El Paso Eye Surgeons, P.A
1201 North Mesa Suite G
El Paso, Texas 79902

New Patient Information

PERSONAL INFORMATION (Please Print)

Name _____ Date _____

Date of Birth _____ Age _____ M / F _____ Soc Security # _____

Address _____
Street City State Zip

Phone: Home (___) _____ Work (___) _____

Occupation _____ Employer _____

Address _____ Phone (___) _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Spouse Name _____ Employer _____

Address _____ Phone (___) _____

Complete if under 18 years or a student

Name of Father _____ Employer _____

Address _____ Phone (___) _____

Name of Mother _____ Employer _____

Address _____ Phone (___) _____

Referred by: Doctor _____ Friend/Relative _____
Name Name

Other _____

INSURANCE INFORMATION

☐ Medicare # _____ ☐ Medicaid # _____

☐ Workers Compensation (job injury) to whom is bill to be sent? _____

☐ Other Medical Insurance _____

Group # _____ ID# _____

Name/Address 2nd Insurance _____

Are you personally responsible for the payment of your fees? ☐ Yes ☐ No If not, who is?

Name _____ Relationship _____ DOB _____

Who to notify in emergency (nearest relative or friend)?

Name _____ Relationship _____

Address _____
Street City State Zip

Home Phone (___) _____ Work Phone (___) _____

FINANCIAL ASSIGNMENT AND AGREEMENT:

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to thedoctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.**
2. **In Order To Control Your Cost of Billings, We Request That Your Charges For Office Visits Be Paid At The Conclusion Of Each Visit Unless You Are Covered By Medicare.**
3. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.
4. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signed (Patient or parent if minor) _____ Date _____

PATIENT SUMMARY SHEET

Patient Name: _____ **D.O.B.** _____

M.R.N. _____ **Pt. home phone #** _____

Referring: Dr. _____ **Site:** _____ **Phone #** _____

Emergency contact: name / relation: _____ **Phone #:** _____

Allergies: _____

Medical History

	Patient:	Family	
Arthritis	Y	/N	
Anemia	Y	/N	
HTN	Y	/N	Y/N
DM	Y	/N	Y/N
Cardiac	Y	/N	Y/N
Pulmonary	Y	/N	
GU/Dialysis	Y	/N	
Cancer	Y	/N	Y/N
CNS	Y	/N	
GI/Liver	Y	/N	
Thyroid	Y	/N	
Inf. Diseases	Y	/N	
HIV/AIDS	Y	/N	
Cholesterol	Y	/N	
Mental Health	Y	/N	

Other: _____

Smoke- Tobacco - Alcohol

Y/N Y/N Y/N

Ocular Diagnosis:

Injuries	Y/N	
Strabismus	Y/N	Y/N
Amblyopia	Y/N	Y/N
Glaucoma	Y/N	Y/N
Cataract	Y/N	Y/N
Retinal	Y/N	Y/N
Blindness	Y/N	Y/N
Prosthesis	Y/N	OD/OS

Other: _____

Pachymetery OD _____

Date: _____ OS _____

General Medications:

UPDATED ➡

Did not bring meds

Ocular Medications

Previous Ocular Surgery / Laser (s):

Performed By:	Date:	Procedure:	OD / OS:

Other surgeries: _____

KEY:
✓ = presently on
x = discontinued
n = new med.

OFFICE POLICY FOR ALL PATIENTS

The doctors of El Paso Eye Surgeons have enrolled in numerous insurance programs so that we may satisfy the needs and request of our patients. All insurance plans vary and in order for us to provide you with complete care from the moment you walk through our doors, we ask you, the policy holder, to be aware of your insurance plan.

Because of the intricacies of all the different insurances plans/policies, it is extremely difficult for us to keep up to date with the specific coverage and requirements of each and every plan, without your full cooperation. Please understand that each plan has different stipulations pertaining to:

Well care vision coverage

Refraction coverage (test to determine glass change or new glass prescription)

Referrals AND Authorizations (which may be required according to your plan)

Annual deductibles

Co-payments

IT IS VERY IMPORTANT THAT YOU, THE PATIENT, COME INTO OUR OFFICE WITH ALL OF THE REQUIRED DOCUMENTATION AND BE FULLY AWARE OF HOW YOUR PLAN WORKS PRIOR TO THE TIME OF YOUR SCHEDULED APPOINTMENT. YOU MAY BE BILLED FOR ANY UNCOVERED SERVICES. YOU, THE PATIENT ARE THE POLICY HOLDER AND IT IS YOUR RESPONSIBILITY TO KNOW YOUR INSURANCE PLAN.

GIVING YOU THE BEST OPHTHALMIC ARE IS OUR GOAL: HOWEVER, WE NEED YOUR COOPERATION TO ATTAIN IT.

I HAVE READ AND UNDERSTAND THE OFFICE POLICY STATED ABOVE AND AGREE TO ACCEPT RESPONSITILITY FOR ANY NON-COVERED SERVICES.

_____ _____

PATIENT NAME DATE

Financial Policy

Thank you for choosing an El Paso Eye Surgeons as your eye care provider. We are committed to providing you with quality and affordable health care. Due to some the changes regarding the Federal Health- Care Reform, we have developed this payment policy for services rendered. As a courtesy we will bill most insurance. HOWEVER, the patient is responsible for the following THE DAY OF YOUR APPOINTMENT:

1. **Co-payment and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
2. **Non-covered services**. Please be aware that some - and perhaps all - of the services you receive may be non-covered or not considered medically necessary by Medicare or other insurers, such as REFRACTIONS (test to determine if you need new eyeglasses). This has a separate charge of $25.00. You must pay for these services in full at the time of your visit. Medicare DOES NOT COVER REFRACTIONS. Before your visit please contact your insurance company to verify that we are participants in your plan, and the services you intend to receive are convered.
3. ***Referral Requirements***
   When a PCP determines the need for medical services or treatment, which will be provided outside the office, he/she must approve and/or arrange referrals to a participating Specialist, (Dr. Gulbas or Dr. Gallardo) It is the PATIENTS responsibility to initiate the referral and bring the day of the visit.

Proof of insurance and Non Covered Patients. All patients must complete our patient information forms before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information the day of your visit, PAYMENT IN FULL is expected. If you are unable to pay your visit or any of the medical services, we ask you to please call PRIOR to your appointment to make payment arrangements.

Claims submission. We will submit your claims and assist you in any reasonable way we can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Coverage charges. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance

Acknowledgement of Review of Notice

Of Privacy Practices

I have reviewed the Notice of Privacy Act, which explains how my medical information will be use and disclosed. I understand that I am entitled to receive a copy of this document. Please list any family members you would like to share your medical information with.

X_____

Signature of Patient or Representative

X_____

Family Member

_____

DATE