



L A S E R C A R E
E Y E C E N T E R

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Baylor Medical Plaza
2020 W. Hwy. 114, Suite 340
Grapevine, Texas 76051

New Patient Information Form

Full Legal Name: _____

What name would you like us to call you: _____

Address: _____
 Number Street Apt #

 City State Zip code

Social Security # _____ - _____ - _____ TX Driver's Lic. #: _____ Sex: M F Age: _____

Date of Birth: _____ / _____ / _____ Marital Status: Married Divorced Single

Employer: _____ Occupation: _____

Address: _____
 Number Street Suite #

 City State Zip code

Home phone: _____ Office phone: _____

Cell phone: _____ Email: _____

During your visit today, do you wish to receive any of the following:

Contact Lenses Exam

Updated Glasses Prescription

Doctor Referral Information

Referring Physician: _____ **Primary Care Physician:** _____
 Address _____ Address _____
 Telephone _____ Tele-

Insurance Information

Primary Insurance Company: _____ Insurance type: HMO PPO POS EPO Other _____

Primary Card Holder Name: _____ Relation to patient: _____

Primary Card Holder's SS#: _____ - _____ - _____ Primary Card Holder's Date of Birth: _____ / _____ / _____

Do you require a referral? Yes No **If Yes, Did you bring your referral for today's visit?** Yes No

Secondary Insurance Company: _____

Secondary Card Holder's Name: _____ Relation to patient: _____

PLEASE FILL OUT THE BACK OF THIS FORM



Patient Name: _____

Emergency Contact Information

Name: _____ Phone: _____ Relationship: _____

Medical and Financial Authorizations (Please read carefully then sign at the bottom)

Financial Agreement and Assignment of Benefits

I authorize direct payment to assignee (LaserCare Eye Center and associated Physicians) for health insurance benefits otherwise payable to me. I request payment of authorized Medicare and Medigap benefits be made on my behalf to assignee for services furnished. I understand it is my responsibility to know my insurance coverage/limitations and I am ultimately responsible for all medical charges. If my insurance fails to pay a claim within 45 days or rejects a claim as "non-covered", a bill will be sent to me and I agree to pay the bill in 5 business days. Failure to pay will result in reporting to Credit Collection agencies and/or legal action. I understand it is my responsibility to pay any collection agency/late fees, or any deductible, co-payment or other outstanding balance not paid by my insurance company. I understand all charges must be paid at the end of each visit, except for charges covered by Insurance. I understand assignee does not accept Insurance or Medicare as payment for Refractions or Contact Lens exams/supplies.

Consent for Release of Information

I authorize assignee to use and disclose my protected health information for the purposes of treatment, payment and other healthcare operations. I authorize holders of medical information about me to release it to the Health Care Financing Administration (HCFA), my health insurance company, my Medigap insurance company or their agents to determine these and related benefits payable. I have a right to review assignee's Notice of Privacy Practices, which details use of this information. I have a right to request assignee restrict use of this information. Such limitations may affect assignee's ability to process my insurance. I may revoke this consent in writing, except to the extent it has already been used in reliance of my consent.

Medical Treatment Consent

I authorize examination by the Physicians and staff of LaserCare Eye Center. I authorize performance of all procedures the judgment of Physicians/staff may deem necessary. I authorize administration of anesthetics and analgesics (including eye drops) which are deemed advisable. Should I elect to refuse a specific procedure, I agree to sign a release absolving assignee of liability related to my refusal. I understand if my eyes are dilated it may not be safe for me to drive.

Privacy Policy

At LaserCare Eye Center, we value the rights that our patients have to privacy. We abide by Privacy Standards outlined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). We have a *Notice of Privacy Practices* that describes how medical information about you may be used and disclosed and how you can get access to this information.

CHECK THIS BOX TO INDICATE THAT YOU HAVE BEEN OFFERED A COPY OF OUR *Notice of Privacy Practices*.

General Acknowledgements

I understand that LaserCare Eye Center, P.A. is a Texas Corporation owned in part or wholly by Sidney Gicheru, M.D. I understand that some of the Physicians at LaserCare Eye Center are Independent contractors(**). I understand that Dr. Gicheru has ownership interest in area healthcare facilities (including Irving-Coppell Surgical Hospital). I have been given a copy of the LaserCare Eye Center Office Policies. I have read, understand and am agreeable with them. I understand that if I have any concerns, I should notify the front desk, who can direct me to an alternate facility. The above consents, acknowledgements, policies and assignments of benefits shall remain in effect until revoked by me in writing. A photocopy of the assignments shall be considered as valid as an original.

CHECK THIS BOX TO INDICATE THAT YOU HAVE BEEN OFFERED A COPY OF OUR *Office Policies*.

Signed _____ **Date:** _____

Please provide the receptionist with your driver's license and insurance card(s) to be copied for your chart.
We accept cash, checks, credit cards, Medicare, most PPO's and select HMO's.
HMO patients MUST have a valid referral from their primary care physician or pay for their visit out-of-pocket.
Thank you for choosing LaserCare Eye Center.