

ALL EYE CARE, P.A.

VISION, MEDICAL & SURGERY

RAJIV RUGWANI, M.D.
Eye Specialist & Eye Surgeon

800 Hwy. 77 N. • Suite #100 • Waxahachie, TX 75165 • (972) 937-4433 • Fax (972) 937-4525

PATIENT INFORMATION:

Name: First _____ MI _____ Last _____

Address: _____ Apt.# _____ City: _____

State: _____ Zip Code: _____ Phone: Home _____ Cell: _____

Sex: F _____ M _____ Marital Status: Single _____ Married _____ Divorced _____ Widowed _____ DOB: _____

SSN: _____ Employer: _____ Phone: _____

Primary Care Doctor: _____ Phone: _____

Preferred Pharmacy: _____ Phone: _____

Emergency Contact: _____ Relationship to patient: _____

Phone: _____ Pt Referred By: _____

GUARANTOR/BILLING INFORMATION:

Name: First _____ MI _____ Last _____

Address: _____ City _____ St _____ Zip _____

Phone: _____ Relationship to patient: _____

INSURANCE INFORMATION:

Primary Insurance Co: _____ ID#: _____

Group# _____ Cardholder Name: _____ DOB: _____

Employer Name: _____ Relationship to Patient: _____

Secondary Insurance Co: _____ ID# _____

Group # _____ Cardholder Name: _____ DOB: _____

Employer Name: _____ Relationship to Patient: _____

X _____ Date: _____

SIGNATURE (Patient, or if minor parent or legal guardian)

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MEDICAL INFORMATION

Last _____ First _____ Date _____

Family Physician _____ Referred By _____

PATIENT HISTORY:

1. Medication Allergies: _____

2. Past Eye History: _____

3. Past Medical History: _____

4. Past Surgical History: _____

5. Current Medications (Name & Purpose) _____

FAMILY HISTORY OF:

SOCIAL HISTORY:

YES NO

- High Blood Pressure
- Heart Disease
- Diabetes
- Other _____

YES NO

- Glaucoma
- Retinal Detachment
- Cataracts
- Eye Disorders
- Macular Degeneration

Tobacco Yes No

Alcohol Yes No

Drugs Yes No

Do you live:

alone with spouse

other _____

PATIENT'S OR GUARDIAN'S SIGNATURE _____ DATE _____

PHYSICIAN'S SIGNATURE _____ DATE _____

UPDATE Year Initials Year Initials Year Initials Year Initials

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Review of Systems

Any problems in the following areas (past or present)? If "yes", provide information.

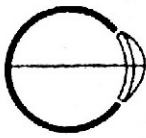
CONSTITUTIONAL	NO	YES	EXPLANATION of PROBLEM
Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	_____
EYES			
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	_____
EARS, NOSE, MOUTH, THROAT			
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	_____
CARDIOVASCULAR			
Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
ENDOCRINE			
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	_____
On Birth Control	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	_____
RESPIRATORY			
Breathing Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma/Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
HEMOTOLOGIC/LYMPHATIC			
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lymph Nodes	<input type="checkbox"/>	<input type="checkbox"/>	_____
GASTROINTESTINAL			
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bladder	<input type="checkbox"/>	<input type="checkbox"/>	_____
MUSCULOSKELETAL			
Weakness/Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
INTEGUMENTARY			
Skin and/or Breast	<input type="checkbox"/>	<input type="checkbox"/>	_____
NEUROLOGICAL			
Weakness/Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Siezuures	<input type="checkbox"/>	<input type="checkbox"/>	_____
ALLERGIC/IMMUNOLOGIC			
Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
PSYCHIATRIC	<input type="checkbox"/>	<input type="checkbox"/>	_____

Any other problems/conditions, _____
please explain _____

PATIENT'S OR GUARDIAN'S SIGNATURE _____ DATE _____

PHYSICIAN'S SIGNATURE _____ DATE _____

UPDATE Year Initials Year Initials Year Initials Year Initials



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ADVISEMENT OF PATIENT RESPONSIBILITY /POLICY

For our office to file a claim with your insurance we must have a copy of your primary and secondary (if applicable) insurance cards to be placed in your file, along with current picture identification. If the primary insurance requires a referral from your PCP to see a specialist (Dr. Rugwani) we must have the referral in our office prior to your visit. **Patient is responsible to obtain a referral from their PCP.** If we are unable to confirm valid insurance coverage, the entire fee will be due and payable at the time services are rendered.

It is the policy of this office that any co-pay, deductible and/or coinsurance amounts identified by insurance as patient responsibility will be collected at the time services are rendered, unless prior arrangements have been made through our business office. Any patient responsibility for cataract surgery must be paid prior to surgery date. All Eye Care, PA/Dr. Rugwani does NOT offer payment plans.

PAYMENT POLICY FOR REFRACTION

Refraction is a separate test that determines the power needed for your eyeglass prescription. A series of test lenses are carefully presented to determine which power provides the clearest and sharpest vision for you. Unfortunately, Medicare and most medical insurance companies DO NOT cover this expense as part of the examination and as such **we will collect our refraction fee of \$25 from the patient at time of service.**

INSURANCE ASSIGNMENT/RELEASE OF INFORMATION AND PATIENT RESPONSIBILITY

I hereby authorize All Eye Care, P.A. to release any information concerning my care for the purpose of filing claims to: federal, state, city or town governmental agencies, third party payers of all categories, doctors and hospitals, in accordance with HIPPA (Health Insurance Portability and Accountability Act) regulations.

The person signing below, whether signing as a patient, or legal representative of the patient, agrees that he/she has read and understands the above terms and conditions and individually obligates himself /herself to pay All Eye Care, P.A. for services rendered. The person signing below understands that a quote of benefits from this office is **NOT A GUARANTEE OF PAYMENT** and actual insurance payments will be determined by patient's policy at the time a claim is processed. In the event insurance does not pay the bill within 90 days he/she will be responsible for payment of the balance in full. Should the account be referred to an attorney for collection, the person signing below will be responsible for all attorney's fees and collection expenses.

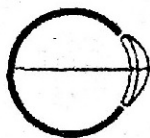
Relationship to patient: Self Spouse Parent Other _____

(PLEASE CIRCLE ONE)

Printed Name

Signature

Date



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Authorization to Release Protected Health Information

I acknowledge I have been given the opportunity to review All Eye Care, P.A.'s Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

As a covered entity under HIPAA (Health Insurance Portability and Accountability Act), All Eye Care, P.A./Rajiv M. Rugwani, M.D., is required to maintain the privacy of your protected health information. We are prohibited by law from disclosing any protected health information to anyone other than you without your written authorization. This agreement authorizes employees of All Eye Care, P.A./Rajiv M. Rugwani, M.D., to disclose protected health information to the person(s) listed below for general disclosure, purposes of treatment, and obtaining payment for our services.

Name

Relationship

Date

<u>Name</u>	<u>Relationship</u>	<u>Date</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

This authorization is valid until revoked in writing by the patient. The patient has the right to revoke this authorization at any time by submitting a written request. A revocation is not valid and will not apply to disclosures made prior to the date of the written revocation.

All Eye Care, P.A./Rajiv M. Rugwani, M.D., will not be responsible for any disclosures of protected health information made by the recipients of information authorized by this document.

I understand that by signing this document, I hereby authorize All Eye Care, P.A./Rajiv M. Rugwani, M.D., to release my protected health information for the purposes mentioned previously to those persons I have listed above.

Patient Printed Name

Date

Patient Signature