PROVIDENT
EYE SPECIALISTS

Patient Registration

Name: _____ Today's Date: _____
Last First MI Month / Day / Year

Mailing Address: _____
Street City State Zip

Home Phone: _____ Cell Phone:_____Social Security Number: _____

Age: _____ Date of Birth: _____ Male ____ Female ____ Marital Status: S M W D
Month / Day / Year

Language: _____ Ethnicity: _____ Race: _____

E-Mail: _____

Employed By: _____ Retired ____ Occupation: _____

Address: _____ Telephone: _____

Spouse or Parent's Name: _____ Date of Birth**:** _____

Emergency contact **not living with you**: _____ Relationship: _____

Address: _____ Telephone: _____

Person responsible for payment (**If Not self**) _____ Relationship: _____

Address: _____ Telephone: _____

Date of Birth: _____ Social Security Number: _____

Preferred Pharmacy (Name and location): _____

What is the name of your primary care physician? _____

How did you hear about our office? Yellow Pages Friend Family Member Hospital Health Plan Directory

Another patient, who? _____ Another doctor, who? _____

Health Insurance Information

Do you have health insurance? Yes / No Medicare? Yes / No Insurance ID Number: _____

What is the name of your primary medical insurance? _____

Primary insurance policy holder's name: _____ Date of birth: _____

Do you have secondary medical insurance? Yes / No Secondary Insurance Name: _____

Consent for Examination

Consent for Use of Dilating Medication(s)
Dilating eye drops are used to enlarge the pupil to allow examination of the inside of the eye. Although occurring rarely, risks of these medications include allergic reaction, acute glaucoma, and systemic reactions including increased blood pressure, irregular or fast heart beats and dizziness. Additionally, use of dilating drops will cause blurry vision and light sensitivity which can make driving and certain work conditions hazardous after an eye exam for a period of 4 – 6 hours or more

However, if dilating eye drops are not used, the examination is sub-optimal and certain conditions such as macular degeneration, glaucoma and retinal tumors may go undiagnosed.

_____(Initials) I consent to the use of dilating eye medications.
_____(Initials) I decline the use of dilating eye medications.

Acknowledgement of Refraction Policy and Consent for Refraction
Medicare policy requires that refraction (the exam to determine glasses prescription) be billed separately from an eye exam. Medicare, Medicaid and most insurance carriers do not pay for refraction. Patients are responsible for payment of a refraction. Payment is due in full at the time refraction services are rendered.

If you decline having a refraction, there is a greater risk that there may be a delay in diagnosis of some eye diseases which may cause long term vision impairment. Further, declining refraction prior to some surgeries may result in non-payment of the surgery by your insurance carrier or Medicare in which case you would be responsible for payment.

Charge for Refraction as of 03/17/14: $35

_____(Initials) I acknowledge that I have read and understood the refraction policy.
_____(Initials) I consent to refraction when determined appropriate by my physician.
_____(Initials) I decline refraction at this time.

Financial Responsibility & Consent for Treatment
It is the policy of Provident Eye Specialists, P.A. that payment is due at the time services are rendered. As a benefit to you we will bill services directly to your insurance carrier. However, you are ultimately responsible for all charges including, in the event of default, costs of collection and attorneys' fees.

I hereby authorize the assignment of medical and surgical procedures benefits from Medicare, Medicaid, other governmental insurances and/or private insurance to: Provident Eye Specialists P.A. at 11212 Montwood Dr., El Paso, TX 79936

I authorize Dr. Keak C. Khauv to provide reasonable and appropriate medical and surgical care consistent with the standards of care of the American Academy of Ophthalmology.

_____ _____
(Signature of Patient or legal guardian) Date

_____ _____
(Signature of Witness) Date

_____(Initials) I have read and understood this entire document.
_____(Initials) This document was read to me by:

_____(Initials) This document was presented to me in my native language.

PROVIDENT
EYE SPECIALISTS

11212 Montwood Dr.
El Paso, TX 79936
Tele: (915) 595-4300 Fax:(915)595-4301

Consent & Direction for Release of Protected Health Information (PHI)

In compliance with the HIPAA (Health Insurance Portability and Accountability Act) and to help protect your financial and health information, we ask that you complete this form. You may change your answers to this form at anytime. We will keep a digital copy on file in your chart. We will endeavor to follow your wishes except when required by law as is described in the Notice of Privacy Protection statement which you have read and signed.

With regard to release of your health information, please read through the listed below and check the box that reflects your wishes.

During Examination

☐ Yes ☐ No You (Provident Eye Specialists, P.A.) may speak with any and all persons accompanying me during my examination directly and/ or allow them to hear all information or discussion indirectly. I understand that if I don't want that person privy to the conversation I must ask that person to leave the exam room.

Name: _____ Relationship:_____

_____ _____

Telephone Contacts

☐ Yes ☐ No I consent to receiving any and all information regarding appointments, laboratory, radiology and other testing results as well as financial information, including reminders for outstanding bills on my home telephone and/or personal cellular phone

Please restrict information as follows:

_____

_____

☐Yes ☐ No You may leave voicemail messages or messages on my answering machine regards to appointments, laboratory, radiology and other testing results as well as financial information.

If no, please list restrictions as follows:

_____

_____

How may we leave the above information for you then?_____

_____

☐Yes ☐No You may speak with or leave messages for me with any and all family members or significant others whether calling me as explained above or when or if they call with specific questions about my care.

Electronic Media

☐ Yes ☐ No You may contact me by various methods including e-mail, text messages or other internet or networking contact information that I leave with you and you may forward any information described above. Note that PHI will not be released into what is felt by us (Provident Eye Specialists, P.A.) to be a "non-secure" mode of transmission.

☐ Yes ☐ No Please restrict information or mode or media transmission as follows:

Other Restrictions

☐ Yes ☐ No I request restrictions on release of Protected Health Information as noted below:

Patient Signature _____ Date _____

PROVIDENT
EYE SPECIALISTS

Notice of Privacy Practices

ACKNOWLEDGEMENT OF REVIEW

Date: _____

I have reviewed Provident Eye Specialists, P.A.'s Notice of Privacy Practices (version effective November 7, 2014), which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this notice if requested.

_____ _____

Patient Name (Print) Patient Signature

If completed by a patient's parent, legal guardian or personal representative, please print and sign your name in the space below.

_____ _____

Parent/Guardian/Representative (Print) Parent/Guardian/Representative Signature

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please be specific):

_____

_____ _____

Employee Signature Date