Richard W. Yee, MD

5555 W Loop S Ste 260
Bellaire, TX 77401
Ph 832-289-2020 Fx 713-456-2086

Registration Form

Patient

Name	Gender	Date Of Birth
	M ○ F ○	

Contact

Phone:	Email:	Address:
Cell:		
Home:		
Work:		
Emergency Contact:	Phone:	Relationship?

Insurance

Primary Insurance	Policy #	Group #
Effective Date	Relation to Insured	
	Subscriber's Name	Subscriber's date of birth
Secondary Insurance	Policy #	Group #

Pharmacy

Name	Phone
Address	

Primary Care Physician

Name	Phone

Richard W. Yee, MD PLLC

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EYE AND MEDICAL HISTORY – INITIAL EVALUATION – PAGE 1

Patient Name:______________________________ Date:______________________________

To assist our doctors in providing for your eye care needs, please check any of the following condition that apply to you or to a member of your immediate family.

OCULAR HISTORY

Condition	Patient		Family		Relationship to patient / Notes
	Yes	No	Yes	No	
Cataracts	☐	☐	☐	☐	______________
Glaucoma	☐	☐	☐	☐	______________
Macular Degeneration	☐	☐	☐	☐	______________
Retinal Problems	☐	☐	☐	☐	______________
Amblyopia (Lazy Eye)	☐	☐	☐	☐	______________
Eye Injury	☐	☐			______________
Eye Surgery	☐	☐			______________
Do you wear glasses?	☐	☐			______________
Do you wear contacts?	☐	☐			______________

MEDICAL HISTORY

List the last 10 years of prior surgeries: ______________________________

____

____

List all allergies to medications: ______________________________

____

____

Patient Signature:______________________________ Date:______________________________

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EYE AND MEDICAL HISTORY – INITIAL EVALUATION – PAGE 2

SOCIAL HISTORY

Condition	Patient Yes	Patient No	Notes
Do you previously smoke?	☐	☐	Packs per week______ Notes______________________
Do you currently smoke?	☐	☐	Packs per week______ Notes______________________
Do you drink alcohol?	☐	☐	Amount______________________________________
Do you use a computer?	☐	☐	Hours per day__________ Notes________________
Do you exercise?	☐	☐	Times per week_______________________________
Do you take nutritional supplements?	☐	☐	What do you take_____________________________

Current Occupation: ____

Hobbies:____

MEDICAL AND FAMILY HISTORY / REVIEW OF SYSTEMS

Condition	Patient Yes	Patient No	Family Yes	Family No	Condition	Patient Yes	Patient No	Family Yes	Family No
High blood pressure	☐	☐	☐	☐	Hepatitis	☐	☐	☐	☐
Heart condition	☐	☐	☐	☐	Tuberculosis	☐	☐	☐	☐
Congestive heart failure	☐	☐	☐	☐	AIDS	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	Positive HIV	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	Lupus	☐	☐	☐	☐
Bleeding disorder	☐	☐	☐	☐	Arthritis/Joint pain	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	Thyroid disease	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	Bladder disease	☐	☐	☐	☐
Emphysema	☐	☐	☐	☐	Kidney disease	☐	☐	☐	☐
Chronic Cough	☐	☐	☐	☐	Ulcer	☐	☐	☐	☐
Sinus/Allergies	☐	☐	☐	☐	Chronic constipation	☐	☐	☐	☐
Headaches	☐	☐	☐	☐	Chronic diarrhea	☐	☐	☐	☐
Migraines	☐	☐	☐	☐	Weight loss/gain	☐	☐	☐	☐
Seizure disorder	☐	☐	☐	☐	Depression	☐	☐	☐	☐
Hearing problems	☐	☐	☐	☐	Cancer	☐	☐	☐	☐

Patient signature:____

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Authorization for Release for Medical Records

(PLEASE PRINT OR TYPE)

Patient's Full Name: ____

Date of Birth: ____

Social Security Number: ____

I, the undersigned, hereby authorize ____

____

To release my medical records and diagnostic reports to:

Richard W. Yee MD, PLLC

5555 West Loop South, Suite 260

Bellaire, TX 77401

Phone: (832)289-2020 Fax: (713)456-2086

The above information is only released for the following purposes:______________________________
I have the right to revoke this authorization at any time with the understanding that all or part of this information may have been used in good faith to the revocation. I understand that this authorization authorizes the release of all medical records including, but not limited to records concerning psychiatric, drug, or alcohol abuse, and communicable diseases such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS)

Public Law 93-255, Section 408; Public Law 93-282, Section 333; or Federal Regulation 42 CFR, Part 2, may protect the use of this information. The information provided is confidential and any re-disclosure by the recipient is prohibited without written consent.

Patient's signature: ________________________________ Date: ____________________

Parent or Legal Guardian: ____________________________ Date: ____________________

Witness Signature: _________________________________ Date:____________________

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Dr. Richard Yee and Staff:

☐ Should not discuss my medical information with anyone but myself.

☐ Can email or leave a message at:______________________________ in regards to my medical information

☐ Can discuss my billing or medical information with:
(Please provide: name, relationship, phone # and email)

1. ____

2. ____

3. ____

4. ____

5. ____

Patient signature: ______________________________ Date: ______________

Parent or legal guardian: __________________________ Date: ______________

Witness signature: ______________________________ Date: ______________

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POLICIES

Eye Examinations/Insurance Filing

Richard W Yee MD PLLC is a provider of Medicare and several managed care plans. Please show the receptionist your insurance card so our office can determine if the Doctor is on your plan. Please keep our office notified of any changes in your insurance.

Eye examinations performed for the purpose of prescribing, fitting, or changing of eyeglasses or contact lenses for refractive errors are normally **NOT COVERED** by Medicare and most other insurance plans. Eye exams normally are covered when performed in conjunction with an eye disease such as glaucoma, cataracts, etc. or eye injury. All efforts are made by this office to confirm your coverage before you leave the office. Unfortunately, not all benefits quoted are correct, and you may receive a bill if your insurance company does not pay as quoted.

Refraction Policy

The Health Care Financing Administration (HCFA) uses a system the Resource Based Relative Value Scale (RBRVS) to determine the fees for all Medicare providers. Most other insurance companies use the same system to set their payment schedules.

During your visit, a refraction may be performed at each visit to determine your need for glasses or to evaluate if any further visual improvement can be achieved. This is a necessary and essential portion of your eye exam, and in many cases, is the sole reason for the appointment.

Please be aware that this service is NOT COVERED by Medicare and most other insurance companies and is the responsibility of the patient. There will be an additional fee unless your plan automatically covers the refraction charge. This fee is collected at the time of service in addition to any copayment your plan may require. Prices are subject to change without notice.

We appreciate your cooperation in collecting this fee at the time of service.

Acknowledgement
I have read and received a copy of the above statements.

_______________________________ _______________________
Signature of patient Date

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AUTHORIZATION TO FILE INSURANCE

Patient name: ____

Policy holder: ______________________________ DOB of Policy holder: ______________

Social security number of Policy holder: ______________________________________

I hereby instruct and direct ______________________________ insurance company to pay by check made out and mailed to the following address. If my current policy prohibits direct payment to doctor, I hereby also require the payment check to be made out to me and mail it to the following address:

Richard W. Yee MD, PLLC

5555 West Loop South, Suite 260

Bellaire, TX 77401

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For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a timely manner, any balance of said professional service charges over and above this insurance payment. A photocopy of this agreement shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case/ I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

I understand that if my insurance denies payment for the services provided, I will be responsible for the charges to my account.

______________________________ ______________________

Patient Signature Date

If you are a self-pay/no insurance patient:

WAIVER OF LIABILITY AGREEMENT

I understand the physician at Richard W Yee MD, PLLC is accepting me as a private patient for the duration of my eye care, and I will be responsible for paying for any services I receive. If I am enrolled with an insurance company, the provider will not file a claim to my insurance company for the services provided to me, nor will I hold the insurance company liable for the services provided to me

Patient signature: ______________________________ Date: ______________

Parent or legal guardian: ______________________________ Date: ______________

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ADVANCED BENEFICIARY NOTICE OF NON-COVERAGE (ABN)

NOTE: If Medicare doesn't pay for the D.____________________ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D.__________________ below.

D.	E. Reason Medicare may not pay	F. Estimated Cost
92310 – CONTACT LENSE EVAL	NON COVERED SERVICES	$85.00 - $200.00
92015 - REFRACTION	NON COVERED SERVICES	$75.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D.____________________ listed above.
  Note: If you choose Options 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. Options: Check only one box, we cannot choose a box for you.
☐ **OPTION 1.** I want the D.__________________ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
☐ **OPTION 2.** I want the D.__________________ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for the payment. **I cannot appeal if Medicare is not billed.**
☐ **OPTION 3.** I don't want the D.____________________ listed above. I understand with this choice I am not responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understood this notice. You also receive a copy.

I. Signature:	**J. Date:**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 9038-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 2144-1850.