PROVIDENT
EYE SPECIALISTS

New Patient Registration Form

Name: _____Today's Date:_____
Last First MI Month/Day/Year

Mailing Address: _____
Street City State Zip Code

Home Phone: _____Cell Phone: _____Social Security #_____

Email: _____

Age: _____ Date of Birth: _____ Male: ____ Female: _____
Month/Day/Year

Marital Status (circle one): Married Single Divorced Widowed

Employment Status (circle one): Full Time Part Time Student Unemployed Retired

If employed, please provide Employer name: _____ Occupation: _____

Employment Address: _____ Work Number: _____

Spouse or Parent's Name: _____ Date of Birth: _____
Month/Day/Year

Emergency Contact: _____Relationship: _____

Address: _____ Phone Number: _____

Preferred Pharmacy (Name and Street Address): _____

Name of Primary Care Physician : _____

How did you hear about us? (Circle one): Internet Referral Friend/Family Hospital Insurance

Consent for Examination

Consent for Use of Dilating Medication(s)

Dilating eye drops are used to enlarge the pupil to allow examination of the inside of the eye. Although occurring rarely, risks of these medications include allergic reaction, acute glaucoma, and systemic reactions including increased blood pressure, irregular or fast heart beats and dizziness. Additionally, use of dilating drops will cause blurry vision and light sensitivity which can make driving and certain work conditions hazardous after an eye exam for a period of 4 – 6 hours or more. Because driving may be difficult immediately after an examination it is best if you make arrangements not to drive yourself.

However, if dilating eye drops are not used, the examination is sub-optimal and certain conditions such as macular degeneration, glaucoma and retinal tumors may go undiagnosed.

_____(Initials) I consent to the use of dilating eye medications.

_____(Initials) I decline the use of dilating eye medications.

Acknowledgement of Refraction Policy and Consent for Refraction (Optional)

Medicare policy requires that refraction (the exam to determine glasses prescription) be billed separately from an eye exam. Medicare, Medicaid and most insurance carriers do not pay for refraction. Patients are responsible for payment of a refraction. Payment is due in full at the time refraction services are rendered.

Further, declining refraction prior to some surgeries may result in non-payment of the surgery by your insurance carrier or Medicare in which case you would be responsible for payment.

Charge for Refraction as of 01/01/2022: $50

_____(Initials) I acknowledge that I have read and understood the refraction policy.

_____(Initials) I consent to refraction when determined appropriate by the physician.

_____(Initials) I decline refraction currently.

Financial Responsibility & Consent for Treatment

It is the policy of Provident Eye Specialists, P.A. that payment is due at the time services are rendered. As a benefit to you we will bill services directly to your insurance carrier. However, you are ultimately responsible for all charges including, in the event of default, costs of collection and attorneys' fees.

I hereby authorize the assignment of medical and surgical procedures benefits from Medicare, Medicaid, other governmental insurances and/or private insurance to: Provident Eye Specialists P.A. at 11212 Montwood Dr., El Paso, TX 79936

I authorize Dr. Keak C. Khauv to provide reasonable and appropriate medical and surgical care consistent with the standards of care of the American Academy of Ophthalmology.

Signature of Patient: _____ Date: _____

Signature of Witness: _____ Date: _____

Consent & Direction for Release of Protected Health Information (PHI)

In compliance with the HIPAA (Health Insurance Portability and Accountability Act) and to help protect your financial and health information, we ask that you complete this form. You may change your answers to this form at any time. We will keep a digital copy on file in your chart. We will endeavor to follow your wishes except when required by law as is described in the Notice of Privacy Protection statement which you have read and signed.

Regarding the release of your health information, please read through the listed below and check the box that reflects your wishes.

During Examination

☐ Yes ☐ No You (Provident Eye Specialists, P.A.) may speak with all persons accompanying me during my examination directly and/ or allow them to hear all information or discussion indirectly. I understand that if I don't want that person privy to the conversation, I must ask that person to leave the exam room.

Name: _____Relationship: _____

Telephone Contacts

☐ Yes ☐ No I consent to receiving all information regarding appointments, laboratory, radiology, and other testing results as well as financial information, including reminders for outstanding bills on my home telephone and/or personal cellular phone

Patient Signature: _____Date: _____

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OFFICE POLICY

ACKNOWLEDGEMENT OF REVIEW

Please initial next to each policy for acknowledgement.

_____ I agree to call 24 hours before my appointment to cancel or reschedule.

_____ I understand that by not calling 24 hours prior to my appointment to cancel or reschedule, will result in a $25 no show fee. (This fee cannot be billed to the insurance; it is the patient's responsibility)

_____ I understand that if I am more than 15 minutes late, my appointment must be rescheduled.

_____ I understand that all copayments and deductible costs are my responsibility and is due during the day of my appointment.

_____ I understand that if I need to request medical records to be printed for my records, that there is a $40 medical record fee.

_____ I understand that it is my responsibility to provide current medical health insurance information for my office visit.

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Notice of Privacy Practices

ACKNOWLEDGEMENT OF REVIEW

Date: _____

I have reviewed Provident Eye Specialists, P.A.'s Notice of Privacy Practices (version effective November 7, 2014), which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this notice if requested.

Patient Name: _____ Patient Signature: _____

If completed by a patient's parent, legal guardian, or personal representative, please print and sign your name in the space below:

Parent/Guardian/ Representative (Print): _____

Parent/Guardian/ Representative Signature: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

□ Individual refused to sign

□ Communication barriers prohibited obtaining the acknowledgement

□ An emergency situation prevented us from obtaining acknowledgement

□ Other (Please be specific):

_____

_____ _____

Employee Signature Date