round rock eye consultants

Joseph L. Meyer, M.D.
1880 Round Rock Avenue, Suite 100,
Round Rock, Texas 78681
P: 512-248-4007 / F: 512-236-5128
www.roundrockeye.com

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____/_____/_____

Gender Identity: M___ F___ Other _____ Age: _____ Marital Status: Single___ Married___Divorced___ Widowed___

Race **(please circle one):** African-American American Indian Asian Caucasian Other Decline to Answer

Ethnicity **(please circle one):** Hispanic / Latino Not Hispanic / Latino Decline to Answer Primary Language: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: (_____) _____ Home Phone: (_____) _____ Work Phone: (_____) _____

Email: _____Employer: _____ Occupation: _____

****PLEASE NOTE THAT WE DO APPOINTMENT REMINDERS VIA TEXT OR EMAIL ONLY. NO PHONE CALLS****

POLICY HOLDERS INFORMATION

Name: _____ Date of Birth: _____/_____/_____ Age: _____

Address (if different): _____

Home Phone: (_____) _____ Cell Phone: (_____)_____ Work Phone: (_____)_____

Employer: _____ Occupation: _____

EMERGENCY CONTACT (If different from above)

Name: _____ Relationship to Patient: _____

Home Phone: (_____) _____ Cell Phone: (_____)_____ Work Phone: (_____)_____

DOCTOR/VISIT INFORMATION

Primary Care Doctor: _____ Optometrist: _____

Referred By: Patient_____ Doctor_____

Reason for Visit: _____

CONTACT/RELEASE OF INFORMATION

In the event that Round Rock Eye Consultants needs to contact you (the patient) regarding an appointment, lab results, medication refill, or for any other reason, it is permissible to:

*Leave a message on an answering machine or cell **(Please circle one)** **NO** **Yes**

*Speak with spouse/significant other/family members **(Please circle one)** **NO** **YES** **(If yes, please list below)**

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Round Rock Eye Consultants will not release your information to anyone unless listed above. Please print name and be as detailed as possible.

_____ _____/_____/_____

Signature of Patient or Guardian or Personal Representative Today's Date

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AUTHORIZATION / ACKNOWLEDGMENT

CONSENT TO TREAT

I have requested medical services from Round Rock Eye Consultants on behalf of myself. I agree to and understand that my eyes may be dilated in order for the doctor to thoroughly check the health of my eyes. I understand that if my pupils are dilated, I may not be able to safely operate a motor vehicle and that the staff and doctors of Round Rock Eye Consultants request that I arrange alternate transportation.

FINANCIAL POLICY

I understand I am fully financially responsible for any and all charges incurred in the course of treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original. I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), Medicare, Medicaid, private insurance and any other health/medical plan, to issue payment check(s) to Round Rock Eye Consultants for medical services rendered to myself regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

REFRACTION WAIVER

A refraction is the process of determining your best corrected vision and potential need for corrective lenses (glasses or contact lenses). It is a crucial part of your eye examination. Unfortunately, most medical insurance plans consider this a non-covered service. Round Rock Eye Consultants charges $40.00 should you choose to receive an eyeglass prescription. Payment is due at time of service. If you have checked your MEDICAL benefits and feel that the refraction should be covered, we will be happy to bill your insurance for this service. If your insurance does pay for the refraction we will reimburse you the $40.00 paid at time of service.

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Round Rock Eye Consultants to: (1) release any information necessary to insurance carriers regarding my treatments; (2) process insurance claims generated during examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

APPOINTMENT/SURGERY CANCELLATION AND NO-SHOW POLICY

We request our patients provide us with at least 24-hours' notice to cancel/reschedule an appointment. Should you fail to come to your appointment or to provide proper notice to cancel, your visit will be considered a "NO SHOW." No-shows are costly to the practice and prevent other patients from utilizing appointment times. A $50.00 no-show fee will be charged to your account (not the insurance company) and will need to be collected prior to rescheduling your appointment. (Surgery cancellations require two (2) business days to cancel and are subject to a $100.00 fee.) Please be aware that as a courtesy, RREC sends out text/email reminders. If you do not receive a reminder, this policy remains in effect regardless.

_____

Print Patient Name

_____ _____/_____/_____

Signature of Patient or Guardian/Parent ***Date***