Eye Associates of Georgetown, LLPC

Paige Quinlivan, O.D. & David Quinlivan, O.D.

Mr. Mrs. Ms. Miss. Rev. Dr. Name: (Last) _____

(First) _____ (Mid. Intl.) _____ Nickname: (if any) _____

Address: _____

City: _____ State: _____ Zip Code_____

Cell Phone: _____ Work Phone: _____

Home Phone: _____ Alternate Phone: _____

****<u>Preferred</u>** Phone Number or <u>Method</u> for Contact: Phone _____ Text _____**

E-mail: _____

Date of Birth: _____ / _____ / _____ Gender: _____Male _____Female

Marital Status: _____Minor Child _____Single _____Widowed _____Married _____Divorced

Social Security _____-_____-_____ Drivers Lic. # _____

Student: Full or Part Time ___ not Employed Occupation: _____

Employer or School _____

*****How did you hear about our office**: _____

*****Primary Care Doctor:** _____ Phone: _____

*****Preferred Pharmacy:** _____ Phone: _____

***** If <u>YOU</u> are <u>NOT</u> the Primary insured, <u>please complete the section below</u>:**

Primary Insured: (Last) _____ (First) _____ (Mid Intl.) _____

Date of Birth: ___ / ___ / ____ **Social Security:** _____ - ____ - _____ **Phone:** _____

☐ **Different Address**: _____

City: _____ **State:** _____ **Zip Code:** _____

Employer: _____

Medical History

Name: _____D.O.B._____

PCP: _____

EYE HISTORY – past and present

- ☐ Cataract
- ☐ Blurred Vision Near
- ☐ Blurred Vision Distance
- ☐ Amblyopia (Lazy Eye)
- ☐ Color Blindness
- ☐ Macular Degeneration
- ☐ Glaucoma
- ☐ Retinal Detachment
- ☐ Dryness
- ☐ Eye Pain or Soreness
- ☐ Itching
- ☐ Burning
- ☐ Drooping Eyelid
- ☐ Glasses
- ☐ Surgery: _____
- ☐ Other: _____

GENERAL HEALTH – past and present

- ☐ Diabetes
- ☐ Headaches
- ☐ Head Trauma
- ☐ Allergies
- ☐ Asthma
- ☐ Seizures
- ☐ Muscles, Bones, Joints
- ☐ Anxiety &/or Depression
- ☐ Cancer: _____
- ☐ Other: _____

FAMILY

- ☐ Amblyopia
- ☐ Blindness
- ☐ Color Blindness
- ☐ Retinal Detachment
- ☐ Macular Degeneration
- ☐ Glaucoma

- ☐ Tired Eyes
- ☐ Glare/Light Sensitivity
- ☐ Redness
- ☐ Infection of Eye or Lid
- ☐ Excess Tearing/Watering
- ☐ Foreign Body Sensation
- ☐ Strabismus (crossed Eyes)
- ☐ Sandy or Gritty Feeling
- ☐ Distorted Vision (Halos)
- ☐ Double Vision
- ☐ Floaters or Spots
- ☐ Fluctuating Vision
- ☐ Loss Vision or Side Vision
- ☐ Flashes of Light
- ☐ Refractive Surgery
- ☐ Contact Lenses

- ☐ Lung Disease
- ☐ Heart Disease &/or Cholesterol
- ☐ Arthritis
- ☐ Vascular Disease
- ☐ High Blood Pressure
- ☐ Lupus
- ☐ Skin Disease
- ☐ Blood/Lymph
- ☐ Shingles

****Please list all Medications, Vitamins and Supplements you take.**

- ☐ Strabismus
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Stroke
- ☐ Arthritis

*****We are REQUIRED to ask the following *** questions by Federal Mandate.**

Race:

___Declined ___Caucasian/White

___Hispanic ___Asian

___Black or African American

___American Indian or Alaska Native

___Native Hawaiian or Pacific Islander

Ethnicity: __ Hispanic/Latino __Non-Hispanic

****

Preferred Language:

___English __Spanish __Declined

___ Other: _____

Do you smoke? ___ Yes ___No ___Former

Do you consume alcohol? __No __Yes

__Socially ___Rarely ___Occasionally

_____Height _____Weight

Medications, Supplements and Vitamins:

Eye Associates of Georgetown, LLPC

Paige Quinlivan, O.D. & David Quinlivan, O.D.

Financial Policy and Agreement

Thank you for choosing Eye Associates of Georgetown for your eye care needs. We are committed to providing you with quality health care. The purpose of this financial policy and agreement is to advise you of your responsibility for services rendered. This agreement is between Drs. Paige and David Quinlivan, as creditor, and you the patient or guarantor of the patient. By executing this agreement, you are agreeing to pay for all services and materials received.

1. **Insurance** Knowing your insurance benefits is your responsibility. Your insurance benefit is a contract between you and your insurance company. Please contact your insurance company with any questions you may have regarding your coverage. If you are insured by a plan we are contracted with but don't have an up-to-date insurance card, payment in full is required until we can verify your coverage. Non-Network Insurance If you are not insured by a plan we are contracted with, payment in full is expected at time of visit.
2. **Proof of identification and insurance** All patients must complete our patient information form prior to seeing the doctor. We must obtain a copy of an identification card (i.e. driver's license) and current proof of insurance. If you fail to provide us with correct insurance information, you may be responsible for the balance of the claim.
3. **Co-Pays and Deductibles** All co-pays and deductibles must be paid at the time of service. This agreement is part of your contract, with your insurance company.
4. **Non-covered Services** Please be aware that some or all services you may receive may not be covered services by your insurer. You are responsible for payment of these services.
5. **Claims submission** As a courtesy to our patients, we will submit your (in-network) claim to your primary and secondary insurance company. We will assist you in any reasonable way we can, to help get your claims paid. We do not file to a tertiary insurance company. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request. You are responsible for any remaining balances after your insurance processes your claim, per your contract with the insurance company.
6. **Coverage changes** It is your responsibility to notify us if your insurance changes. Please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
7. **Eye wear and Contact lenses** When materials (frame and lenses) are purchased with insurance, full payment is required, to place the order. Frame and lenses purchased without insurance, require a minimum deposit of 50%, before they will be ordered. The remaining balance will be due at time of pick-up.
   Contact lenses require payment in full, at the time of order.
8. **Returned Checks** Our office charges a $35 fee for returned checks.

9. **Monthly Statement** If you have a balance on your account, we will send you a monthly statement. It will show all charges, payments and any credits to the account.
10. **Payments** Unless other arrangements have been approved in writing, the balance on your statement is due and payable, when the statement is issued. Please call our office if you have questions regarding your statement. (512) 863-4400 ext. 22
11. **Late Fees** A late fee of $10.00 will be imposed on each account that is over 30 days past due. The account is considered past due if it is not paid by the next billing cycle.
12. **Finance Charges** A finance charge will be imposed on each item of your account that has not been paid within 30 days of the time the item was added to the account. The finance charge will be computed at the rate of 2% per month or an annual percentage rate of 24 %. The finance charge on your account is computed by applying the periodic rate 2% to the "overdue balance" on your account. The "overdue balance" of your account is calculated by taking the balance owed thirty days ago, and then subtracting any payments or credits applied to the account during that time.
13. **Nonpayment** Please be aware that if a balance remains unpaid, we may refer your account to a collections agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular mail or certified mail, that you have 30 days to find alternative medical care. During that 30-day period our physicians will only be able to treat you on an emergency basis only.

**I have read and understand the financial policy and agree to abide by its guidelines. In addition, I hereby authorize the providers to receive direct payment for benefits payable to me from services rendered.

Patient Name: _____ D.O.B. _____

Patient Signature: _____ Date: _____
(Guardian if patient is a minor.)

Eye Associates of Georgetown

Paige Quinlivan, O.D.

David Quinlivan, O.D.

107-A Wagon Wheel Trail, Georgetown, Texas 78628

Authorization and Acknowledgment

All data or information pertaining to the diagnosis, treatment or Health of

_____who receives care through

Eye Associates of Georgetown shall be held in confidence and shall not be disclosed to any person except (1) to the extent that it may be necessary to carry-out purposes required by or to administer insurance or health maintenance benefits, or (2) upon the express written consent of the patient.

Contact Release of Information

In the event that Eye Associates Georgetown needs to contact you (the patient) regarding an appointment, lab result, medication or for any other reason, it is permissible to:

***Please mark all that apply:**

- o Leave a message on an answering machine/voicemail
- o Speak with spouse or significant other
- o Speak with family members
- o Other

Name(s): _____

*Relationship to Patient*_____

_____ _____ / _____ / _____

Signature of Patient/Guardian/Personal Representative *Date*