

**PATIENT INFORMATION FORM**

**Please print and provide complete information for each item**

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_ Maiden Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home/Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_ M \_\_\_ F

Marital Status: \_\_\_\_\_ Social Security #: \_\_\_\_\_ E-mail: \_\_\_\_\_

If you have been seen here, under what name and what year were you last seen: \_\_\_\_\_

Referred By: \_\_\_\_\_ Family Physician/PCP: \_\_\_\_\_

**EMPLOYER INFORMATION:**

Employer's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_ Telephone: \_\_\_\_\_

**RESPONSIBLE PARTY:**

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employers Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**EMERGENCY CONTACT NAME:** \_\_\_\_\_ Relationship: \_\_\_\_\_

Contact's Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

**MEDICARE and/or MEDICAID:**

Medicare Number: \_\_\_\_\_ Medicaid Number: \_\_\_\_\_

**PRIMARY INSURANCE:**

Insurance Company: \_\_\_\_\_ Name of Policyholder: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Group number: \_\_\_\_\_ Policy number: \_\_\_\_\_

Policyholder's Employer and Address: \_\_\_\_\_

**SUPPLEMENTAL INSURANCE INFORMATION:**

Insurance Company: \_\_\_\_\_ Name of Policyholder: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Group number: \_\_\_\_\_ Policy number: \_\_\_\_\_

Policyholder's Employer and Address: \_\_\_\_\_

**LAB SERVICES**

I understand that I may receive a separate bill if my personal medical care includes lab, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not covered by my insurance for whatever reason.

**CONSENT TO TREATMENT**

I hereby authorize the physicians and staff of Cornea Associates of Texas to perform procedures necessary to assess, diagnose and treat my condition as necessary.

**PATIENT SIGNATURE:** \_\_\_\_\_ **DATE** \_\_\_\_\_

**GUARANTOR SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_  
(If different from patient)

**GUARANTOR NAME: (Please Print)** \_\_\_\_\_

**CORNEA 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 Health Record/ Information**

This notice describes the practices of Cornea Associates of Texas (hereinafter “Cornea Associates”) and that of its physicians with respect to your protected health information created while you are a patient at Cornea Associates. Physicians and personnel of Cornea Associates authorized to have access to your medical chart are subject to this notice. In addition, physicians of Cornea Associates may share medical information 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 Cornea 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 records of your care at Cornea Associates.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

**Your Health Information Rights**

Although your health record is the physical property of Cornea Associates, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your

information for treatment, payment, health care operations and as to disclosures permitted to persons, including family members involved with your care and as provided by law. However, we are not required by law to agree to a requested restriction;

- Obtain a paper copy of this notice of protected health information practices;
- Inspect and request a copy of your health record as provided by law;
- Request that we amend your health record as provided by law. We will notify you if we are unable to grant your request to amend your health record;
- Obtain an accounting of disclosures of your health information as provided by law;
- Request communication of your health information by alternative means or at alternative locations. We will accommodate reasonable requests; and
- Revoke your authorization to use or disclose health information 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, except for requests to obtain a paper copy of the notice, to the Cornea Associates’ Privacy Officer at 1001 N. Waldrop Drive, Suite 502, Arlington , Texas 76012.

**Our Responsibilities**

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

- Maintain the privacy of your health information;
- Provide you with a notice as to our legal duties and privacy practices with respect to information we maintain about you;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction on certain uses and disclosures;
- We reserve the right to change our practices and to make the new provisions effective for all protected health information 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 Cornea Associates’ location. The revised notice will also be posted at our offices and on the Cornea Associates’ web page at [www.CorneaTexas.com](http://www.CorneaTexas.com); and

- We will not use or disclose your health information without your written authorization, except as described in this notice.

**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 medical 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 health information 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 Cornea 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 Cornea Associates.

*We will use your health information 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 health information 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 health information as otherwise allowed by law. The following are some examples of how we may use or disclose medical information about you.*

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

**Notification:** We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general 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.

**Funeral directors:** We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

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

**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.

**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.

**Worker's compensation:** We may disclose health information 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 health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

**Abuse, neglect or domestic violence:** As required by law, we may disclose health information 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 health information about you for judicial, administrative and law enforcement purposes.

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

**For More Information or to Report a Problem**

If you have questions and would like additional information, you may contact Cornea Associates' Privacy Officer at Metro (817) 261-9282.

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

**EFFECTIVE DATE: 04/01/03**

**VERSION: 1**

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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**

Cornea Associates of Texas (hereinafter referred to as “Cornea Associates”) will maintain a record of the care and services you receive at Cornea Associates. This consent only covers your protected health information created while you are a patient of Cornea Associates. Your protected health information pertains to your diagnosis and/or treatment at Cornea 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 Cornea 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 Cornea 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 Cornea 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

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## Patient Authorization To Release Protected Health Information

I authorize Cornea 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

\_\_\_\_\_  
Name Relation

\_\_\_\_\_  
Name Relation

Description of the information to be used or disclosed:

- Patient's demographic information
- Patient's medical information
- Patient's billing information

I understand that this authorization will be in effect during the time period I am a patient at Cornea 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 *Cornea Associates of Texas* in writing at *800 5th Avenue, Suite 140 Fort Worth, Texas 76104*. 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 or Patient's Representative

\_\_\_\_\_  
Relationship to patient or Legal Authority

*Cornea Associates of Texas*  
**MEDICAL HISTORY QUESTIONNAIRE**

Date \_\_\_\_\_ Name \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_

**Drug Allergies/Reactions:**  No known drug allergies  Yes (please list) \_\_\_\_\_

**Have you ever had an adverse reaction to latex or been diagnosed with a latex allergy?**  Yes  No

**Please list all medications you take (prescription, over-the-counter, and vitamins)**


**Past/Present Medical History** (Check all that apply)

- No known health problems**
- Ears, Nose, Throat**     Hearing Loss     Other \_\_\_\_\_
- Cardiovascular**     High Blood Pressure     Atrial Fibrillation     Congestive Heart Failure     Heart Attack  
 Stroke     Heart Disease     Other \_\_\_\_\_
- Respiratory**     Asthma     Emphysema     Other \_\_\_\_\_
- Gastrointestinal**     Acid Reflux     Ulcer     Hiatal Hernia     Other \_\_\_\_\_
- Genital/Kidney/Bladder**     Prostate Disorder     Incontinence     Other \_\_\_\_\_
- Muscles/Bones/Joints**     Arthritis     Rheumatoid Arthritis     Osteoporosis     Other \_\_\_\_\_
- Skin**     Rosacea     Eczema     Acne     Other \_\_\_\_\_
- Neurological**     Migraines     Multiple Sclerosis     Parkinson's     Alzheimer's     Other \_\_\_\_\_
- Psychiatric**     Anxiety     Depression     Insomnia     Other \_\_\_\_\_
- Endocrine**     Diabetes     Thyroid     Other \_\_\_\_\_
- Blood/Lymph**     High Cholesterol     Anemia     Cancer \_\_\_\_\_     Other \_\_\_\_\_
- Allergic/Immunologic**     HIV +     Lupus     Sjogren's     Allergies     Other \_\_\_\_\_

**Eye Surgeries**     No prior eye surgeries

Type of Surgery	Eye	Doctor	Date



# CORNEA ASSOCIATES OF TEXAS

## PATIENT FINANCIAL AGREEMENT

### INSURANCE ASSIGNMENT AND PATIENT RESPONSIBILITY

The person signing below agrees, whether he/she signs as patient or representative of the patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of the Cornea Associates of Texas at the regular rates and terms of Cornea Associates of Texas. Should the account be referred to an attorney for collection, the person signing below shall pay reasonable attorney's fees and collection expenses.

**"I assign payment for the unpaid charges for certain medical treatment and/or supplies furnished by the physicians and staff of Cornea Associates of Texas for whom Cornea Associates of Texas is authorized to bill. I understand that I am responsible for any health insurance deductibles, coinsurance and non-covered services at the time services are rendered."**

### MEDICARE AND/OR MEDICAID CERTIFICATION

The person signing below certifies that he/she has read this document, and is the patient, or is duly authorized by the patient as the patient's representative, to execute the above and accepts its terms.

**"I certify that the information given by me in applying for payment under Title XVIII and/or Title XIX of the Social Security Administration is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries any information needed, for this or related Medicare claims. I request that payment of authorized benefits be made on my behalf."**

### ASSIGNMENT OF BENEFITS:

In consideration of services rendered, I hereby assign to Cornea Associates of Texas, and/or any physician who has treated me, all rights, title, and interest in any payment due for services described herein as provided in the policy, or policies, of insurance. I agree to pay any balance due, including co-insurance and co-payment amounts, not paid by the insurance company or companies.

**Relationship to Patient:**  Self     Child     Dependent     Other \_\_\_\_\_

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Witness

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date