Patient Registration Form

This form is posted on our website www.kidseyecare.net

PEDIATRIC OPHTHALMOLOGY ASSOCIATES

Caring For the Vision of Our Future

Catherine M. Chen, M.D.
1105 North Central Expressway, Suite 240 Allen, TX 75013
11330 Legacy Drive, Suite 203, Frisco, TX 75033
Phone: (972) 908-2555 Mobile: (214) 592-5246
Fax: (972) 908-2562

Patient Last Name: _____First Name: _____ Sex : Male / Female

Date of Birth: _____SS #:_____-_____-_____ Phone: (_____) _____

Address: _____

City: _____ State: _____ Zip: _____

Pediatrician /Family Practitioner: _____Referring Physician: _____

Parent Information

Parent 1 Name: _____ DOB: _____ SS #:_____-_____-_____

Home #: (_____) _____ Work #: (_____) _____ Cell: (_____) _____

Address: _____ Email: _____

City: _____ State: _____ Zip: _____

Parent 2 Name: _____ DOB: _____ SS #:_____-_____-_____

Home #: (_____) _____ Work #: (_____) _____ Cell: (_____) _____

Address: _____ Email: _____

City: _____State: _____ Zip: _____

Legal Guardian: _____

PARENT BRINGING CHILD FOR APPOINTMENT WILL BE RESPONSIBLE FOR CHARGES

Insurance Information

Primary Insurance: _____ ID Number: _____ Group #:_____

Insured Last Name: _____ First Name: _____ DOB:_____

SS#: _____-_____-_____ Insured Relationship to Patient: _____

I hereby authorize and direct my insurance benefits to be paid directly to Pediatric Ophthalmology Associates. I also authorize the release of information regarding medical records. As the parent / guardian of the above patient. I consent to treatment of the said patient. I understand I am financially responsible for any fees incurred, including fees for medical services not covered by my insurance. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Signed: _____ **Date:** _____

Relationship to Patient: _____

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Patient Medical History Form
Page 1

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Date: _____

Patient First Name: _____ Last Name: _____

DOB: _____ Age: _____(years) _____ (months)

Past Medical History:

Mother's Length of Pregnancy: _____ (weeks) Birth Weight : _____

Medical Problems During Pregnancy: _____

Child's Pre-existing Medical Conditions : _____

_____

Medications, Including Eye Medications: _____

_____

Drug Allergies: _____

Food / Environmental Allergies: _____

Ocular History:

Past Eye Trauma: Y / N _____

Child's Pre-existing Eye Conditions: Y / N _____

Past Eye Surgery: Y / N _____

Social History:

Patient lives with _____

Brothers _____ Sisters: _____

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Patient Medical History Form
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Review of Systems
(Please Circle All That Apply)

Constitutional: Fevers Weight Loss Swollen Glands Fatigue

Nervous System: Headaches Seizures Poor Coordination Dizziness Paralysis

Skin: Rashes Birth Marks/Discoloration Nodules/Swelling Easy Bruising Jaundice

Endocrine: Diabetes Thyroid Problems Blood Clotting Abnormality

Kidneys/GU: Ulcerations Kidney Stones Increased Urination Blood in Urine

Ears/Nose/Throat: Mouth Sores Hearing Problems Nosebleeds Hoarseness

Cardiovascular: Heart Valve Abnormalities Other: _____

Lungs/ Respiratory: Asthma Cough Other: _____

Stomach / GI: Diarrhea Constipation Other: _____

Muscles / Bones: Joint Swelling Joint Pain Hyper-mobility Unusual Height for Age

Infectious: Exposure Travel Cold Sores Other: _____

Known Genetic Abnormalities or Congenital Syndromes: Yes / No

Please Specify: _____

_____

Office Policy

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In order to improve our efficiency and ensure a pleasant office visit, please note the following:

- A complete pediatric ophthalmology exam is detailed and through. Please allow a minimum of two hours for an initial exam and at least an hour for any follow up visits.
- Please bring any current glasses or contact lens with you to every office visit.
- Please help us stay on schedule by arriving on time for your scheduled visit. If you arrive more than 20 minutes late, your appointment may have to be rescheduled.
- To minimize distractions to you child during the exam, if possible, please do not bring siblings.
- If it is necessary to cancel your appointment, please give us 24 hours notice.
- As we are a consultative pediatric ophthalmology practice, your child must have primary care physician. We will keep your pediatrician or family practitioner informed of you child's eye health and test results.
- Please provide us with your group and policy number of your insurance carrier, as well as the contact numbers found on the back of your card at the time your appointment is made. This will help facilitate the pre-authorization process.
- If your insurance requires a referral (all HMO, some PPO, POS, EPO), please provide us with the referral number at the time your appointment is made, prior to your office visit. This can be obtained through your primary care physician.
- We are affiliated with most HMO, PPO, EPO, and POS plans. As specified in our financial responsibility statement, you are required to pay your co-pay and co-insurance amount at the time of service. On traditional 70/30, 80/20, and 90/10 plans, we ask that you ay your portion at the time of the visit. If your deductible has not yet been met for the year, we ask that you pay for the office visit at the time of service. We will file claims to your insurance as a service to you.
- If the parents are divorced, payment is the responsibility of the parent bringing the child to the office for treatment, regardless of the terms of the divorce decree.
- In compliance with federal privacy regulations, no information regarding patients will be released without written authorization from the parent or guardian. Please visit our website in the "Visiting Us" section for the Medical Records Release Form. Pediatric Ophthalmology Associates will provide this information within 15 business days after date of receipt of the written consent for release. A reasonable fee for furnishing this information may be charged.

Your cooperation with the above policies will enable us to better serve you and your children.
Thank You.

HIPAA Patient Acknowledgment Form

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Our Notice of Privacy Practices provides information about the privacy rights of our patients and how we may use and disclose protected health information.

Federal regulation requires that we give our patients or their authorized representatives the opportunity to review our Notice of Privacy Practices before signing this acknowledgment. A summary of this Notice is available in our office and the hospitals we serve. A copy of our Notice can be made available to you and you may also view our Notice by visiting our Internet web site, www.kidseyecare.net

By signing this form, you are giving consent to Pediatric Ophthalmology Associates to electronically download and share current and past medical information including medication history from other medical offices and pharmacies via Electronic Medical Records.

By signing this form, you also acknowledge that we have provided you with immediate access to our Notice of Privacy Practices.

_____ _____

Signature of Patient or Authorized Representative Date

_____ _____

Print Name of Patient Print Name of Authorized Representative

Pediatric Ophthalmology Associates
Patient Financial Responsibility Statement

As a subspecialty practice we strive to keep our fees as low as possible. It is therefore important that we have a good understanding with our patients regarding financial responsibility. We hope this summary is helpful towards this goal and we encourage you to discuss any questions with us.

We must have a current copy of your insurance card; If this is not available, full payment for the office visit will be expected at the time of service.
Applicable deductibles and co-payments are due at the time of service.
The remainder of your bill will be sent to your health plan for direct payment to our billing service.
If your insurance carrier has not paid our claim within 60 days, we may expect payment from you.
If your health plan mistakenly remits payment directly to you, please forward it to us along with all associated paperwork.
You are responsible for any services not covered by your insurance plan. With 70/30, 80/20, or 90/10 plans, your portion is due at time of visit.
Health Plans sometimes refuse payment of a claim for any of the following reasons:
This is a pre-existing condition not covered by your plan.
You have not yet met your full calendar year deductible.
The type of medical services required is not covered by your plan.
The health plan was not in effect at the time of service.
You have other insurance which must be filed with first.
Although benefits may be verified prior to or at the time of service, the payment collected may not reflect the full patient responsibility. Please understand that financial responsibility for medical services rests between you and your health plan. While we are pleased to be of service by filing your insurance claim for you, we are not responsible for any limitations in coverage by your health plan. If your insurance carrier denies this claim, you will then become responsible for this bill. It is your responsibility as the patient to pay the denied amount in full.
We understand that emergencies or other unexpected obligations occur. However, if you do not call to cancel an appointment, you may be preventing another child from receiving needed medical care. If an appointment is not cancelled 24 hours in advance you will be charged a $25.00 fee; this will not be covered by your insurance company. If a surgery is not cancelled at least 24 hours in advance, you will be charged a $50.00 fee; this will not be covered by your insurance company.

It is our mission to provide you with quality, cost-effective medical care. We are continuously adapting to the changing policies of health insurance carriers. We value you as a patient and strive to provide you with the best possible care. Pediatric Ophthalmology Associates welcomes you to our practice.

I have read and understand my obligations and I acknowledge that I am fully responsible for payment of any services not covered by my insurance carrier.

_____ _____

Patient Signature or Guardian Date

_____