NEWMAN & TAUB VISION CENTER, L.L.P.

**NAME**: LAST: _____FIRST_____

DOB_____ AGE____ MALE_____FEMALE_____SOCIAL SECURITY_____

**MARITAL STATUS**: MARRIED_____WIDOWED_____SINGLE _____

**ADDRESS**: _____APT_____

CITY_____ STATE_____ZIPCODE_____

PHONE: HOME_____WORK_____CELL_____

**EMAIL**: _____

**ETHNICITY**:
HISPANIC_____ CAUCASIAN_____AFRICAN AMERICAN_____ OTHER_____
PREFER NOT TO ANSWER_____

**PREFERRED CONTACT METHOD**:

**PHONE**: HM_____WK_____CELL_____EMAIL_____MAIL_____

**DOCTOR YOU SEE IN THIS PRACTICE**: NEWMAN_____TAUB_____CHU_____

**PREFERRED LOCATION**: DALLAS_____PLANO_____

**WHO REFERRED YOU TO OUR OFFICE**_____

**OPTOMETRIST/PRIMARY EYE DOCTOR**_____

**PRIMARY CARE DOCTOR**_____**PH#**_____

**EMERGENCY CONTACT**_____**RELATION**_____**PH#**_____

**PRIMARY INSURANCE**_____

**NAME OF PERSON WHO CARRIES INSURANCE**: _____

**RELATIONSHIP**_____**DATE OF BIRTH**_____

**EMPLOYER OR GROUP NAME**_____

**SECONDARY INSURANCE**_____

**NAME OF PERSON WHO CARRIES INSURANCE**_____

**RELATIONSHIP**_____**DATE OF BIRTH**_____

**EMPLOYER OR GROUP**_____

**SIGN**_____**DATE**_____

NEWMAN & TAUB VISION CENTER, L.L.P.

# PATIENT HISTORY

**Patient Name: _____Date of Birth: _____**

**Reason for Visit: _____**

**History of Any Eye Diseases/Disorders: _____**
_____

**Past Eye Surgeries?** □Yes □No
If yes, please list below:

| Type of Surgery | Date |
|---|---|
| | |

**Past Major Surgeries?** □Yes □No
If yes, please list below:

| Type of Surgery | Date |
|---|---|
| | |

**Medical History:** Please check all that applies:

□ Asthma
□ Angina/Chest Pain
□ Cancer
□ Chronic Bronchitis
□ Cirrhosis
□ Clotting Disorder
□ Diabetes
□ Emphysema
□ Epilepsy
□ Glaucoma
□ Heart Attack
□ Heart Murmur
□ Headaches
□ Hepatitis
□ High Blood Pressure
□ High Cholesterol
□ HIV positive/AIDS
□ Kidney Disease
□ Migraines
□ Stroke
□ Thyroid Disease
□ Other-Please List Below
_____
_____

**Family History:** Please check all that applies:

□ Cancer
□ Diabetes
□ Glaucoma
□ Heart Attack
□ Heart Disease
□ High Blood Pressure
□ Kidney Disease
□ Liver Disease
□ Macular Degeneration
□ Migraines
□ Stroke

**Social History:**
Tobacco Use: □ Current □ Former □ Never
Alcohol Use: □ Daily □ Socially □ Never
Drug Use: □ Yes □ No
If yes, What type: _____ How often: _____

**Current Medications (Prescribed and/or Over the Counter):**
_____
_____

**Current Eye Medications: _____**

**Drug Allergies: _____**

NEWMAN & TAUB VISION CENTER, L.L.P.

Please check if you have/don't have the following **TODAY**. Date: _____

## REVIEW OF SYSTEMS

**Eyes** □Normal
- Previous Surgery □Yes □No
- Contact Lens □Yes □No
- Pain □Yes □No
- Double Vision □Yes □No
- Glaucoma □Yes □No
- Cataracts □Yes □No
- Macular Degeneration □Yes □No
- Dry Eyes □Yes □No
- Flashes □Yes □No
- Floaters □Yes □No

**ENT** □Normal
- Hard of Hearing □Yes □No
- Ringing in Ears □Yes □No
- Vertigo □Yes □No

**Cardiovascular** □Normal
- Chest Pain □Yes □No
- Dizziness □Yes □No
- Fainting Spells □Yes □No
- Shortness of Breath □Yes □No
- Irregular Heart Beat □Yes □No
- Difficulty Lying Flat □Yes □No

**Constitutional** □Normal
- Fatigue/Weakness □Yes □No
- Fever □Yes □No
- Weight Gain/Loss □Yes □No

**Respiratory** □Normal
- Cough □Yes □No
- Congestion □Yes □No
- Wheezing □Yes □No
- Asthma □Yes □No

**Gastrointestinal** □Normal
- Heartburn □Yes □No
- Nausea/Vomiting □Yes □No
- Jaundice/Hepatitis □Yes □No

**Genito-Urinary** □Normal
- Pain/Difficulty □Yes □No
- Blood in Urine □Yes □No
- History Kidney Stone □Yes □No
- History of STD's □Yes □No

**Psychiatric** □Normal
- Anxiety/Depression □Yes □No
- Mood Swings □Yes □No
- Difficulty Sleeping □Yes □No

**Endocrine** □Normal
- Increased Thirst □Yes □No
- Increased Hunger □Yes □No
- Increased Urination □Yes □No
- Increased Sweating □Yes □No
- Fingernail Changes

**Blood/Lymph nodes** □Normal
- Easy Bruising □Yes □No
- Gums Bleed Easily □Yes □No
- Prolonged Bleeding □Yes □No
- Heavy Aspirin Use □Yes □No

**Musculoskeletal** □Normal
- Stiffness □Yes □No
- Arthritis □Yes □No
- Joint Pain/Swelling □Yes □No

**Skin** □Normal
- Rash/Sores □Yes □No
- Lesions □Yes □No
- Hives/Eczema □Yes □No

**Neurological** □Normal
- Seizures □Yes □No
- Weakness/Paralysis □Yes □No
- Numbness □Yes □No
- Tremors □Yes □No

**Immunologic** □Normal
- Hives □Yes □No
- Itching □Yes □No
- Runny Nose □Yes □No
- Sinus Pressure □Yes □No

NEWMAN & TAUB VISION CENTER, L.L.P.

**NOTICE OF EXCLUSIONS FROM MEDICARE/INSURANCE BENEFITS (NEMB)**

**There are items and services for which Medicare will not pay or Insurance may not pay.**

Medicare does not pay for all of your health care costs. Medicare only pays for covered benefits. Insurance may have policy exclusions. When you receive an item or service that is not a Medicare/Insurance benefit, you are responsible to pay for it, personally or through any other insurance that you may have.

**REFRACTION POLICY**:

**One of the most important parts of your exam is the refraction. This test determines if you need a glasses prescription or if your current prescription has changed. It is <u>NOT covered by Medicare</u>.**

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself.

**Medicare will not pay and Insurance may not pay for:**

| | | |
|---|---|---|
| **Refraction** | **Cost: $45** | **Medicare considers medically Unnecessary** |
| **Contact lens services (no returns or refunds after 60 days)** | **Cost: $45 & Up** | **Elective, Medicare states medically Unnecessary, Service will not be Submitted to Medicare or insurance** |
| **Skin Tag (11200)** | **Cost $123 per eye** | **Cosmetic, Medicare states medically Unnecessary** |

**PLEASE NOTE**: SHOULD YOU CHOOSE NOT TO HAVE A REFRACTION TODAY AND YOU BREAK OR LOSE YOUR GLASSES OR CHANGE YOUR MIND AND NEED A GLASSES PRESCRIPTION WE WILL NOT HAVE ONE ON FILE. **YOU WILL BE SCHEDULED A RETURN APPOINTMENT AND CHARGED ANOTHER OFFICE VISIT AND $45.00 REFRACTION.**

**OPTIONS: Check only one box. We cannot choose a box for you.**

❑ **OPTION 1.** I want the service listed above. I understand Medicare will not pay and I will be asked to pay at the time of service in addition to any copay, deductible, or coinsurance I may have.

❑ **OPTION 2.** I don't want the service listed above. I understand that without the refraction, the doctor may not be able to fully assess the health and function of my eyes.

**Signature**_____**Date**_____This is only a general summary of exclusions from Medicare benefits. It is not a legal document. The official Medicare program provisions are contained in relevant laws, regulations, and rulings.

NEWMAN & TAUB VISION CENTER, L.L.P.

**Gordon H. Newman, M.D**
**Larry R. Taub, M.D**
**Claire Y. Chu, M.D**
**OPHTHALMIC SURGEONS**

5744 LBJ FREEWAY
SUITE 150
DALLAS, TEXAS 75240
972-392-2020

1708 COIT ROAD
SUITE 240
PLANO, TEXAS 75075
972-312-9312

## FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policies.

Payments for services not covered by your insurance plan are due at the time of service. We accept checks (Valid Driver's License required), cash, money orders, and debit cards. MasterCard, Visa, Discover, and American Express are also welcome. We will be happy to file your insurance if we are listed as a "Participating Provider" of your plan. You must realize, however, that:

- Your insurance is a contract between you, the employer, and the insurance company. We are not a party to that contract and are not responsible for knowing the specific benefits of your plan.

- We will file your insurance on plans we participate with only if we have a current copy of your insurance card and all pertinent information required for filing claims.

- If we are unable to verify benefits for a same day procedure, you will be asked to self-pay or reschedule. If you choose to self-pay, we will file for the procedure and upon receipt of the insurance explanation of benefits, if a credit balance exists; we will refund you within 15 business days.

- Not all services are a covered benefit in your insurance contract. Some insurance companies arbitrarily select certain services they will not cover or they may set maximum limitations. Any services identified as such are your responsibility and payment will be due at the time of service.

We must emphasize that the filing of claims is a courtesy that we extend to our patients. All charges are your responsibility form the date services are rendered. It is understood that temporary financial problems may effect timely payment of your account. If such problems arise, please contact us promptly for assistance in the management of your account. If you have any questions regarding the above information, please do not hesitate to ask.

**(OVER)**

**CONTACT LENS SERVICES**

If you have an appointment or express a desire to start wearing contact lens while here for an examination, you will be charged a contact lens evaluation fee. This fee includes a contact lens exam and a pair of trial lens. You will be given an additional appointment with one of our contact lens specialist to learn insert and care instructions for your contact lens, this visit will be a separate charge. If you require more than four trial lens for any reason, you will need to make a follow up appointment to see the doctor. Contact lens prices vary by product and will be collected when dispensed. No returns will be accepted or refunds issued after 60 days from purchase or delivery. Contact lens appointments and services will not be filed with your insurance, however upon request you will be given a receipt to file your own insurance.

**Our office does not sell eye glasses**.

I hereby authorize Dr. Gordon H. Newman, Larry R. Taub, and Claire Y. Chu, M.D., of Newman & Taub Vision Center, L.L.P., to furnish my insurance company, its representatives or any other insurance company or attorney, the customary medical information requested by me. I understand that Newman & Taub Vision Center, L.L.P. will file my insurance on my behalf and that I will be responsible for following up with my insurance company for timely payment of services rendered. I agree to pay in full for all balances due that are not paid for by the insurance company.

**Signature: _____ Date: _____**

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## PHARMACY INFORMATION

Patient Name:_____Dob:_____

Please complete all information in its entirety:

Pharmacy Name:_____

Pharmacy Phone#_____

Pharmacy Address:_____

City State Zip Code

NEWMAN & TAUB VISION CENTER, L.L.P.

**PATIENT AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION/"Notice of Privacy Practices"**

**If you have any questions about this Notice please contact our Privacy Officer at 972-392-2020**

I understand Newman & Taub Vision Center ("NTV") is authorized by me to use or disclose my Protected Health Information for a purpose other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditional upon me signing this authorization.

I specifically authorize duly appointed representatives of NTV to disclose my Protected Health Information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by state or federal privacy regulations. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

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

☐ My entire record
(NOTE: This requires an explanation of why it is necessary to disclose the entire record)
_____
_____

☐ My demographic information (*check all that apply*):

☐Name ☐Address ☐State/Zip Code only☐ Telephone ☐Age ☐Gender ☐Race ☐
Other: _____

☐ Medical Data/Information as related to:
- ☐ Specific condition(s):_____
- ☐ Specific professional service(s): _____
- ☐ Specific medication(s): _____
- ☐ Other: _____

(OVER)

***Please disclose the above information to:***

Name (*organization or individual*): _____Relationship_____

Address: _____

Telephone: _____

Fax number (*if you authorize NTV to fax your information*): _____
Purpose for disclosure of Protected Health Information:
_____ (*Note: If patient is requesting disclosure, the purpose may simply state: "Patient is requesting disclosure."*)

I have a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization. In order for the revocation of this authorization to be effective, NTV must receive the revocation in writing, and the revocation must include:

- My name and address
- The effective date of this authorization, and the recipients of the Protected Health Information according to this authorization
- My desire to revoke this authorization
- The date of the revocation, and my signature.

NTV will accept written revocations of this authorization via:

☐ Certified U.S. Mail

☐ Fax at the following numbers: (972) 392-4054/972-312-9369

This authorization shall expire on _____. After this date, NTV can no longer use or disclose my Protected Health Information for the above purposes without first obtaining a new authorization form.

I fully understand and accept the terms of this authorization. My signature below also acknowledges I have received a copy of the "notice of privacy practices" for Newman and Taub Vision Center, PLLC.

_____ _____
Signature of Patient of Patient's Representative Date

_____
Name of Patient

_____ _____
Name of Patient Representative (if applicable) Representative's authority