

REGISTRATION FORM

TODAY'S DATE _____

PLEASE PRINT

Name: _____
(First) (Middle Initial) (Last)

Address: _____
(Street) (City) (State) (Zip Code)

Home Phone: (____) _____ Cell: (____) _____ Email Address: _____

Single Married Widowed Divorced Sex: Male Female

DOB: _____ Age: _____ SSN: _____

Occupation: _____ Office Phone: (____) _____

Employer: _____ Address: _____

Name of Spouse/Parent or Guardian: _____ DOB: _____

Address: _____ Residence Phone: (____) _____

Employer: _____ Business Phone: (____) _____

How did you hear about us? Doctor Referral Google Patient Social Media Magazine Commercial TOC Med Spa Health Fair Website Other: _____ Appointment confirmation preference: Phone Call Text Message Email Do not confirm

Ethnic Background: Hispanic Not Hispanic

Race: Indian/Eskimo/Aleut Asian/Pacific Islander Black Caucasian Other: _____

Primary Medical Insurance: _____
(Name) (Policy Number) (Group Number)

Policy Holder's Name: _____ SSN: _____ DOB: _____

Secondary Medical Insurance: _____
(Name) (Policy Number) (Group Number)

Policy Holder's Name: _____ SSN: _____ DOB: _____

In Case of Emergency, Please Notify: _____
(Name) (Relationship)

Work Phone: (____) _____ Home Phone: (____) _____

I understand that my physician may release any medical record information of mine or my dependent to evaluate, treat and submit claims to my insurance company. I understand and agree that payment of medical benefits due to me be paid directly to Texas Oculoplastic Consultants. I understand that I am responsible for payment of all services rendered on my behalf or my dependent not covered by my insurance. I agree that payment is due at the time of service unless other arrangements have been made and agreed upon. If payment is not received by agreed dates, I will reimburse TOC Eye and Face the fees of any collection agency, which may be based on a percentage at a maximum of 30% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts. If required, I also understand that a check of my credit history may be made. This consent will remain in effect until revoked by me in writing.

PAYMENT IS EXPECTED AT THE TIME THAT OFFICE SERVICES ARE RENDERED. THANK YOU.

Signature: _____ Date _____

I acknowledge that the Notice of Privacy Practices has been made available to me in the lobby of Texas Oculoplastic Consultants.

Signature: _____ Date _____

TOC MEDICAL HISTORY FORM

Name _____ DOB _____ Age _____ Height _____ Weight _____ Date _____

Reason for Visit: _____

MEDICAL ALLERGIES OR SENSITIVITIES

- Do you have any medication or food allergies/sensitivities?
 No Yes If so, please list: _____
- Have you ever had any reaction to latex/rubber? No Yes Adhesive No Yes

If yes to either, please explain: _____

Can you walk without assistance? Yes No Please indicate: Inability to stand Walker Wheelchair

MEDICATION None

Do you take a daily aspirin? No Yes Is it preventative No Yes

Please list all over the counter and prescribed medications you take:

- | | | |
|----------|-----------|-----------|
| 1. _____ | 6. _____ | 11. _____ |
| 2. _____ | 7. _____ | 12. _____ |
| 3. _____ | 8. _____ | 13. _____ |
| 4. _____ | 9. _____ | 14. _____ |
| 5. _____ | 10. _____ | 15. _____ |

OCULAR HISTORY: please check box if you currently have or have ever had these conditions

- | | | |
|--|--------------------------------|-------------------------------|
| <input type="checkbox"/> Anophthalmia (lost an eye) | <input type="checkbox"/> Right | <input type="checkbox"/> Left |
| <input type="checkbox"/> Amblyopia (lazy eye) | <input type="checkbox"/> Right | <input type="checkbox"/> Left |
| <input type="checkbox"/> ARMD (macular degeneration) | <input type="checkbox"/> Right | <input type="checkbox"/> Left |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Right | <input type="checkbox"/> Left |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Right | <input type="checkbox"/> Left |
| <input type="checkbox"/> Graves' thyroid eye disease | <input type="checkbox"/> Right | <input type="checkbox"/> Left |
| <input type="checkbox"/> Retinal detachment | <input type="checkbox"/> Right | <input type="checkbox"/> Left |
| <input type="checkbox"/> Strabismus (crossed eyes) | <input type="checkbox"/> Right | <input type="checkbox"/> Left |
| <input type="checkbox"/> None | | |

STAFF USE ONLY:	COVID-19 VAC
BP: _____	YES
Pulse: _____	
BMI: _____	NO

MEDICAL HISTORY: please check box if you currently have or have ever had these conditions

- | | |
|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Liver disease (hepatitis) Type _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Stomach ulcers |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Gastroesophageal reflux disease (GERD) |
| <input type="checkbox"/> Cancer Type: _____ | <input type="checkbox"/> Diabetes |
| Treatment: <input type="checkbox"/> Chemo <input type="checkbox"/> Radiation <input type="checkbox"/> Surgery | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Angina (chest pain) | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Irregular heart rhythm or rapid heartbeat (atrial fib, SVT) | <input type="checkbox"/> Lung disease (emphysema / COPD) |
| <input type="checkbox"/> High blood pressure (hypertension) | <input type="checkbox"/> Requires continuous oxygen |
| <input type="checkbox"/> Heart disease (coronary artery disease or heart attack) | <input type="checkbox"/> Obstructive sleep apnea <input type="checkbox"/> Requires CPAP |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Stroke or other Brain injury Date _____ |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Anesthesia Complications |
| <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> None | |
| <input type="checkbox"/> FEMALES: date of last menstrual period? _____ | |

FAMILY HISTORY:

- Anesthesia complications
- Bleeding disorders
- Diabetes

- Heart disease
- High blood pressure (hypertension)
- Thyroid disease

SURGICAL HISTORY: please included ALL previous surgeries, even if not listed

- Cataract surgery Right Left LASIK refractive surgery
- Glaucoma surgery Right Left Eyelid surgery
- Cardiac pacemaker/defibrillator Face lift
- When was your last check? _____ Nose surgery (rhinoplasty)
- Cardiac stent placement When? _____
- Coronary artery bypass (CABG) When? _____
- Other _____
- None

SOCIAL HISTORY

- Do you smoke? No
- Yes Packs per day _____ How many years? _____
- Formerly When did you quit? _____

- Alcohol use? No
- Yes Frequency Daily Weekly Rarely

- Recreational drug use? No
- Yes Type _____
- Formerly When did you quit? _____

CURRENT PHYSICIANS

Primary Care Physician

Name: _____ Address: _____

Telephone: (_____) _____ City/State: _____

Cardiologist (please indicate if not applicable)

Name: _____ Address: _____

Telephone: (_____) _____ City/State: _____

Physician Who Referred You (if not your Primary Care Physician)

Name: _____ Address: _____

Telephone: (_____) _____ City/State: _____

Preferred Pharmacy (location you would like us to send any medications prescribed)

Name: _____ Address: _____

Telephone: (_____) _____ City/State: _____

X _____

Patient Signature

Date

HIPAA Release of Information
AUTHORIZATION FORM

This optional Authorization grants permission to the Designated party (ex: spouse, parent, etc.) named below to:

- Make or confirm appointments
- Have access to x-ray, laboratory, or test findings
- Have access to telephone communication and answering machine messages as well as other common means of communication, including but not limited to text messages containing personal health information.
- Pick up sample medications
- Be made aware of my diagnosis, prognosis, and treatment plans
- Have access to my financial health information and medical records.

I hereby authorize TOC Eye and Face to use and disclose my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that once this information is released to the Designated Party(ies) named below, the released information may no longer be protected by federal privacy regulations.

Patient Name: _____ Date of Birth: _____

Mobile Phone: _____

Designated party: _____ Relationship to patient: _____

Address _____

Phone: _____

Designated party: _____ Relationship to patient: _____

Address: _____

Phone: _____

The patient or patient's representative must read and initial the following statements:

1. I understand that this authorization will: (*Must check one*)
() expire 1 year from the date signed by the patient or patient's representative; or
() be effective for the lifetime of the patient unless revoked
2. I understand that I may revoke this authorization at any time by notifying in writing; however, if I do revoke the authorization, it will not have any effect on any actions taken by *Texas Oculoplastic Consultants* prior to their receipt of the revocation.
3. I understand that my treatment cannot be conditioned on whether I sign this authorization.

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Signature of patient or patient's representative
(Form **MUST** be completed before signing or will not be valid)

Date

Printed Name of Patient's
Representative: _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION



CONSENT TO PHOTOGRAPHY

I hereby authorize photographs to be taken for medical purposes.
I agree to the use of the negative, prints, copies or reproductions for insurance documentation,
teaching and for monitoring my condition.

Signature of patient

Date

Printed Name

If the patient is a minor or unable to sign, complete the following:

Father _____

Mother _____

Guardian or other person/relationship _____

Texas Oculoplastic Consultants

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.

Our goal is to take appropriate steps to attempt to safeguard any medical or other personal information that is provided to us. The Privacy Rule under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires us to (i) maintain the privacy of medical information provided to us, (ii) provide notice of our legal duties and privacy practices and (iii) abide by the terms of our Notice of Privacy Practices currently in effect.

WHO WILL FOLLOW THIS NOTICE

- This notice describes the practices of our employees and staff. This notice applies to all TOC individuals, entities, sites and locations. In addition, these individuals, entities, sites and locations may share medical information with each other for treatment, payment and health care operation purposes described in this notice.

INFORMATION COLLECTED ABOUT YOU

In the ordinary course of receiving treatment and health care services from us, you will be providing us with personal information such as:

- Your name, address and phone number.
- Information relating to your medical history.
- Your insurance information and coverage.
- Information concerning your doctor, nurse or other medical providers.

In addition, we will gather certain medical information about you and will create a record of the care provided to you. Some information also may be provided to us by other individuals or organizations that are part of your “circle of care” – such as the referring physician, your other doctors, your health plan and close friends or family members.

HOW WE MAY USE AND DISCLOSE INFORMATION ABOUT YOU

We may use and disclose personal and identifiable health information about you for a variety of purposes. All of the types of uses and disclosures of information are described below, but not every use or disclosure in a category is listed.

Required Disclosures. We are required to disclose health information about you to the Secretary of Health and Human Services, upon request, to determine our compliance with HIPAA and to you, in accordance with your right to access and right to receive an accounting of disclosures, as described below.

For Treatment. We may use health information about you in your treatment. For example, we may use your medical history, such as any presence or absence of diabetes, to assess the health of your eyes.

For Payment. We may use and disclose health information about you to bill for our services and to collect payment from you or your insurance company. For example, we may need to give a payer information about your current medical condition so that it will pay us for the eye examinations or other services that we have furnished you. We may also need to inform your payer of the treatment you are going to receive in order to obtain prior approval or determine whether the service is covered.

Disclosures to Persons Assisting in Your Care or Payment for Your Care. We may disclose information to individuals involved in your care or in the payment for your care. This includes people and organizations that are part of your “circle of care” – such as your spouse, your other doctors or an aide who may be providing services to you. We may also use the disclosure health information about a patient for disaster relief efforts and to notify persons responsible for a patient’s care about a patient’s location, general condition or death. Generally, we will obtain your verbal agreement before using or disclosing health information in this way; however under certain circumstances such as in an emergency situation, we may make these uses and disclosures without your agreement.

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PERSUANT TO: 84TH TEXAS LEGISLATIVE REGULAR SESSION, HB 764 SECTION 108.0095.
NOTIFICATION OF DATA COLLECTION which states: A provider shall provide to a patient whose data is

being collected under this chapter written notice on a form prescribed by the department of the collection of the patient's data for health care purposes. The notice provided under this section must include the name of the agency or entity receiving the data and of an individual within the agency or entity whom the patient may contact regarding the collection of data. The department shall include the notice required under this section on an existing department form and make the form available on the department's internet website.

This document shall provide notice to patients that the Texas Department of State Health Services, Texas Healthcare Information Collection program (THCIC) receives patient claim data regarding services performed by the named Provider. The patients claim data is used to help improve the health of Texas, through various methods of research and analysis. Patient confidentiality is upheld to the highest standard and is not subject to public release. THCIC follows strict internal and external guidelines as outlined in Chapter 108 of the Texas Health and Safety Code and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

For further information regarding the data being collected, please send all inquiries to: Chris Aker

THCIC

Dept. of State Health Services

Center for Health Statistics, MC 1898 PO

Box 149347

Austin, Texas 78714-9347

Location

Moreton Building, M-660 1100

West 49th Street Austin, TX

78756

Phone: 512-776-7261

Fax: 512-776-7740

Email: thcichelp@dshs.state.tx.us