GLAUCOMA ASSOCIATES OF TEXAS

RONALD L. FELLMAN, M.D.
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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	BIRTH DATE	SOCIAL SECURITY NO.	RACE	ETHNICITY*	PREFERRED LANGUAGE
☐ M ☐ F				☐ HISPANIC/LATINO ☐OTHER	☐ ENGLISH ☐OTHER

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

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

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?	MEDICARE NO.	DO YOU HAVE MEDICAID?	MEDICAID NO.
☐ YES ☐ NO		☐ YES ☐ NO	

DO YOU HAVE TEXAS COMMISSION FOR THE BLIND?	COUNSELOR NAME & CITY
☐ YES ☐ NO	

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?	DATE OF INJURY	PERSON TO CONTACT	PHONE NO.	FAX NO.
☐ YES ☐ 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
Allergies to latex, shellfish, etc.	☐ 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

WELCOME TO THE GLAUCOMA ASSOCIATES OF TEXAS

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
PSYCHOLOGICAL: 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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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Glaucoma Associates of Texas (hereinafter referred to as "Glaucoma Associates") to use and/or disclosure protected health information about me for treatment, payment, health care operations, and as otherwise allowed by law. I understand that protected health information ("PHI") for purposes of this consent, is information that individually identifies me; is related to my physical or mental health or condition, the provision of health care to me, or payment for such health care; and is created or received by Glaucoma Associates. I understand that I may revoke my consent in writing except to the extent that Glaucoma Associates has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, I understand that Glaucoma Associates may decline to provide treatment to me.

I hereby give my consent for Glaucoma Associates to use the contact information I have provided to call my home and/or other alternative location and leave a message for me by voice mail or person in reference to any items that assist the practice in carrying out treatment, payment, or health care operations, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory test results, among others. I further give my consent for Glaucoma Associates to send mail to my home and/or other alternative location and e-mail to the e-mail address(es) I have provided in reference to any items that assist the practice in carrying out treatment, payment, or health care operations, such as appointment reminder cards and patient statements. I understand I have the right to request that Glaucoma Associates restrict how it uses or discloses my PHI. I further understand that Glaucoma Associates is not required to agree to my requested restrictions.

I acknowledge I have received a copy of Glaucoma Associates' Notice of Protected Health Information Practices (the "Notice") and have had an opportunity to review it before signing this consent. I understand that Glaucoma Associates reserves the right to revise its Notice at any time and that a copy of the revised Notice may be obtained by forwarding a written request to Glaucoma Associates' Privacy Officer at 10740 N. Central Expressway, Suite 300, Dallas, Texas 75231.

______________________________ ______________________________
Signature of Patient or Legal Representative — Witness

____
Date

GLAUCOMA ASSOCIATES OF TEXAS
NOTICE OF PROTECTED HEALTH INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding Your Protected Health Information

This notice describes the practices of Glaucoma Associates of Texas (hereinafter "Glaucoma Associates") and that of its physicians with respect to your protected health information created while you are a patient at Glaucoma Associates. Your protected health information ("PHI"), for purposes of this notice, is information that individually identifies you; is related to your physical or mental health or condition, the provision of health care to you, or payment for such health care; and is created or received by Glaucoma Associates. Physicians and personnel of Glaucoma Associates authorized to have access to your PHI are subject to this notice. In addition, physicians of Glaucoma Associates may share PHI with each other for treatment, payment or health care operations described in this notice.

We create a record of the care and services you receive at Glaucoma Associates. We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. This notice applies to all of the PHI concerning your care at Glaucoma Associates.

This notice will tell you about the ways in which we may use and disclose your PHI. Other uses and disclosures of PHI not described in this notice will be made only with your written authorization. We also describe your rights and certain obligations we have regarding the use and disclosure of your PHI.

Your Rights regarding Your PHI

Although the health records created and received by Glaucoma Associates are the physical property of Glaucoma Associates, your PHI belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your PHI for treatment, payment, and health care operations and as to disclosures permitted to persons, including family members involved with your care and as provided by law. We are not required by law to agree to a requested restriction, except for a request to restrict disclosure of your PHI to a health plan if: (A) the disclosure is for purposes of carrying out payment or heath care operations and is not otherwise required by law; and (B) the PHI pertains solely to a health care item or service for which you or a person other than your health plan, has paid Glaucoma Associates in full;
- Obtain a paper copy of this notice of Glaucoma Associates' PHI practices;
- Inspect and request a copy of your PHI as provided by law;
- Request that we amend your PHI as provided by law. We will notify you if we are unable to grant your request to amend your PHI;
- Obtain an accounting of disclosures of your PHI as provided by law;
- Request communication of your PHI by alternative means or at alternative locations. We will accommodate reasonable requests; and
- Revoke your authorization in writing to use or disclose PHI except to the extent that action has already been taken in reliance on your authorization.

You may exercise your rights set forth in this notice by providing a written request to Glaucoma Associates' Privacy Officer at 10740 N. Central Expressway, Suite 300, Dallas, Texas 75231.

Our Responsibilities

In addition to the responsibilities set forth above, we are also required to:

- Maintain the privacy of your PHI;
- Provide you with a notice as to our legal duties and privacy practices with respect to PHI we maintain about you;
- Abide by the terms of our Notice of Protected Health Information Practices currently in effect;
- Notify affected individuals following a breach of unsecured PHI; and
- Notify you if we are unable to agree to a requested restriction on certain uses and disclosures of your PHI.

We reserve the right to change our practices and to make the new provisions effective for all PHI we maintain, including information created or received before the change. Should our information practices change we are not required to notify you, but we will have the revised notice available for you to request at any Glaucoma Associates' location. The revised notice will also be posted at our offices and on the Glaucoma Associates' web page at: www.GlaucomaAssociates.com.

Examples of Disclosures for Treatment, Payment, Health Care Operations and As Otherwise Allowed By Law

The following categories describe different ways that we use and disclose protected health information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information should fall within one of the categories.

We will use your PHI for treatment.

For example: We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at Glaucoma Associates. We may share medical information about you in order to coordinate different treatments, such as prescriptions, lab work and x-rays. We may also provide your physician or a subsequent health-care provider with copies of various reports to assist in treating you once you

are discharged from care at Glaucoma Associates.

We will use your PHI for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your PHI for regular health care operations.

For example: We may use the information in your health record to assess the care and outcome in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and services we provide.

We will use your PHI as otherwise allowed by law. The following are some examples of how we may use or disclose your PHI.

Business associates: There are some services provided to our organization through agreements with business associates. Examples include answering services and copy services. To protect your PHI, however, we require business associates to appropriately safeguard your information.

Communications for treatment and health care operations: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Notification: We may use or disclose your PHI to notify or assist in notifying your family members, personal representatives, or other persons responsible for your care regarding your location and condition.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to protect the privacy of your health information.

Decedents: We may disclose PHI to coroners, medical examiners, and funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose PHI to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, medications, devices, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers' compensation: We may disclose PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Public health: As required by law, we may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, or disability and health oversight agencies for oversight activities authorized by law.

Abuse, neglect or domestic violence: As required by law, we may disclose PHI to a governmental authority authorized by law to receive reports of abuse, neglect, or domestic violence.

Judicial, administrative, and law enforcement purposes: Consistent with applicable law, we may disclose PHI about you for judicial, administrative, and law enforcement purposes.

Personal Representative/Family Members: Consistent with applicable law, we will disclose information to your lawfully designated or appointed personal representative with authority to (a) act on your behalf in making health care related decisions or (b) act on behalf of your estate. We may also disclose your PHI to a person involved in your current health care (such as a family member, other relative, close personal friend, or other person you identify) if that PHI is directly related to the person's involvement with your current health care or payment related to that health care.

Fundraising: We may contact you to raise funds for Glaucoma Associates and you have a right to opt out of receiving such communications.

Required or allowed by law: We will disclose PHI about you when required or allowed to do so by federal, state, or local law.

Examples of Uses and Disclosures that Require Your Authorization

We will not use or disclose your PHI without your written authorization, except as described in this notice. For example, the following uses and disclosures will not be made absent your written authorization.

Psychotherapy Notes: We must obtain an authorization for any use or disclosure of psychotherapy notes, except to carry out certain treatment, payment, or health care operations provided by law.

Marketing: We must obtain an authorization for use or disclosure of your PHI for marketing communications, except for where the marketing communication is made face-to-face or where the marketing communication consists of a promotional gift of nominal value provided by Glaucoma Associates.

Sale of Protected Health Information: We must obtain a valid authorization for the disclosure of your PHI where Glaucoma Associates receives direct or indirect remuneration from the entity to whom such information is disclosed.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact Glaucoma Associates' Privacy Officer at (214) 765-9703.

If you believe your privacy rights have been violated, you can file a complaint with Glaucoma Associates' Privacy Officer or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

EFFECTIVE DATE: 10/01/2018
VERSION: 3

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