Matthew G. McMenemy, M.D.
Theresa Leung, M.D.
3515 Town Center Blvd., South
Sugar Land, TX 77479
Phone: (281) 277-8400
Fax: (281) 277-8408

PATIENT INFORMATION

NAME: _____ DOB: _____ /_____/ _____ SEX: M ◯ F ◯

MAILING ADDRESS: _____

CITY: _____ST: _____ ZIP: _____ EMAIL: _____

CELL PHONE: _____ HOME PHONE: _____ SSN: _____ - ____ - _____

DRIVER'S LICENSE: _____ CONTACT PERSON IN CASE OF EMERGENCY: _____

RELATIONSHIP: _____ CONTACT PHONE: _____ ALTERNATE PHONE: _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

REFERRAL SOURCE: _____ RELATIONSHIP: _____

GUARANTOR NAME: _____DOB: _____ / _____ / _____

RELATIONSHIP TO PATIENT: _____ SSN: _____- ____- _____PHONE: _____

VISION INSURANCE PLAN: _____ SUBSCRIBER NAME: _____

ID #: _____ GROUP #: _____

RELATIONSHIP TO PATIENT: _____DOB: ____ / _____ / _____ EMPLOYER: _____

PRIMARY MEDICAL INSURANCE: _____ HMO ◯ PPO ◯

ID #: _____GROUP #: _____ SUBSCRIBER NAME: _____

SECONDARY MEDICAL INSURANCE: _____ HMO ◯ PPO ◯

ID #: _____ GROUP #: _____ SUBSCRIBER NAME: _____

PREFERRED METHOD OF CONTACT:

CELL PHONE ◯
HOME PHONE ◯
EMAIL ◯
TEXT ◯

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account. I certify that the above information is true and correct to the best of my knowledge. I will notify you of any changes in the above information

_____ _____

Patient/Guarantor Signature **Date**

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MEDICATION LIST

PATIENT NAME: _____

PHARMACY NAME & LOCATION: _____

PHARMACY PHONE: _____

ALLERGIES/REACTION:

_____

_____

_____

_____

_____

MEDICATION	DOSAGE/FREQUENCY	START DATE	END DATE

Matthew G. McMenemy, M.D.
Theresa Leung, M.D.

PATIENT MEDICAL HISTORY

PATIENT NAME: _____ DOB: ____ / _____ / _____ GENDER: M ◯ F ◯

What is the reason for your appointment today?

_____

_____

Please answer the following question about your medical status and history:

1. Have you ever been treated for any medical conditions (e.g. diabetes, high blood pressure, arthritis, etc.)?
Yes ◯ No ◯ If YES, please explain: _____

_____

2. Have you ever had any eye disease or injury (e.g. glaucoma, cataract, lazy eye, or retinal detachment)?
Yes ◯ No ◯ If YES, please explain: _____

_____

3. Have you ever had surgery?
Yes ◯ No ◯ If YES, please explain: _____

_____

4. Have you ever been hospitalized?
Yes ◯ No ◯ If YES, please explain: _____

_____

Review of Systems:	**Yes**	**No**	**If YES, please explain:**
Chronic fever, unexpected weight loss/gain, fatigue	◯	◯	_____
Ear/Nose/Throat problems	◯	◯	_____
Heart problems	◯	◯	_____
Respiratory problems	◯	◯	_____
Gasrointestinal problems	◯	◯	_____
Urinary problems	◯	◯	_____
Musculoskeletal problems	◯	◯	_____
Neurological problems	◯	◯	_____
Psychiatric problems	◯	◯	_____

Family and Social History:

1. Do any medical or eye diseases run in your family (e.g. diabetes, high blood pressure, cancer, glaucoma, etc)?
Yes ◯ No ◯ If YES, please explain: _____

_____

2. Do you smoke? Yes ◯ No ◯ If YES, how much? _____

3. Do you drink alcohol? Yes ◯ No ◯ If YES, how much? _____

4. Any other medical issues not addressed above? _____

_____

_____

_____ _____

Patient/ Guarantor Signature **Date**

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CONSENT FOR PURPOSE OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

I consent to the use of the disclosure of my protected health information by **Lone Star Eye Care** for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills, or to conduct health care operations. I understand that diagnosis or treatment of me by **Lone Star Eye Care** may be continued upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment or payment of healthcare operations of the practice. **Lone Star Eye Care** is not required to agree to the restrictions that I may request. However, if **Lone Star Eye Care** agrees to a restriction that I request, the restriction is binding by **Lone Star Eye Care.**

I have the right to revoke this consent in writing at any time, except to the extent that **Lone Star Eye Care** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information collected from me and created or received by my physician, another healthcare provider, a healthy plan, my employer, or a health clearing house. This protected health information relates to my past, present, or future, physical or mental health or condition that identifies me, there is a reasonable basis to believe the information may identify me.

I understand I have the right to review **Lone Star Eye Care's** Notice of Privacy Practices prior to signing this document. The **Lone Star Eye Care's** Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of performance of the healthcare of **Lone Star Eye Care**. The Notice of Privacy Practices also describes my rights and **Lone Star Eye Care's** duties with respect to my protected health information.

Lone Star Eye Care reserves the right to change the privacy practices that are described in the Notice of Privacy Practice. I may obtain a revised Notice of Privacy Practice by calling the office and requesting a revised copy be sent by mail or asking for one at the time of my next appointment. Unless I have requested otherwise, **Lone Star Eye Care** may discuss health or accounting information about me to my immediate family and/or spouse regarding appointment and/or treatment.

_____ _____

Patient/Guarantor Signature **Date**

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PATIENT FINANCIAL POLICY

Thank you for allowing us to participate in your eye care. If you have medical/vision insurance, we are committed to helping you receive your maximum allowable benefits. We understand that the medical insurance field can be quite confusing. Our Financial Policy is provided to assist you in understanding your responsibility to both Lone Star Eye Care, P.A and your insurance carrier.

Medicare/Medicaid: We are providers with Medicare and Medicaid. We agree to bill and accept contractual adjustments for both programs. You are responsible for all deductibles and copays. There may be services and supplies rendered that are not covered by Medicare and therefore require an Advanced Beneficiary Notice (ABN) be signed by the patient/guarantor. By signing the ABN, you understand that you are financially responsible for payment of those services and/or supplies.

Supplemental Insurance: If you have supplemental insurance, we will send a claim to them as a courtesy to you. Refraction Service and Fee. Refraction is the process of determining your best-corrected vision. It is an essential part of an eye examination and is necessary to write a prescription for glasses or contact lenses. Refractions may be done for routine eye exams or medical exams. We do not file the charge for refraction with a health insurance plan unless we know that your plan covers the refraction charge. Our fee for refraction is **$45.00** and will be collected at the time of the service. Refraction is *not a covered Medicare benefit.*

Insurance: Your insurance policy is a contract between you and the insurance company. As medical providers, our relationship is with you and not with your insurance company. While the filing of insurance claim forms is a courtesy we extend to our patients, all charges are your responsibility from the date the services are rendered. **You are expected to know and follow all regulations or procedures as agreed to by you and your insurance company regarding referrals, second opinions or pre-certifications. Any out-of-pocket expenses such as deductible, coinsurance and copays must be paid at the time of service.** Failure to provide correct information (current insurance carrier, policy number, etc) may result in denial of your claim, and you will be held responsible for the balance. If you belong to an HMO (needing a referral from your Primary Care Physician), we cannot see you without a referral unless you pay for the visit yourself.

Vision Insurance vs. Medical Insurance: Your vision insurance is intended to provided you with a baseline eye exam. If any medical complaints or problems are addressed and evaluated (i.e. corneal disorders, diabetes, cataracts, floaters, glaucoma suspect, double vision, etc.) during the time of your visit, you are being provided with medical care. Typically, your vision insurance does not provide coverage for medical care. Therefore, we will file a claim with your medical insurance according to the results of your exam for visit related to medical complaints and problems.

Co-Pays: In accordance with your insurance contract, your copay is due at the time of service.

No Insurance: Payment in full is due at the time of service.

Methods of Payment: We accept cash, check, Visa, MasterCard and Discover.

NSF Checks: Any check that does not clear your bank account will result in a $30.00 fee.

Outstanding Balance: We realize that financial difficulty is a reality. Patients with an outstanding balance **90 days** or more overdue must make arrangements for payment prior to scheduling appointments.

Statements: If there is a balance on your account after filing to your insurance carrier, you will receive a statement. Payment is expected **within 30 days** from receiving your statement. If you have any questions regarding your statement, please contact the Billing Department immediately.

By signing below, I am acknowledging that I have read and have fully understand the financial policy of Lone Star Eye Care, P.A. regarding payments and insurance. I agree to pay for services and tests that may not covered by my insurance plan. I also understand that I am responsible for following my insurance plan's regulation, policies and procedures.

_____ _____

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AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Persons Authorized to Receive Information
Health information Lone Star Eye Care collects or received about you may be disclosed to the following persons:

_____ _____
Name of Person **Relation**

_____ _____
Name of Person **Relation**

Use and Disclosure of Information
I authorize the person(s) listed above to receive all health information about appointments, treatments and/or other information pertinent to my healthcare and/or payment for my healthcare provided at Lone Star Eye Care.

Expiration Date of Authorization
This authroization is effective through _____ / _____ / _____ unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to Lone Star Eye Care. You should contact our Privacy Officer to terminate this authorization.

Potential to Re-disclosure
This person to whom health information is sent may repeatedly disclose health information that is identified by this authorization. The privacy of this information may not be protected under any federal privacy regulation.

_____ _____
Patient Signature **Date**

_____
Name of Person (Print of Type)

_____ _____
Signature of Patient Representative **Relationship to Patient**