GLAUCOMA ASSOCIATES OF TEXAS

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The physicians and staff of Glaucoma Associates of Texas wish to welcome you. An appointment has been scheduled for you at our office for:

Dr._____

On:_____At:_____

Please arrive at_____ with all paperwork completed. Arriving late for your appointment may result in rescheduling your appointment.

We provide the full spectrum of ophthalmic services needed to take care of all glaucoma-related problems. Our surgeons are board-certified by the American Board of Ophthalmology. Each has extensive sub-specialty training and experience in the management of the most difficult glaucoma cases. In specific situations, on-site consultation can be arranged with other eye care specialists including retina, cornea, pediatric, plastics and neurology.

We are here to serve you, the patient, and we want to help you understand what will take place at your first visit. Your first visit will last between 1-3 hours. A complete medical and family history must be taken during your initial exam. This includes questions about your general health, allergies, medications and past surgeries or diseases. **A medical questionnaire has been enclosed with this letter. We ask that you or a family member fill it out and bring it with you to your first visit.** The medical questionnaire is also available on our website: www.glaucomaassociates.com. **Please bring all of your medicines, including all eye drops.** If old records are available, we would appreciate your bringing them with you or having the records faxed to us ahead of time. Our fax number is 214-739-8562.

Your physician will give you a comprehensive eye examination. Routinely, a special exam called gonioscopy will be performed. This helps the doctor to decide what type of glaucoma is present. **You should anticipate having the pupil of your eye dilated.** This will result in blurred vision for 3-4 hours. **We ask that someone be present to drive you home safely.** Additional tests may be required to document the status of your eyes, such as photography of the optic nerve, plotting of the visual field and pachymetry.

The information obtained from the course of your examination will be used to formulate a treatment plan. If a medical or surgical problem is diagnosed, your physician may recommend

prescription medication, further testing, laser treatment or an operative procedure. Every attempt will be made to educate you concerning your condition.

The risks and benefits of the treatment plan will be reviewed with you, and a consultation letter will be sent to the referring physician or doctor of your choice.

Refraction (checking glasses) is not part of your comprehensive eye exam. This is considered a separate service. We recommend this be done by your referring ophthalmologist or optometrist.

Please bring your insurance card to this appointment so we can file your insurance for you. Your insurance reimbursement may not cover the full cost of your studies or physician services. **Regardless of insurance, payment of services remains your responsibility**. Our patient accounts representative can answer any questions you may have.

We participate in the Medicare and Texas State Medicaid program, and we accept most POS, PPO and HMO plans. If you are an HMO patient, it is your responsibility to obtain a referral prior to your appointment. **Failure to do so will result in your having to pay for services in full or the appointment may be rescheduled so that the referral may be obtained. Deductibles, co-pays and co-insurance are due at time of service.** If you are a self-pay patient, full payment is expected the same day services are rendered.
We accept cash, check, money order, debit and all major credit cards.

New patient appointments are available on a limited basis; with this in mind, kindly notify us at least 24 hours prior to your scheduled time if you are unable to keep your appointment. Failure to do so may result in a $25 missed-appointment fee.

Cellular phones, food and drinks are not allowed in our office

Our physicians and staff are looking forward to meeting you. Our goal is for you to have a positive experience at Glaucoma Associates of Texas. However, if any problems occur during your visit please notify me.

Sincerely,

Sheila Smalls
New Patient Coordinator

GLAUCOMA ASSOCIATES OF TEXAS
PATIENT INFORMATION SHEET

PATIENT'S NAME	NICKNAME	REFERRING PHYSICIAN
ADDRESS	CITY, STATE, ZIP	E-MAIL ADDRESS
HOME PHONE ( )	WORK PHONE ( )	CELL PHONE ( )	PREFERRED METHOD OF COMMUNICATION ☐ HOME ☐ OTHER:

SEX ☐ ☐ M F	BIRTH DATE	SOCIAL SECURITY NO.	RACE	ETHNICITY* ☐ HISPANIC/LATINO ☐OTHER	PREFERRED LANGUAGE ☐ ENGLISH ☐OTHER

PATIENT'S EMPLOYER	OCCUPATION	EMPLOYER'S ADDRESS (STREET, CITY, STATE, ZIP)

MARITAL STATUS ☐ ☐ ☐ ☐ S M W D	AGE	SPOUSE'S NAME	SPOUSE'S EMPLOYER (NAME & ADDRESS)

NOTIFY IN CASE OF EMERGENCY	ADDRESS (STREET, CITY, STATE)	PHONE NO. ( )
NOTIFY IN CASE OF EMERGENCY (NOT IN SAME HOUSEHOLD)	ADDRESS (STREET, CITY, STATE)	PHONE NO. ( )

*For more information regarding Race and Ethnicity, see supplemental handout

DO YOU HAVE MEDICARE? ☐ YES ☐ NO	MEDICARE NO.	DO YOU HAVE MEDICAID? ☐ YES ☐ NO	MEDICAID NO.
DO YOU HAVE TEXAS COMMISSION FOR THE BLIND? ☐ YES ☐ NO	COUNSELOR NAME & CITY		
WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL?			
HOW WILL THE BILL BE PAID TODAY?			

NAME OF PRIMARY INSURANCE CO.	POLICY NO.	IS PREAPPROVAL REQUIRED? ☐ YES ☐ NO

NAME OF INSURED	**INSURED DOB**	INSURED SS#	PATIENT'S RELATIONSHIP TO INSURED

NAME OF SECONDARY INSURANCE CO.	POLICY NO.	IS PREAPPROVAL REQUIRED? ☐ YES ☐ NO

NAME OF INSURED	**INSURED DOB**	INSURED SS#	PATIENT'S RELATIONSHIP TO INSURED

IS THIS A WORKER'S COMPENSATION CLAIM? ☐ YES ☐ NO	DATE OF INJURY	PERSON TO CONTACT	PHONE NO. ( )	FAX NO. ( )

"I hereby authorize the Physicians and staff of GLAUCOMA ASSOCIATES OF TEXAS to perform such treatments to me as may be prescribed by my attending physician during any and all my visits to GLAUCOMA ASSOCIATES OF TEXAS".
It is the policy of our office not to treat minors without the consent of a parent or legal guardian. If a written consent cannot be obtained, a phone consent will be required.
"I understand that I am financially responsible for ALL charges arising from services rendered to me by GLAUCOMA ASSOCIATES OF TEXAS".

PATIENT'S SIGNATURE: _____ DATE: _____

I AUTHORIZE GLAUCOMA ASSOCIATES OF TEXAS TO FILE ON ANY AND ALL INSURANCE FOR ANY CHARGES THAT I INCUR. I REQUEST THAT ALL PAYMENTS FROM ANY OF THESE INSURANCES TO BE MAILED DIRECTLY TO GLAUCOMA ASSOCIATES OF TEXAS. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATIONS AND ITS AGENTS, OR ANY INSURANCE COMPANY, ANY INFORMATION NEEDED TO DETERMINE DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

PATIENT'S SIGNATURE: _____ DATE: _____

WELCOME TO THE GLAUCOMA ASSOCIATES OF TEXAS

Name:	Date:	Date of birth:
Address:		Telephone #:
Referring physician:		Telephone #:
Address:		
Primary care physician:		Telephone #:
Address:		

MEDICAL, FAMILY & SOCIAL HISTORY: Please check the following as they apply to yourself (S) or to family members (F):

S	F		S	F		S	F	
		anemia			emphysema			
		arthritis			gout			kidney disease
		asthma			heart attack			stroke
		cancer			hepatitis			thyroid disease
		diabetes			high blood pressure			vascular disease

Cause of death of parents, siblings and children:_____

List all current medications (do not include eye medicines):	☐ none
List all previous:	
Surgeries & dates-not eye surgeries	☐ none
Hospital stays-not eye surgeries (dates & reason)	☐ none
Allergies-no eye related (include drug reactions)	☐ none

Please circle "yes" or "no". Explain any "yes" answers.

Are you using non-prescription drugs?	no	yes,_____
Do you use street drugs?	no	yes,
Do you drink alcohol	no	yes, how much?
Do you smoke?	no	yes, how much?
Have you ever been exposed to the AIDS virus?	no	yes,_____
Have you ever had a sexually transmitted disease?	no	yes,_____
Do you get allergy shots?	no	yes,

Marital status: ☐ single, ☐ married, ☐ widowed, ☐ divorced, ☐ other

Work status: Current occupation: Previous occupation:
Any known toxic exposure? no / yes

Living arrangements: ☐ home, ☐ apartment, ☐ nursing home, ☐ other

Live alone? yes / no Status: ☐ independent / ☐ need assistance

Education level: ☐ high school, ☐ college, ☐ post-graduate degree, ☐ other

Driving:	Do you drive in the day?	yes / no	with difficulty?	yes / no
	Do you drive at night?	yes / no	with difficulty?	yes / no

Name:_____ **Date:**_____

REVIEW OF SYSTEMS: If you are currently having any problems in the following areas, circle and explain (if necessary).

CONSTITUTIONAL: headaches, fatigue, fever, weakness, insomnia, weight loss, weight gain, Other:	☐ none
ENT: hearing loss, ringing in ears, sinus problems, nasal congestion, sore throat, hoarseness, vertigo, Other:	☐ none
RESPIRATORY: asthma, cough, shortness of breath, wheezing, pain with breathing, blood in sputum, TB exposure, Other:	☐ none
CARDIOVASCULAR: calf pain with exercise, chest pain or pressure, irregular heart rhythm, leg swelling, pacemaker, palpitations, rapid heart rate, shortness of breath with exertion, slow heart rate, Other:	☐ none
GASTROINTESTINAL: abdominal pain, black tarry stools, constipation, decreased appetite, diarrhea, food intolerance, heart burn, increased appetite, jaundice, nausea, trouble swallowing, vomiting, Other:	☐ none
GENITOURINARY: blood in urine, pain with urination, urinary urgency, urinary discharge, genital sores, abnormal menstruation, Other:	☐ none
INTEGUMENTARY: skin color change, skin rash, skin lump, skin ulcer, itchy skin, dry skin, abnormal hair change, abnormal finger nails, abnormal lesions, sores, hives, Other:	☐ none
ENDOCRINE: bulging eyes, cold intolerance, heat intolerance, increased thirst, increased urination, mass in front of neck, Other:	☐ none
NEUROLOGICAL: balance problems, dizziness, fainting, headaches, local weakness, memory problems, numbness of extremities, seizures, tingling, tremors, vertigo, Other:	☐ none
PSYCOLOGICAL: nervousness, tension, low mood, excessively elevated mood, irritability, hallucinations, frequent nightmares, Other:	☐ none
MUSCULOSKELETAL: joint pain, joint stiffness, back pain, muscle pain, muscle wasting, night cramps, easily broken bones, Other:	☐ none
HEMATOLOGIC AND LYMPHATIC: enlarged lymphnodes, tender lymphnodes, bleeding, bruising, blood transfusion, Other:	☐ none
IMMUNOLOGICAL: hives, seasonal allergies, Other:	☐ none

This form completed by:_____

To be completed by physician: History reviewed: Date:

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Patient Authorization To Release Protected Health Information

I authorize Glaucoma Associates of Texas to release protected health information to the individual (s) listed below for the purpose of assisting with my care and/or payment.

Name	Relation	Phone Number
Name	Relation	Phone Number
Name	Relation	Phone Number

Description of the information to be used or disclosed (*check all that apply):*

- ☐ Patient's demographic information
- ☐ Patient's medical information
- ☐ Patient's billing information
- ☐ Appointment Status

I understand that this authorization will be in effect during the time period I am a patient at Glaucoma Associates of Texas.

I further understand that this authorization is voluntary and that my health care and the payment of my health care will not be affected if I do not sign this form.

I further understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations.

I further understand that I may revoke this authorization at any time by notifying Glaucoma Associates of Texas in writing at 10740 N. Central Expressway, Suite 300, Dallas, TX 75231. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

_____ _____
Signature of Patient or Patient's Representative Date

_____
Printed name of Patient's or Patient's Representative

_____
Relationship to Patient or Legal Authority

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RELEASE OF MEDICAL RECORDS

To: _____

From: _____
(Patient's name)

This is to request that you release copies of the above named patient's medical records, registration forms, correspondence and materials pertinent to the patient's care. Include chart dictation, procedure notes, flow sheets, GDx, OCT, VF, ORB, photographs, past medication and allergies.

Please send this information to:

Glaucoma Associates of Texas
10740 N. Central Expwy.
Suite 300
Dallas, Tx. 75231

Signed:_____
(Signature of patient or person responsible for patient)

_____
Relationship

Date: _____

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CONSENT

TO THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, HEALTH CARE OPERATIONS, AND AS OTHERWISE ALLOWED BY LAW

Glaucoma Associates of Texas (hereinafter referred to as "Glaucoma Associates") will maintain a record of the care and services you receive at Glaucoma Associates. This consent only covers your protected health information created while you are a patient of Glaucoma Associates. Your protected health information pertains to your diagnosis and/or treatment at Glaucoma Associates, including but not limited to information concerning mental illness (except for psychotherapy notes), use of alcohol or drugs, or communicable diseases such as Human Immunodeficiency Virus ("HIV"), and Acquired Immune Deficiency Syndrome ("AIDS"), laboratory test results, medical history, treatment progress, or any other such related information.

By signing this form, you consent to Glaucoma Associates' use and/or disclosure of protected health information about you for treatment, payment, health care operations, and as otherwise allowed by law. Our *Notice of Protected Health Information Practices* provides information about how Glaucoma Associates and its physicians may use and/or disclose protected health information about you for treatment, payment, health care operations, and as otherwise allowed by law. **By signing this form, you also acknowledge that you have received a copy of Glaucoma Associates' Notice of Protected Health Information Practices and an opportunity to review it before signing this consent.**

_____ _____

Signature of Patient or Legal Representative Witness

_____

Date

10740 N. CENTRAL EXPRESSWAY • SUITE 300 • DALLAS, TX 75231 • (214) 360-0000 • (800) 683-0386 • FAX (214)360-0083
417 W. MAGNOLIA AVENUE • FORT WORTH, TX 76104 • (817) 923-2000 • FAX (817) 923-6639
1708 COIT ROAD • SUITE 200 • PLANO, TX 75075 • (972) 612-9522 • FAX (972) 612-9502
WWW.GLAUCOMAASSOCIATES.COM