Account #_________________

PATIENT INFORMATION

Today's Date ______________

Name ________________________________ **Cell Phone** ________________ **Home Phone** _______________

Address ___________________________ **City** _____________ **Zip** _________ **Work Phone**_______________

Birth Date ________ **Social Security #**_____________ **Driver's License #** _____________ **Marital Status** ___

If Patient is under age 18, list Parent/Guardian and SS# ____

Employer ____ Employer Telephone _________________________

Spouse ________________________ Spouse's Social Security # ____________________________________

Spouse's Employer _________________________________ Spouse's Business Telephone ___________________

Who may we contact in case of an emergency? __________________________ **Phone** ___________________

How did you choose our practice? ____

Referring Physician __________________ Phone_____________ Primary Care Physician __________________

Reason for Visit ____

Do you have an injury that you feel is employment related? ______________________________________

Have you or any family members ever seen any of the doctors at Ophthalmology Associates? _______________

____

List any medications to which you are allergic____

New Patient Information Only | **Insurance Information**

Primary Insurance _____________________ Policy Holder's Name & SS# ________________________________

Primary Ins. Policy # ___________________ Primary Policy Group # ____________________________________

Secondary Insurance ___________________ Policy # and Holder ______________________________________

List any additional Insurance Carriers ____

Who is financially responsible for this bill? ____

I authorize this office to release any information necessary to expedite insurance claims and hereby assign medical benefit payments directly to Ophthalmology Associates of San Antonio. I understand that I am responsible for all charges, regardless of insurance coverage.

If I am the parent or guardian of the patient who is a minor or if I am authorized to act for a patient who is otherwise not competent to consent to treatment, I authorize treatment on the patient's behalf.

I understand that I may be given a return appointment in order to follow-up on my ocular status or condition. In the event that, for any or no reason, I do not keep that return appointment and do not promptly re-schedule, I agree not to hold Ophthalmology Associates of San Antonio, it's Physicians, and/or staff responsible for any resulting consequences. Appointments cancelled with less than 24 hours notice may be charged to your account.

Signature ____ **Date** ____________________

☐ **Self** ☐ **Parent or Guardian of Minor Child** ☐ **Acting on Behalf of Patient**

OPHTHALMOLOGY ASSOCIATES
OF SAN ANTONIO

RECORDS RELEASE

ARLO C. TERRY, M.D.
JOHN A. CAMPAGNA, M.D.
ROBERT P. GREEN, JR., M.D.
COOPER M. CLARK, D.O.
MARK J. TREVINO, M.D.

NIX MEDICAL CENTER, SUITE 400
414 NAVARRO STREET • SAN ANTONIO, TX 78205
(210) 223-5561
FAX: (210) 223-5093

Date ______________________________

To:

____

I hereby authorize you to release to:

____

____

any information including ALL diagnosis and records of any treatment or examination rendered to me.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing the information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: ________________ .
If I fail to specify an expiration date, event or condition, this authorization will expire in six (6) months.

Print or type name: ____

Signature: ____

SS# and DOB: ____

Witness Signature: ____

PATIENT ACKNOWLEDGMENT
REGARDING THE HEALTH INFORMATION PRACTICES OF
OPHTHALMOLOGY ASSOCIATES OF SAN ANTONIO

I have been provided the opportunity to read, or have read to me, the Notice of Health Information Practices at Ophthalmology Associates of San Antonio (OASA).

I understand that Ophthalmology Associates of San Antonio is committed to holding and using protected health information responsibly.

As it relates to my records at Ophthalmology Associates of San Antonio, I understand my rights and how information about me may be used and disclosed.

I understand that my health record is the physical and legal property of Ophthalmology Associates of San Antonio, but the information belongs to me. I may have access to inspect, amend, or obtain a copy of my health information. There is a cost for copies of my records, and appointments must be made with the Privacy Officer to inspect, access, or amend my health information.

I understand that Ophthalmology Associates of San Antonio is required to maintain the privacy of my health information. Ophthalmology Associates of San Antonio will require my authorization to release my health information to outside sources, with the exception of disclosures for purposes of Treatment, Payment and Healthcare Operations. These may include the following: access to my health insurance information by Ophthalmology Associates of San Antonio staff and physicians; billing to myself or third party payer; business associates of Ophthalmology Associates of San Antonio may, from time to time, have access to my health information, but I am assured that proper Business Associates Agreements are in place to ensure the protection of my health information; upon the physicians best judgment, OASA may disclose to a family member, relative, close personal friend, or any other persons I identify the health information relevant to that person's involvement in my care; research; funeral directors; organ procurement; marketing; FDA; public health or legal authorities; and/or law enforcement purposes.

Ophthalmology Associates of San Antonio may call me with appointment reminders or cancellations and may leave voice mail messages at my home or place of employment.

I have read and understand the Health Information Practices of Ophthalmology Associates of San Antonio.

____

Patient Signature

____

Date

____

Witness

OPHTHALMOLOGY ASSOCIATES
OF SAN ANTONIO

Refractions

Many insurance companies, including Medicare, do not cover refractions. Refraction is a test which allows a physician to monitor any changes in your vision and for glasses. The charge for this special test is **$60.00** and is due at the time of service.

______________________________ ______________

Patient Signature **Date**

400 NIX MEDICAL CENTER • 414 NAVARRO STREET • SAN ANTONIO, TEXAS 78205-2505

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