date of birth and telephone number of anyone who has permission to call for appointment, billing or treatment information.

Name	DOB	Relationship to patient	Phone Number

Electronic Communication:
I authorize Ophthalmology Consultants, PA to communicate via text and/or leave medical information via voice mail at the above phone number(s) and email address. I understand that the physician may communicate with me via text messaging or email and that this type of communication may not be a secure form of communication. By participating in text messaging and/or email, I release Ophthalmology Consultants and its physicians of any liability for lost/compromised information.

_____ _____

Patient / Parent Signature Date

DOS:

PT ID: Patient: DOB:

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 medical 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 $85.00 if not covered by your insurance plan. Medicare does not cover refractions. The refraction amount is due at the time of service if not covered by your insurance in addition to any co-payment under your plan requirements. Due to the nature of our specialist practice we do not file routine vision. If you have vision insurance, we do not accept it. To use your vision insurance elsewhere, call your vision insurance directly for a list of providers.

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.

08/06/2020

Signature of patient or legal guardian Date

Patient Information

DOCTOR OF RECORD
Kartik Kumar MD

Ophthalmology Consultants, P.A.

PATIENT NAME (First Name, Middle Initial, Last Name) PATIENT ID (Office Use Only)	Mom Cell	Dad Cell	THIRD PHONE (MOBILE)
ADDRESS DATE OF BIRTH	SOCIAL SECURITY NUMBER	SEX (M or F) [ ]M [ ]F	MARITAL STATUS [ ]Married [ ]Single [ ]Other
CITY, STATE, ZIP AGE	EMERGENCY CONTACT PERSON	RELATIONSHIP TO PATIENT	CONTACT PHONE
EMPLOYER	OCCUPATION	PATIENT E-MAIL ADDRESS	
REFERRING DOCTOR NAME & ADDRESS			
PRIMARY CARE DOCTOR NAME & ADDRESS			

Responsible Party

RESPONSIBLE PARTY NAME (First Name, Middle Initial, Last Name)	Mom Cell	Dad Cell	THIRD PHONE (MOBILE)
ADDRESS		DATE OF BIRTH	SOCIAL SECURITY NUMBER
CITY, STATE, ZIP		SEX (M or F) [ ]M [ ]F	PATIENT'S RELATION TO RESP
EMPLOYER		OCCUPATION	RESP PARTY ID (Office Use Only)

Primary Insurance

WHO IS THE PRIMARY INSURED PARTY (CHECK ONE)
[ ] Patient (same as above) [ ] Responsible Party (same as above) [X] Other (complete below)

INSURANCE COMPANY NAME COPAY AMOUNT	INSURED'S NAME (First Name, Middle Initial, Last Name)		
INSURANCE COMPANY ADDRESS	INSURED'S ADDRESS, CITY, STATE, ZIP		
INSURANCE COMPANY CITY, STATE, ZIP	INSURED'S DATE OF BIRTH	Mom Cell	Dad Cell
INSURANCE COMPANY PHONE NUMBERS	INSURED'S SOCIAL SECURITY NO. --	INSURED'S SEX (M or F) [ ]M [ ]F	PATIENT'S RELATION TO INSURED
INSURED'S POLICY NUMBER INSURED'S GROUP #	INSURED'S EMPLOYER		INSURED'S OCCUPATION

Secondary Insurance

WHO IS THE SECONDARY INSURED PARTY (CHECK ONE)
[ ] Patient (same as above) [ ] Responsible Party (same as above) [ ] Other (complete below)

INSURANCE COMPANY NAME	INSURED'S NAME (First Name, Middle Initial, Last Name)		
INSURANCE COMPANY ADDRESS	INSURED'S ADDRESS, CITY, STATE, ZIP		
INSURANCE COMPANY CITY, STATE, ZIP	INSURED'S DATE OF BIRTH		
INSURANCE COMPANY PHONE NUMBERS	INSURED'S SOCIAL SECURITY NO.	INSURED'S SEX (M or F)	PATIENT'S RELATION TO INSURED
INSURED'S POLICY NUMBER INSURED'S GROUP #	INSURED'S EMPLOYER		INSURED'S OCCUPATION

Authorization and Acknowledgement

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

I hereby authorize the physicians and medical personnel of Ophthalmology Consultants, PA to provide medical treatment to my minor child/dependant.

Guarantor Signature: _____ Date: _____

Patient Information

DOCTOR OF RECORD
Kartik Kumar MD

Ophthalmology Consultants, P.A.

PATIENT NAME (First Name, Middle Initial, Last Name) PATIENT ID (Office Use Only)	Mom Cell	Dad Cell	THIRD PHONE (MOBILE)
ADDRESS DATE OF BIRTH	SOCIAL SECURITY NUMBER	SEX (M or F) [ ]M [ ]F	MARITAL STATUS [ ]Married [ ]Single [ ]Other
CITY, STATE, ZIP AGE	EMERGENCY CONTACT PERSON	RELATIONSHIP TO PATIENT	CONTACT PHONE
EMPLOYER	OCCUPATION	PATIENT E-MAIL ADDRESS	
REFERRING DOCTOR NAME & ADDRESS			
PRIMARY CARE DOCTOR NAME & ADDRESS			

Responsible Party

RESPONSIBLE PARTY NAME (First Name, Middle Initial, Last Name)	Mom Cell	Dad Cell	THIRD PHONE (MOBILE)
ADDRESS		DATE OF BIRTH	SOCIAL SECURITY NUMBER
CITY, STATE, ZIP		SEX (M or F) [ ]M [ ]F	PATIENT'S RELATION TO RESP
EMPLOYER		OCCUPATION	RESP PARTY ID (Office Use Only)

Primary Insurance

WHO IS THE PRIMARY INSURED PARTY (CHECK ONE)
[ ] Patient (same as above) [ ] Responsible Party (same as above) [X] Other (complete below)

INSURANCE COMPANY NAME COPAY AMOUNT	INSURED'S NAME (First Name, Middle Initial, Last Name)		
INSURANCE COMPANY ADDRESS	INSURED'S ADDRESS, CITY, STATE, ZIP		
INSURANCE COMPANY CITY, STATE, ZIP	INSURED'S DATE OF BIRTH	Mom Cell	Dad Cell
INSURANCE COMPANY PHONE NUMBERS	INSURED'S SOCIAL SECURITY NO. --	INSURED'S SEX (M or F) [ ]M [ ]F	PATIENT'S RELATION TO INSURED
INSURED'S POLICY NUMBER INSURED'S GROUP #	INSURED'S EMPLOYER		INSURED'S OCCUPATION

Secondary Insurance

WHO IS THE SECONDARY INSURED PARTY (CHECK ONE)
[ ] Patient (same as above) [ ] Responsible Party (same as above) [ ] Other (complete below)

INSURANCE COMPANY NAME	INSURED'S NAME (First Name, Middle Initial, Last Name)		
INSURANCE COMPANY ADDRESS	INSURED'S ADDRESS, CITY, STATE, ZIP		
INSURANCE COMPANY CITY, STATE, ZIP	INSURED'S DATE OF BIRTH		
INSURANCE COMPANY PHONE NUMBERS	INSURED'S SOCIAL SECURITY NO.	INSURED'S SEX (M or F)	PATIENT'S RELATION TO INSURED
INSURED'S POLICY NUMBER INSURED'S GROUP #	INSURED'S EMPLOYER		INSURED'S OCCUPATION

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I hereby authorize the physicians and medical personnel of Ophthalmology Consultants, PA to provide medical treatment to my minor child/dependant.

Guarantor Signature: _____ Date: _____

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

Name: **Physician:**

DOB:

DOS: **PCP:**

Chief Complaint & Present Illness: _____
(What is the main problem that led to this visit) _____

Past Medical History:

☐ None **Allergies to Medication:** or... _____

☐ None **Known Allergies:** _____

☐ Up to Date **Immunizations:** ☐ Partial ☐ None

☐ None **Medical Conditions:** or...

☐ None **Previous Hospitalization:** 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:

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

__Musculoskelatal __Psychiatric __ Trouble in School __ ADD-ADHD __Systemic

_____

Details: _____

_____