Flores Eye Care Clinic

Dr. Amador Flores, Jr.
Dr. Heather L. Hickson

Patient Information

Name _____
Address_____
City_____ Zip Code_____
Male___Female___ Date of Birth_____
Social Security Number_____
Marital Status Single____ Married____
Daytime Phone #_____
Cell Phone #_____
Email Address_____
Employer_____
Occupation_____
Work Phone #_____

Emergency Contact_____
Relation to Patient_____
Contact Phone #_____

Ethnicity Asian___ Black___ Other___
Caucasian___ Hispanic___ Middle Eastern___
Race White___ Black___ Other___
Preferred Language English___ Spanish___
How were you referred to us?
Phonebook___ Newspaper___Walk-In___
Internet ___ School___ Other___
Patient Referral Name_____
Doctor Referral Name_____ ____

Primary Insurance_____
Name of Policy Holder_____
Policy Holder's Date of Birth_____
Relation to Policy Holder_____
Policy Number_____

Secondary Insurance_____
Name of Policy Holder_____
Policy Holder's Date of Birth_____
Relation to Policy Holder_____
Policy Number_____

Due to Federal Patient Confidentiality Laws known as HIPAA, we will need your permission to do the following:

Call, Email or Text Message to confirm appointments YES___ NO___
Leave Messages with someone at home or on Answering Machine YES___ NO___
Call or Leave Messages on your cell phone YES___ NO___
Call at Work Phone YES___ NO___
Pharmacy of Choice:_____

****It is our policy to notify patients of their appointments via text and/or email. This is done as a courtesy reminder. If checking NO above, you will not receive a reminder for your appointments.**

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Financial Policy Agreement

As a courtesy to our patients, Flores Eye Care Clinic offers to bill insurance companies on your behalf. Please understand that having insurance is not a guarantee of payment. We strive to verify benefits prior to your visit so that we may explain the coverage your policy offers and what your requirements are. However, it is ultimately the patient's responsibility to pay 100% of any balance not covered by insurance. Deductibles, co-payments, or co-insurances are the patient's responsibility and must be paid at the time services are rendered. You will aid us in not billing **YOU** by kindly replying to insurance information requests in a timely manner. I authorize Flores Eye Care Clinic to release medical and personal information to third party insurance carriers for the purpose of filing insurance claims related to my care. I further authorize Flores Eye Care Clinic to receive payment from my insurance carrier(s) for those services received from the clinic and/or its designees.

Signature_____ Printed Name_____ Date_____

One of the most important parts of your eye exam today is the refraction. That is the part of the exam by which we determine whether you can be helped in any way by a new glasses prescription. It is also how we determine the best possible visual acuity and function of your eye, which is essential medical information for us to have as we assess your eyes and look for problems. **It is NOT a covered service by Medicare and many other insurance plans.** These plans consider refraction a "vision" service not a "medical" service. Our office fee for refraction is $30.00. A contact lens exam is separate from the annual eye exam, because there are unique procedures used only on contact lens wearers. Our office fee for the contact lens evaluation is $50.00. Unless your plan automatically covers the refraction charge and/or the contact lens charge; the fees are collected at the time of service in addition to any co-payment your plan may require. Should your plan pay us for either service, we will reimburse you accordingly. The patient's own insurance makes refraction a non-covered service. Most insurance companies take the position that if your vision can be corrected with glasses, then contacts are not medically necessary and therefore are not covered. **"We don't make the rules but we all have to live with them."**

I have read the above information and understand that the refraction and contact lens evaluation is a non-covered service. I accept full financial responsibility for the cost of this service and understand it is due at time of service. I understand that any co-payment, coinsurance or deductible I may have are separate from and not included in the refraction fee and contact lens evaluation. I further understand that any refraction and/or co-pay charges must be paid in order for my eyeglass prescription to be released.

Signature _____ Printed Name_____ Date_____

Appointments: Patients arriving more than **15 minutes late** may be **rescheduled** for the next available appointment. Text/Email/Phone Messages are provided as a **courtesy** reminder for appointments, it is the patient's responsibility to provide Flores Eye Care Clinic with accurate phone numbers in order to provide this courtesy.

Special Services Fees: A service fee will apply for non-medical services provided by Flores Eye Care Clinic and/or its designees. These services include, but are not limited to copies of medical records, any forms requiring doctors' review, or other services requiring special attention. The special services fee generally runs about $25.00 and is due at the time of request. In certain cases, this fee may be higher.

Signature_____ Printed Name_____ Date_____

Receipt of Notice of Privacy Policies & Consent Form

Flores Eye Care Clinic / Amador Flores, Jr., O.D. / Heather L. Hickson, O.D.
6801 McPherson, Suite 111
956-753-7373

Patient Name:_____ Chart #_____

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The *Notice of Privacy Practices* you have been given describes these uses and disclosure in detail. You are free to refer to this notice at any time before you sign this form. As described in our *Notice of Privacy Practices,* the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as many be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our *Notice of Privacy Practices.* Our *Notice of Privacy Practices* will be updated whenever our privacy practices change. You can get an updated copy here at the office.
When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our service and to perform healthcare operations. You also signify that you have received a copy of our *Notice of Privacy Practices*.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our *Notice of Privacy Practices,* we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our *Notice of Privacy Practices* describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices* from Flores Eye Care Clinic.

Signature_____ Date_____

If signing as a personal representative of the patient describe the relationship to the patient and source of authority to sign this form:

_____ _____
Relationship to Patient Print Name

Source of Authority_____