3507 TOWN CENTER BLVD S
SUGAR LAND TX 77479 TEL: 281 242 1242

Today's Date: ___________________

PATIENT INFORMATION

PLEASE PROVIDE YOUR DRIVER'S LICENSE AND INSURANCE CARDS TO THE STAFF.

(PLEASE PRINT LEGIBLY)

Patient Last Name: _____________________________First Name: _____________________M.I.: _____

Sex : M_____F_____DOB: ______/______/_______ SS # : _______________________________________

Address: ____Apt # _____________

City: _______________________ State: _____ Zip Code: _________ Email: _______________________

Home Phone:________________ Work #:_________________ Mobile #: _____________________

Marital Status: ___________ Emergency Contact: _______________ Phone: _____________________

Relationship:________________

Primary Physician: ________________________________ Phone # _____________________________

Referring Physician: _______________________________ Phone # _____________________________

Pharmacy Name and Address: ____

Phone # _________________________

If we need to contact you regarding medical or billing information, please indicate below how you wish to be contacted:____

Other individuals with whom we can discuss medical and billing information: ______________________

Phone Number: ________________ Relationship to Patient: __________________________________

Who referred you to us? ____

Last Name ________________ First Name ________________ Middle Initial ___

Date of Birth ________________ Gender ☐ Male ☐ Female

Primary Care Physician ________________ Phone Number ________________

Referring Doctor's Name: ________________ Phone Number________________

Pharmacy ________________ Phone Number ________________

Please check all that apply to you.

Personal Medical History

☐ Anxiety
☐ Asthma
☐ Arthritis
☐ Atrial Fibrillation
☐ Cancer (specify type below)
____
☐ COPD
☐ Diabetes
☐ Depression
☐ GERD
☐ Heart Disease
☐ Hyperlipidemia
☐ Hypertension
☐ Kidney Disease
☐ Prostate Hyperplasia
☐ Seizures
☐ Stroke
☐ Thyroid Disease
☐None
Other ________________

Surgical History

☐ Appendectomy
☐ Back
☐ Coronary Stent
☐ Coronary Artery Bypass
☐ Gallbladder Removal
☐ Hip ☐ Right ☐ Left
☐ Hysterectomy
☐ Knee ☐ Right ☐ Left
☐ Neck
☐ None
Other ________________

Ocular History

☐ Cataract Surgery ☐ Right ☐ Left
☐ Contact Lenses
☐ Dry Eye Syndrome
☐ Floaters
☐ Glasses
☐ Glaucoma
☐ LASIK
☐ Macular Degeneration
☐ None
Other ________________

Family Medical History (Parents or Siblings)

☐ Cancer (specify type below)
____
☐ Diabetes
☐ Glaucoma
☐ Heart Disease
☐ Hypertension
☐ Hyperlipidemia
☐ Macular Degeneration
☐ Stroke
☐ None
Other ________________

Medication Allergies

☐ Latex – Reaction ________________
☐ Penicillin – Reaction ________________
☐ Sulfa – Reaction ________________
☐ None
Other ________________

Social History

Tobacco Use ☐ No ☐ Yes Frequency ________________________________ Former Smoker ☐ Yes
Alcohol Use ☐ No ☐ Yes Frequency ________________________________
Occupation ____

Medications (Please include name, dosage, and frequency)

1) ____

2) ____

3) ____

4) ____

5) ____

6) ____

7) ____

8) ____

9) ____

10) ____

OFFICE POLICIES

Updated Records:
It is your responsibility to inform Outlook Eye & Laser Center of any changes to your insurance, telephone numbers, and address. Please have your insurance card available at all office visits. Patients will be required to fill out forms every year or as requested.

Authorization for Treatment:
By signing below, you hereby consent to all medical and surgical procedures for the evaluation and treatment of the conditions for which you present yourself to this office. You acknowledge that you are legally responsible for all charges in connection with the medical care and treatment administered by Outlook Eye & Laser Center and promise to pay whatever charges in return for the medical care and services provided to you in accordance with this terms stated herein. You understand that this consent will remain valid and in effect as long as you receive care at Outlook Eye & Laser Center. This authorization will remain valid and in effect until revoked in writing.

Assignment of Benefits:
By signing below, you hereby appoint as your authorized representative, and assign to, Outlook Eye & Laser Center all of your right, title, and interest in and to, and relating in and to the recovery of, any and all health care and/or surgical benefits otherwise payable to you or to which you are entitled for medical treatment rendered by Outlook Eye & Laser Center. You also authorize Outlook Eye & Laser Center, on your behalf, to file and prosecute any required appeal, grievance, litigation or arbitration with your health plan for payment of medical claims and to exert or receive any other rights or benefits under your health plan with respect to the treatment rendered by Outlook Eye & Laser Center. You further authorize Outlook Eye & Laser Center to release to your health plan, or its agents, any information about you needed to determine the benefits payable for medical treatment rendered by Outlook Eye & Laser Center. You certify that the information given by you to Outlook Eye & Laser Center in applying for insurance coverage or other protection is correct and complete. This assignment will remain valid and in effect until revoked in writing.

Medical Records; Disability Forms:
The cost for copying your records is $25.00 per every 100 pages, which shall not be prorated.
There is a $25.00 fee for any disability form, or other paperwork, that are to be completed by Outlook Eye & Laser Center on your behalf. Please allow 10 business days to fulfill requests for copies or complete disability forms.

Appointments:
If you are having an emergency, please dial 911 immediately. Appointments can be made by calling during office hours or online. If you are unable to keep your appointment, please reschedule at least one day prior to your original appointment. If you fail to appear for an appointment, you will be charged a $25.00 no-show fee. If you arrive late for your appointment, you may be rescheduled or worked in depending on our schedule.

Financial Policy:
Payment for services is due, in full, at the time Outlook Eye & Laser Center renders service. You acknowledge full responsibility for the payment of services.

You understand that your insurance coverage is an agreement between you and your insurer. It is your responsibility to remit payment for charges not covered by your insurance or for any remaining balance that your insurance company states is your responsibility, according to terms of your plan. Please contact your insurance company for clarification of benefits, as they do not always provide that information to our

office. Our charges are an estimate of you each insurance company's fee schedule, and you will be asked to pay this estimated amount. Payment for all copays and deductibles are due at the time of your appointment.

HMO Plans: You are responsible for getting referral information 72 hours in advance of your scheduled appointment with a specialist. If you do not get a referral, you will be responsible for the office visit in full.

PPO Plans: You are responsible for any coinsurance costs, non-covered service, pre-existing coverage and deductibles, as stated in your plan.

Traditional Indemnity Plans: You are responsible for the stated percentage of total charges (prior to any adjustments made by the healthcare plan). A bill will be mailed to you in the event this deductible was not satisfied.

Medicare/Medicare Insurance Type Plans: As a participating provider, we will file directly with your plan and secondary insurance, if one has been elected. You will be billed for the deductible and coinsurance according to plan.

Secondary Insurance: Having more than one insurance policy does not necessarily mean that your services are covered at 100%. You are responsible for any balance after your insurance companies have processed your claim. Please advise which plan is primary and which is secondary to assist with your claim processing.

Private Pay Patient: If our office does not accept your insurance, or if you do not maintain insurance, you will be accepted as a private pay patient at the time services are provided. You understand that you are responsible for payment for all services or items you request and receive by Outlook Eye & Laser Center.

Outstanding Payment: For outstanding balances, monthly statements are mailed to the address provided to our office and are to be paid by you in fill within 30 days of receipt. Should your account be turned over for collections or processing, you will be responsible for the account balance and fees incurred to collect payment. We may bill your insurance company as a courtesy, but you are ultimately responsible for payment should you insurance fail to pay within 90 days.

There is a $50.00 charge for all returned or canceled checks.

Consent:
By signing below, I fully understand the Office Policies of Outlook Eye & Laser Center and agree with all terms stated herein. I also understand, and agree, that terms of this Office Policies may be amended by Outlook Eye & Laser Center at any time without prior notice to me. A photocopy or electronic version of this Office Policies is considered as valid as the original.

Patient Name: ______________________________________

Patient Signature: ________________________________ Date: _____________

As applicable:
Parent or Legal Guardian Name: ________________________________

Parent or Legal Guardian Signature: ________________________________ Date: _____________