Date: ________________

Patient's Name: ____
Last First MI

Date of Birth: ____________________ Sex: □M □F

Address: ____
Street City State Zip

Preferred Phone # ____________________________ Alternate Phone # ____________________________

E-mail: _____________________________________ Language Preference: ________________________

Insurance Information (If any):

Name of insurance company to be filed? ____
(Please circle one) Vision or Medical

Primary Policy Card Holder Information:

Full Name: ____ DOB: _______________

Member ID# or SSN# _______________________________ Relationship to Patient: ____________

Group# (Only if medical insurance is being filed) ____

How did you hear about us? (Please be specific): ____

Certain races or ethnicities have an increase risk for different conditions so we ask you please complete the following:

Check the applicable RACE below:

□ American Indian □ Native Hawaiian/Pacific Islander □ Black/African American
□ Asian □ White □ Other Race □ Unknown/Decline

Check the applicable ETHNICITY:

□ Latino □ Non-Latino □ Unknown/Decline

Referring Eye Doctor/Physician: ___________________________ Phone # _____________ Last Exam: _________

In case of emergency, please contact: ______________________________ Phone # _________________________

I hereby consent to a health examination, related diagnostic procedures and treatments provided by Mann Eye 2. I also authorize the use of my photographs or data collections taken to document my ocular condition for routine care or use in research and professional publication. Photo static copies of this authorization will be considered valid as the original.

By signing below, I authorize the following person to receive information regarding my treatment or care. (If you wish to add names later on, please confirm this in writing, or contact our staff.)

Name: ____ Relationship to Patient: _____________________
(Authorized person to receive information)

Signature: ____ Printed Name: ________________________________

(Please circle one) Patient Legal Guardian

Signature on File, Assignment of Benefits, Financial Agreement HIPAA Notice

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Mann Eye2 for services furnished me by Doctor(s). I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS 1500 form, my signature authorizes releasing the information to the insurer or agency shown. Mann Eye2 accepts the charge determination of the Medicare carrier as the full charge, and I am responsible for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

2. **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA1500 form, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Mann Eye2, if possible or otherwise to me.

3. **OTHER INSURANCE:** I authorize payment of my medical and surgical insurance benefits to Mann Eye2.

   I understand I am financially responsible for any charges whether or not paid by said insurance. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Mann Eye2. I authorize Mann Eye2 to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

4. **NON-COVERED SERVICES:** I understand that Mann Eye2's contract with health care services plans (i.e., HMOs, PPOs) relates only to items and services which are "covered" by the health care service plans. Accordingly, I accept full financial responsibility for all items or services, which are determined by the health care service plans not to be covered, including the refraction fee. I agree to cooperate with Mann Eye2 to obtain necessary health care service plan authorizations.

5. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to me by Mann Eye2, I will pay my account at the time service is rendered. If my account is sent to an agency for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance are hereby assigned to Mann Eye2. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Mann Eye2. However, I understand that I am primarily responsible for the payment of my bill.

6. **HIPAA NOTICE OF PRIVACY PRACTICES:** I acknowledge that I have received the Notice of Privacy Practices Issued by Mann Eye2 that was effective April 14, 2003. I agree to allow electronic communication as defined in security practices effective April 21st, 2005.

Please direct complaints to: Texas Department of State Health Services
110 West 49th Street, Austin, TX. 78756
Phone: 1.888.973.0022

I have read and understand these instructions and have a copy for my review.

Name (print): ____

Signature: ________________________________ **Date:** ________________

Medical History Questionnaire

Name: ______________________ Date of Birth: ______________ Date: ______________

Height: Weight: Do you wear contacts or glasses? ○ Yes ○ No Type:

List any **medications** you currently take **with dosage** (Rx or over-the-counter):	Do you have allergies to any medications? ○Yes ○No If yes, please list medications
Your Pharmacy Phone#:	

Have you or any of your family members been diagnosed with any of the following conditions?

Condition:	**You**	**Family**	**Details**
Glaucoma	○	○	
Macular Degeneration	○	○	
Cataracts	○	○	
Retinal Detachment	○	○	
Keratoconus	○	○	
Dry Eyes	○	○	

Please list any surgeries you've had: ____

____

Please list any other medical conditions you may have (Diabetes, High Blood Pressure, Thyroid, etc):

____

____

Other: AIDS, HIV+, Hepatitis, Cancer etc. ______________________ Pregnant/Nursing?

Do you drink alcohol? ○ Yes ○ No How much?

Do you smoke? ○ Yes ○ No How much?

Please check the box if you are having problems in any of the following areas:

Allergic/Immuno	**Cardio**	**Constitutional**	**Endocrine**
○Environmental Allergies ○ Food Allergies ○ Seasonal Allergies Details:	○Chest pressure or discomfort ○ Irregular Heartbeat/Palpitations Details:	○ Fatigue ○ Fever ○ Night Sweats Details:	○ Cold Intolerance ○ Heat Intolerance ○ Excessive thirst/dry mouth ○ Excessive Hunger Details:
ENMT	**GI**	**GU**	**Hema/Lymph**
○Hearing loss Details:	○Constipation ○ Diarrhea ○ Vomiting Details:	○Difficulty urinating ○ Blood in urine ○ Excessive urination Details:	○ Bleeding ○ Bruising Details:
Integumentary	**MS**	**Psych**	**Neuro**
○ Rash Details:	○Joint pain ○ Joint swelling ○ Muscle weakness Details:	○Emotional Changes ○ Depression Details:	○Dizziness ○ Abnormal walking ○ Headache Details:

Respiratory	**Chief Complaint: Please check any of these you are experiencing**				
○Cough ○ Wheezing Details:	○ Blurry Vision ○ Decreased Vision ○ Foreign Body ○ Other, Please explain:	○Trouble Reading ○Floaters ○Trouble Driving ○Bloodshot	○Halos ○Glare	○Redness ○Headaches Flashes ○ Tired Eyes	○Dryness ○ Pain ○ Burning ○ Failed Vision Screening