K. Randy Pierce, MD
Mark A. Plunkett, MD
Eric Dai, MD
Peter Ryg, MD

EYE PHYSICIANS OF AUSTIN
Advanced Eye Care

Dawn C. Buckingham, MD
Peter T. Wollan, MD
Haumith Khan-Farooqi, MD

Dear Patient:

Please complete the enclosed registration form and bring it with you to your scheduled appointment at our office. **Do not mail or fax this form to our office prior to your visit.**

We will screen every visitor that comes to our facility upon arrival. Please plan to arrive no more than five minutes before your appointment time and come with a mask or face covering. During this time, you may be asked to reschedule if you are not wearing a face covering. Please wait for admission to the building by our staff as we complete screenings. We have allowed for ample time in our schedules to complete screenings on each visitor. We ask that only one companion accompany the patient to their appointment if necessary and that only children scheduled for an appointment visit our building.

You must bring your insurance card or cards to your office visit.

If your insurance plan has an office visit co-pay or does not cover refractions, please expect to pay for those at time of service.

If you have an insurance plan such as an HMO that requires a referral number, please verify with our office that the referral number has been received prior to your visit.

If you wear glasses or contact lenses please be sure to bring them with you for your office visit.

Please bring a list of any medications you are taking.

Please expect to be in our office approximately 90 minutes for a complete eye examination.

Thank you for your cooperation; we look forward to serving you.

Sincerely,

Eye Physicians of Austin, P.A.

Patient Information Form
(PLEASE PRINT)

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Patient's Name_____
(First) (MI) (Last)

Gender: M F **Date of Birth:** _____ **Social Security #** _____

Mailing Address: _____
(Street) (City) (State) (Zip Code)

Responsible Party: _____ **Phone:** (____) _____

Phone Contacts:		**Circle One**	**Preferred Method of Contact**
Home: (____) _____	Okay to leave message?	YES NO	☐
Cell: (____) _____	Okay to leave message/text?	YES NO	☐
Work: (____) _____	Okay to leave message?	YES NO	☐
E-mail Address: _____			☐

***I understand that email is not a secure method of communication and that personal health information sent via email may not be private. Eye Physicians may occasionally send promotional information via email.*

Patient's Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced

Race: ☐ African American ☐ American Indian ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Other

Primary Language: _____

Emergency Contact Name: _____ **Relationship:** _____

Emergency Telephone: Cell (____) _____ Home (____) _____ Work (____) _____

Patient's Primary Care Physician: _____ **Phone: (**____) _____

Patient's Referring Physician: _____ **Phone:** (____) _____

Insurance Subscriber: _____ ☐ Insurance Subscriber same as patient

DOB: _____ **Relationship to Subscriber:** _____

Patient/Parent/Legal Guardian Signature **Date**

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Financial Policy & Notice of Privacy Practices

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service.

Financial Responsibility Agreement- I hereby authorize this office to apply for benefits on my behalf for services rendered. I thoroughly understand that my insurance is an agreement between the insurance provider and myself, **not** between the insurance provider and this medical office. I therefore request payment from my insurance company be made to **Eye Physicians of Austin**. I also understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account and for medical services rendered. I understand that during my treatment I may be billed by a third party provider, such as a lab, for services rendered at **Eye Physicians of Austin.**
When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account as soon as the same day you make your payment, and you will not receive your check back from your bank.

Non-covered Services- In the event that your health plan determines a service to be **"not covered"** you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. If you disagree with your insurance company's determination, you must contact your insurance company. Most medical insurance plans, including Medicare, **DO NOT COVER A REFRACTION FEE.** Refraction is a measurement of the lens power necessary to prescribe or change your glasses and/or corrective lens. Refractions may also be done for diagnostic purposes. If your examination includes refraction, there will be a minimum $47.00 fee **DUE THE DAY OF SERVICE** in addition to your co-payment.

I certify that the information I have reported with regard to my insurance coverage is correct. I authorize the release of any necessary information, including medical records, to determine insurance benefits to which I may be entitled.

Referral Policy- HMOs and some other insurances require an official referral/authorization number or form. If authorization has not been received by our office at time of service, you will be asked to sign a Referral Waiver that states you will be financially responsible at time of service.

Minor Patients- For services rendered to minor patients, we expect the adult accompanying the minor to settle charges for services. Payment arrangements must be made in advance for unaccompanied minors.

Contact Lens Prescriptions- If contact lenses are prescribed, you consent to receive your prescription electronically (email or portal). A physical copy of your prescription will be available in the office upon request.

Notice of Privacy Practices and TCPA- Our goal is to take appropriate steps to attempt to safeguard any medical or other personal information that is provided to us. The Privacy Rule under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires us to: (i) maintain the privacy of medical information provided to us; (ii) provide notice of our legal duties and privacy practices; and (iii) abide by the terms of our Notice of Privacy Practices currently in effect. Our Notice of Privacy Practices is posted in our lobby and available to you on your patient portal. You have the right to restrict personal health information to your health plan if disclosure is for payment and pertains to a service for which you have paid out of pocket and in full. By signing this, you agree to allow us to contact you at the phone numbers you have provided, including leaving a message on your voice mail/answering machine.

I acknowledge the receipt of Notice of Privacy Practices of Eye Physicians of Austin and the acceptance of the financial policy.

_____
Print patients name

_____ _____
Patient Signature (or person authorized to sign for patient) **Date**

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