NTEC
North Texas Eye Center

Dr. Lewis J. Frazee, M.D. - Dr. Ellen Ngo, M.D. - Dr. James Passmore, M.D.

Patient Information

Thank you for choosing North Texas Eye Center. In order to serve you properly, we need the following information. Please print **LEGIBLY**. All information will be confidential.

Date_____Patient Name_____

SSN_____DOB_____ ☐ Male ☐ Female

Address_____

City_____State_____ Zip_____

Home phone_____Cell phone_____

May we leave voicemail messages? _____

Email address_____

May we email medical correspondence? _____

☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Other

Primary Language_____Race_____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Employer_____ Work phone_____

Emergency contact _____Relationship to you_____

Address_____Phone # _____

Primary Care Physician_____

Who referred you to us_____

4100 W. 15th Street, Suite 210, Plano, TX 75093 – 751 Hebron Pkwy, Suite 230, Lewisville, TX 75057
Phone: 972-867-7777 – Fax: 972-941-3771 – Patient Portal: www.northtexaseyecenter.com

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RESPONSIBLE PARTY

Person responsible for this account if not patient_____

Relationship to patient _____ Address if different from patient

City_____State_____ Zip_____ Phone number _____

INSURANCE INFORMATION

Primary insurance_____

Name of insured_____Relationship to patient_____

DOB _____ SSN _____ Group number _____

Secondary
insurance_____

Name of insured_____Relationship to patient_____

DOB _____ SSN _____ Group number _____

Vision insurance_____

Name of insured_____Relationship to patient_____

DOB _____ SSN _____ Group number _____

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Patient name: _____Date of birth: _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby permit North Texas Eye Center to release and furnish all medical and financial data related to my care that may be necessary now or in the future for the purposes of treatment, payment or healthcare operations and to assist with, aid in, or facilitate the collection of data for the purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to family members, caregivers, insurance companies, HMOs and PPOs, managed care organizations, IPAs, Medicare/Medicaid, or other governmental or third party payors, or any other organizations contracting with any of the above entities to perform such functions.

You have the right to request that this office restrict uses and disclosures of your health information; however, this office is not required to agree to a requested restriction. You have a right to revoke this consent in writing, except to the extent that this office has previously taken action in reliance of this consent. Your treatment by this office is conditional upon you signing this consent.

Signed: _____ Date: ____/____/____

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DESIGNATED INDIVIDUALS RELEASE FORM
(HIPAA RELEASE FORM)

Patient name: _____Date of birth: _____

Release of Information

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

☐ Spouse _____
☐ Child(ren) _____
☐ Other _____

☐ Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call ☐ my home ☐ my work ☐ my cell Number:_____
If unable to reach me:
☐ you may leave a detailed message
☐ please leave a message asking me to return your call
☐ _____

The best time to reach me is (day)_____ between (time)_____

Signed: _____ Date: ____/____/_____

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PATIENT FINANCIAL RESPONSIBILITY

Recognizing the need for patients to understand what is expected regarding payment of medical services, we have established our financial policy. Some of these items are required by law. It is our goal to remain sensitive to our patients' needs while providing quality medical care, and we encourage you to contact our office if a problem should arise regarding your account.

1. **All co-pays and co-insurance required by your insurance company must be paid at the time services are rendered.** We accept cash, checks, and Visa, MasterCard, Discover and American Express cards. There is a $25.00 service charge on all returned checks. After receiving a returned check, North Texas Eye Center will only accept cash, money order, or credit card.

2. **It is the patient's responsibility to be aware of the contract benefits of his/her insurance carrier or any co-payment, deductible or referral obligation.** If your insurance requires referrals for full benefits to be paid, it is your responsibility to verify that the referrals are in place prior to your visit. Additionally, I hereby waive all indemnity from this responsibility that may otherwise be afforded to me by my insurance carriers. Accordingly, I agree to pay for all charges not covered by my insurance carriers relating to absent, incorrect, improper, expired, or otherwise unacceptable referrals. I understand that I am responsible for payment of fees for any specialized test requested by my physician for diagnostic purposes if my Medicare or insurance company denies payment of such diagnostic test for any reason.

3. **Our facility will file both primary and secondary insurance claims for medical services rendered.** Claims for a third insurance contract will not be filed unless required by our contract with the carrier. We cannot file claims correctly without accurate information from you. Proof of insurance must be presented at each visit. I understand that by signing this form that I am requesting my insurance company to pay claims directly to this office.

4. **If you do not have insurance,** payment in full is expected at the time of service unless financial arrangements have been made in advance with our billing department.

5. **You will receive a statement from our office within 45 days of your insurance company's response.** If you are dissatisfied with their payment, please contact your insurance carrier. Payment of the patient's portion of the balance is due upon receipt of the statement. Failure to comply may result in the involvement of a collection agency. The only exclusion to this policy are HMOs and PPOs where except for deductibles and co-payments, balance billing is prohibited.

6. **We are participating providers for Medicare.** This means that we must accept Medicare's allowed charge for the services rendered. Medicare will pay 80% of the approved amount. The patient is responsible for the remaining 20%, plus any out-of-pocket deductible. We will write off the difference between what we charge and what Medicare approves. If you have secondary insurance, we will submit the claim for the remaining balance after Medicare has paid. Please remember that although we accept assignment for Medicare, the patient, by federal law, is responsible for any portion of the approved amount not paid by Medicare or a secondary insurance company.

7. **Responsibility for payment for services rendered to the child/children of divorced or separated parents** rests with the parent who seeks treatment. Any court ordered judgment must be between the individuals involved, without including our facility.

8. **In the unlikely event your payment is returned to us unpaid,** we may elect to re-present your payment, either electronically or by paper draft, to your financial institution up to two more times. We may also collect a return processing charge by the same means, in an amount not to exceed that permitted by state law.

9. **We offer contact lens services.** I understand that in order to get a contact lens prescription with a routine eye examination it will require a contact lenses fitting. I understand that there is an additional charge for the contact lens fitting. Furthermore, I understand that I must keep the container in which my contact lenses were delivered to me. Doctors Frazee, Passmore and Ngo cannot return defective lenses without it. Financial obligation for ordered lenses is initiated at the time the order is placed.

It is our hope that you will find this information helpful. If you have questions, please speak with our billing staff at (972) 867-7777 option 7

Signed: _____ Date: ____/____/____

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ALLERGIES AND MEDICATIONS

Medication Allergies (Include the name of the medication and the reaction that you have to that medication): _____

_____

Please bring a list of all current medications and dosages with you to your appointment.

Medication:

Medication	Strength	How Taken	Frequency	Last Taken

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PAST EYE HISTORY:

DO YOU HAVE	NO	(Y) RIGHT EYE	(Y) LEFT EYE	COMMENTS
Distance Glasses	☐	☐	☐	_____
Reading Glasses	☐	☐	☐	_____
Bifocals	☐	☐	☐	_____
Contact Lenses	☐	☐	☐	_____
Lazy Eye	☐	☐	☐	_____
Vision Loss	☐	☐	☐	_____
Blurry Vision	☐	☐	☐	_____
Eye Pain	☐	☐	☐	_____
Redness	☐	☐	☐	_____
Itching	☐	☐	☐	_____
Discharge	☐	☐	☐	_____
Floaters	☐	☐	☐	_____
Flashes of Light	☐	☐	☐	_____

HAVE YOU EVER BEEN TOLD:

	NO	(Y) RIGHT EYE	(Y) LEFT EYE	COMMENTS
Cataracts	☐	☐	☐	_____
Eye Surgery-Cataracts	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Retinal Disease	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____
Eye Surgery-Glaucoma	☐	☐	☐	_____
Eye Surgery-Other	☐	☐	☐	_____
Other	☐	☐	☐	_____

ALCOHOL USAGE:

Denies	☐	Occasionally	☐	2 per day	☐
Socially	☐	1 per day	☐	+2daily	☐

TOBACCO USAGE:

☐ Current tobacco non-user
☐ Current tobacco smoker
☐ Current tobacco smokeless tobacco user (eg. chew, snuff, vapor)

If smoker, smoking history is: ____ packs per day for how long _____

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GENERAL MEDICAL HISTORY:

	YES	NOTES
Patient denies any history of medical conditions or diseases	☐	_____
CARDIOVASCULAR		
Congestive heart failure	☐	_____
Coronary artery disease	☐	_____
Elevated cholesterol	☐	_____
Heart attack	☐	_____
Heart valve disease	☐	_____
Hypertension	☐	_____
Pacemaker	☐	_____
Other cardiovascular	☐	_____
DERMATOLOGICAL		
Keloid formation	☐	_____
Shingles	☐	_____
Skin cancer	☐	_____
Other dermatological disease	☐	_____
GASTROINTESTINAL		
Colon cancer	☐	_____
Crohn's	☐	_____
GI bleeding	☐	_____
Ulcerative colitis	☐	_____
Other gastrointestinal	☐	_____
GENITOURINARY		
Enlarged prostate	☐	_____
Kidney disease	☐	_____
Other genitourinary	☐	_____
HEMATOLOGIC		
Anemia	☐	_____
Bleeding disorder	☐	_____
Blood clots	☐	_____
Leukemia	☐	_____
Sickle cell	☐	_____
Other hematologic	☐	_____

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	YES	NOTES
INFECTIOUS DISEASE		
Hepatitis C	☐	_____
HIV	☐	_____
MRSA	☐	_____
Tuberculosis	☐	_____
Other infectious disease	☐	_____
METABOLIC/ENDOCRINE		
Diabetes, Type I	☐	_____
Diabetes, Type II	☐	_____
Thyroid disease	☐	_____
Other metabolic/endocrine	☐	_____
MUSCULOSKELETAL		
Gout	☐	_____
Osteoarthritis	☐	_____
Rheumatoid arthritis	☐	_____
Other musculoskeletal	☐	_____
NEUROLOGICAL		
Dementia	☐	_____
Migraines	☐	_____
Multiple sclerosis	☐	_____
Seizures	☐	_____
Stroke	☐	_____
Other neurological	☐	_____
PULMONARY		
Asthma	☐	_____
COPD	☐	_____
Lung cancer	☐	_____
Sacroid	☐	_____
Sleep apnea	☐	_____
Other lung disease	☐	_____
PSYCHIATRIC		
Anxiety	☐	_____
Bipolar	☐	_____
Depression	☐	_____
Schizophrenia	☐	_____
Other psychiatric	☐	_____

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	YES	NOTES
WOMEN'S HEALTH		
Breast Cancer	☐	_____
Ovarian cancer	☐	_____
Other women's health	☐	_____

PAST SURGICAL HISTORY:

	SURGERY DETAILS	DATE
1.	_____	
2.	_____	
3.	_____	
4.	_____	
5.	_____	
6.	_____	
7.	_____	
8.	_____	
9.	_____	
10.	_____	

FAMILY HISTORY:

	FATHER	MOTHER	SIBLING	COMMENTS
Cancer	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Heart disease	☐	☐	☐	_____
High blood pressure	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Macular degeneration	☐	☐	☐	_____
Retinal detachment	☐	☐	☐	_____
Blindness	☐	☐	☐	_____
Parkinson's	☐	☐	☐	_____
Alzheimer's	☐	☐	☐	_____
Unknown	☐	☐	☐	_____
Other	☐	☐	☐	_____
No significant family history	☐	☐	☐	_____