SHAVANO EYE CENTER: Welcome to our Practice

Referrals: If you have an insurance which requires a referral, **it is your responsibility to obtain the referral from your primary care physician before your appointment.** Otherwise, the visit will not be covered by insurance, and you will be responsible for the payment. Please notify us if your insurance requires pre-authorization for office procedures.

Insurance Policy: We are happy to submit for you to receive full benefits of your coverage; additionally, an estimation of coverage provided by the insurer may differ from the final charges. Because the insurance policy is an arrangement between you and the insurance company, we ask that all patients be directly responsible for all charges. Please know that we will do everything possible to see that you receive full benefits of your policy. We will not handle disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance, and "usual and customary" fees. If for some reason your insurance company has not paid their portion within 30 days from the start of treatment, you are responsible for payment at that time.

Please note Shavano Eye Center is considered a **medical practice and will fall under your **medical insurance**, therefore no vision insurance will be accepted for services rendered at this facility**

Dilation Policy **If you are being seen for a complete exam, or any condition that requires dilation to diagnose, please plan on having your eyes dilated. One Dilated exam is required per year.**

Refraction policy (Glasses Prescription): Refractions for glasses prescriptions are **NOT included in a standard medical eye exam and are NOT COVERED by Medical insurance.** Refractions are a **separate service provided upon request** by the patient for a **fee of $50.00.** The patient is responsible for the refraction fee, and we do not send any refraction claims to medical insurance. If we are fitting you for contact lenses as well, additional fees will apply (see contact lens page).

Medical Records Release Fee: In accordance with the Texas Medical Board, we will charge a **$25.00 fee** for the first 20 pages of medical records requested for release, and 50 cents for each additional page. The fee for electronic records in $25.00 for 500 pages.

Returned Check Fee: There will be a $**35**.00 fee for returned checks.

School/FMLA/similar FORMS needing completion by the Doctor: $25 fee and 7 day turnaround time.

Acknowledgement of Limited Authorization & Release Form: Please list any other parties who can have access to your health information: (This includes stepparents, grandparents and any caretakers who can have access to this patient's records):

Name: ____ Relationship: ____________________________

Name: ____ Relationship: ____________________________

May confidential messages regarding appointments, labs/test results, billing, and insurance inquiries be left on the voicemail of the telephone numbers provided? _________ YES _________NO

Welcome to Shavano Eye Center, and thank you for selecting our healthcare team! To assist us in serving you, please fill out these confidential forms.

Patient Information (PLEASE PRINT)

First Name: ______________________ Initial:_______ Last Name: ____________________________

Address: ______________________________ City: ______________ State: _______ Zip: _________

Email: ____

Home Phone: (___) _________ Work Phone: (___) _________ Ext: _____ Cell Phone: (___) _________

Date of Birth: _______________ Age: _______________ Sex: M / F Marital Status: S / M / D / W

Social Security #: _________________ Driver's License #: ________________ Occupation: _________

Primary Language: _________________

Parent/Guardian/Responsible Party Information (PLEASE PRINT)

Full Name: ____ Relationship:____________________

Address: ______________________________ City: ______________ State: _______ Zip: _________

Date of Birth: _______________ Phone: (___) _________

Emergency Contact Information (PLEASE PRINT)

Full Name: ______________________________ Relationship:________ Phone: (____) _____________

Insurance Information (PLEASE PRINT)

Primary Insurance: ____

Policy Holder Name:___________________________________ Date of Birth: ______________

Patient Relation to Policy Holder: Self / Spouse / Child / Other: ___________________________

Secondary Insurance (if applicable): ____________________________

Policy Holder Name:___________________________________ Date of Birth: ______________

Patient Relation to Policy Holder: Self / Spouse / Child / Other: ___________________________

How did you hear about our office? ____

Patient's or Authorized Person's Signature

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or other health practitioners, I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. PAYMENT IS EXPECTED IN FULL EACH VISIT.

Patient/Guardian Signature: ____ Date: ________________

Preferred method for receiving appointment reminders: (Circle) EMAIL TEXT CALL NONE

CONTACT LENS POLICY

At Shavano Eye Center, we do not prescribe contact lenses without a complete eye examination by our physicians. We believe it is extremely important to be certain that there is no medical contraindication to wearing contacts and to diagnose any other potential problems that might be detected unrelated to contact lens wear. If a "contact lenses only" exam is what you desire, please feel free to see a local optometrist.

We do not accept vision insurance, nor do we file a claim to your health insurance; therefore our refraction and contact lens fees are collected at the time of the visit. These fees are nonrefundable and cover the cost of fitting, necessary imaging of the cornea, training of insertion and removal (if applicable), trial contact lenses, and follow up care with the technician for up to 60 days from the initial contact lens exam.

- **Refraction** (performed at every annual visit to determine the prescription): **$50**
- **Contact lens fitting and training fee** (for **first time** contact lens wearers): **$100**
- **Contact lens fitting fee** (for patients **already wearing** contacts): **$55**

I understand that there are alternatives to contact lenses for the correction of my vision and that, even with proper care, there are risks associated with contact lens wear, including contact lens intolerance, irritation from solutions or protein build up, conjunctivitis, corneal vascularization, severe and potentially blinding corneal infections, and loss of eye.

I acknowledge that I have been properly instructed in the care of my contact lenses and that, if I do not properly care for my lenses, I put myself at risk for developing serious infections that could lead to vision loss or loss of the eye.

I understand that this **contact lens prescription is good for ONE YEAR**. After one year, I will need to be seen by the ophthalmologist for my annual dilation and contact lens eye exam to receive and updated prescription for contact lenses.

I understand that the following symptoms are normal when first wearing contact lenses:

- Unusual sensation or itching
- Occasional blurry vision
- Headaches

I understand that I should refrain from doing the following in contact lenses:

- Swimming
- Sleeping
- Storing contacts in water or using saliva/water to put contacts in
- Activities or work that create a dusty/dirty environment

Hygiene is VERY important in preventing infection, always wash your hands before handling contacts, store in fresh solution every day, and keep your contact case clean and dry.

Shavano Eye Center does not provide contact lenses for purchase.

Patient/Guardian Signature____ Date________________________

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize ______________________________ (Name of business) to disclose my complete ophthalmic records to:

Shavano Eye Center

4114 Pond Hill Road, Suite 202

San Antonio, TX 78231

Fax# 210-200-8543

In furtherance of this authorization, I do hereby waive all provision of law and privileges relating to the disclosures hereby authorized.

Dated this __________________________ day of ____________________________, 20___

Patient's Name (please print): ____

Patient's Date of Birth: ____

Patient's (or responsible party's) signature ____

Shavano Eye Center – 4114 Pond Hill Rd Suite 202 – San Antonio, TX 78231

Name: ____ DOB: _________________________

ID# ______________ (Office use only)

Medical History: (Please include any past or present systemic diagnosis) ☐ None

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Sjogren's
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Pregnant or nursing
- ☐ Thyroid Disease
- ☐ Cancer
- ☐ Psoriasis
- ☐ Flu Vaccine – Date: _________
- ☐ COVID vaccine – Date: __________
- ☐ COVID: Date(s) of illness: ______________________________

Surgical History: ☐ None

__________________________ ____________________________
__________________________ ____________________________
__________________________ ____________________________

Ocular History and Surgeries: ☐None ☐ Current contact lens wearer

- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Other: __________________________
- ☐ Retinal Tear/Detachment
- ☐ Strabismus (Eye muscle misalignment)
- ☐ Corneal disease (Fuchs' or Keratoconus)

Please list all current EYE medications: ☐ None

__________________________ ____________________________
__________________________ ____________________________
__________________________ ____________________________

Please list all other current medications: (or attach a list) ☐ None

Are you on Plaquenil/hydroxychloroquine? Yes No

__________________________ ____________________________
__________________________ ____________________________
__________________________ ____________________________ __________________________
____________________________ __________________________ ____________________________

Please list all MEDICATION allergies: ☐ No Known Drug Allergies

____________________ ___________________ ________________
____________________ ___________________ ________________

PLEASE TURN OVER AND COMPLETE THE OTHER SIDE OF THIS FORM

Pharmacy information:

Name of Pharmacy: ______________________________ Phone Number: _____________________

Street Address: ____

Family History: (list family member)

☐ Heart Problems: _____________ ☐ Glaucoma: ____________________

☐ Cancer: ____________________ ☐ Macular Degeneration: ___________

☐ Diabetes: ___________________ ☐ Fuchs' Dystrophy: ______________

☐ Thyroid Disease: ____________ ☐ Keratoconus: __________________

☐ Stroke: ____________________ ☐ Other: _______________________

Social History:

Smoker: ☐ Never ☐ Former ☐ Current Smoker

Alcohol: ☐Never ☐ Daily ☐Socially ☐Occasionally

Recreational Drugs: ☐ Yes ☐No

Occupation: ______________________________ Do you drive: ☐ Yes ☐ No

Primary Care Physician: ____

Referring Physician: ____ (if different from PCP)

Other managing physicians: ____

Review of Systems: (Please circle all that apply within the last week)

Skin: ☐ None
Rash
Lumps
Itching

Head/Neck/Ears: ☐ None
Neck pain/stiffness
Swollen glands
Lumps
Decreased Hearing

Nose: ☐ None
Nasal discharge/drainage
Frequent nosebleeds
Sinus pain

Respiratory: ☐ None
Frequent cough
Coughing up phlegm/blood
Shortness of breath
Wheezing

Cardiovascular: ☐ None
Chest pain or discomfort
Chest Tightness
Palpitations (rapid heartbeat)
BP under good control
BP NOT under good control

Gastrointestinal: ☐ None
Heartburn
Nausea
Constipation
Diarrhea
Blood in stool

Urinary: ☐ None
Frequent urination
Burning/painful urination
Dark or bloody urine
Decreased urine

Musculoskeletal: ☐ None
Painful joints
Frequent muscle aches
Swollen joints
Joint redness
Back pain

Neurologic: ☐ None
Dizziness
Fainting
Seizures
Weakness
Tingling/numbness
Tremor (shaky hands)
Headache

Psychiatric/Behavioral: ☐ None
ADHD
Bipolar Disorder
Depression
Anxiety

NO SHOW POLICY FOR DOCTOR APPOINTMENTS

We understand that there are times when you must miss an appointment due to emergencies or pre-existing obligations. If you need to cancel or reschedule an appointment, we require a call 24 hours prior to your scheduled appointment. If proper notification is not provided, a "no-show" fee of **$50.00**, which is not covered by insurance, will be charged. If a patient "no-shows" for an appointment 3 times, the patient may be dismissed from the practice at the doctor's discretion.

Signature: ____Date:__________________

Witness: ____Date:__________________