CARTER EYE CENTER

_____
TODAY'S DATE

PATIENT INFORMATION

◯ Dr. ◯ Mr. ◯ Mrs. ◯ Ms. _____

Marital Status: ◯ Single ◯ Married ◯ Widowed ◯ Divorced Sex: ◯ Female ◯ Male

Address _____ Apt # _____

City _____ State _____ Zip _____

DOB ____/____/____ Social Security # _____ Home Phone _____

Driver's License # _____ State _____ Occupation _____

Employer _____ Work Phone _____ Cell Phone _____

Hobbies _____ Email _____

Who referred you to our office? _____ *(we would like to thank them)*

Spouse's Information – Name _____ Employer _____ Work Phone _____

Who to Contact in Emergency _____

Relationship _____ Phone _____

Name of nearest relative not living with you _____

Relationship _____ Phone _____

INSURANCE INFORMATION

Medicare number _____ Medicaid Number _____

Other Insurance _____ Policy Number _____

Primary Cardholder's Name _____ Group Number _____

Cardholders Date of Birth _____ Social Security Number _____

AUTHORIZATION FOR EXAMINATION AND FILING OF INSURANCE CLAIMS

I authorize and request examination by a physician of Carter Eye Center or their staff. I authorize the performance of whatever procedures the judgment of above named staff may deem necessary during the treatment. I also authorize the administration of any anesthetics and analgesics (including eye drops) which the above staff deem advisable. I may request that any procedure not be performed.

I understand that if I have HMO coverage that requires physician referral for examination or surgery that I am responsible for obtaining the referral. I also understand that if I do not obtain my referral before the service is rendered, I am financially responsible for the charges.

I request that payment of authorized Medicare/Insurance benefits be made on my behalf to Carter Eye Center/Carter Optical for any services furnished me. I also authorize any holder of medical information about me to release to the Centers of Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits payable for related services.

Patient's Signature _____ Date _____

CARTER EYE CENTER

PATIENT FINANCIAL POLICY

PAYMENT RESPONSIBILITY - The patient or legal representative is ultimately responsible for all charges incurred.

NON-DISCRIMINATION OF SERVICES - Necessary medical services will be provided regardless of the patient's ability to pay.

PARTIAL INSURANCE COVERAGE - Patients with insurance policies that cover only a portion of treatment must pay their deductibles, co-pays, and or co-insurance amounts that may be due between the contracted allowed amounts and the anticipated insurance payment. This payment may be requested and is due at the time of service. A pre-treatment deposit may be required. Any patient that has joined a Medicare HMO must notify Medicare and our office prior to any service being rendered: otherwise they will be responsible for all charges incurred.

UNINSURED PATIENTS/NON-COVERED SERVICES - Payment for all charges which are not covered by insurance are due and payable at the time of service. A pre-treatment deposit may be required.

VERIFICATION OF INFORMATION - All information given regarding the ability to pay, third party insurance, employment, etc., will be subject to verification.

UNPAID INSURANCE BALANCES - Patients may be requested to make full payment of unpaid balances when insurance payments are not received after 60-days from date of billing.

THIRD PARTY LITIGATION - The physician will not become involved in disputes arising from third party claims (i.e., automobile accidents, liability claims, etc.) with the exception of claims involving Medicare and Medicaid.

PRIOR UNPAID ACCOUNTS - Prior to providing services, payment of prior outstanding accounts may be requested and should be received or specific payment arrangements approved by the Patient Finance Department.

DELINQUENT OR BAD DEBT ACCOUNTS - Patients with unpaid delinquent accounts or accounts which have been written off to bad debt may be denied treatment if not medically required.

PAYMENT METHODS - The following payment methods will be accepted: Cash, Personal Check (upon approval), Cashier Check, Money Order, Visa, Mastercard, American Express, Discover, CareCredit

OUTSIDE COLLECTIONS - Accounts which cannot be collected by the physician after normal in-house collection procedures may be referred to a magistrate or attorney for further collection action in accordance with the physician's established guidelines.

DISCOUNTS - Accounts will not be reduced or discounted unless approved by the physician or delegated representative.

CHARITY ALLOWANCES - If a patient is determined to be financially indigent, the Patient Finance Department will assist the patient in qualifying for financial assistance. All charity allowances must be approved by the physician or delegated representative.

REFUNDS - Overpayments will be refunded to the appropriate party in the form of a check. Patient refunds will not be processed until all active or past due balances are paid in full. Refunds of less than $15.00 will not be issued unless specifically requested.

PAYMENT ARRANGEMENTS - If a patient is unable to make full payment of the patient balance when due, periodic partial payments may be approved in accordance with credit and collections procedures, as authorized by the physician or his designee. A patient financial evaluation may be requested to determine appropriate payment arrangements.

I have read and understood this financial policy and have received a copy as well.

Patient's Signature _____ Date _____

Witness _____ Date _____

CARTER EYE CENTER

RACE/ETHNICITY QUESTIONNAIRE

Patient Label _____ Date ____/____/____

Patient Name _____

In compliance with THCIC (Texas Health Care Information Collection Center for Health Statics), the information regarding the race and ethnicity of the patient population per attending physician is required. This is to plan for and support the development of a healthcare system that meets the current and future healthcare needs of the people of Texas. In doing so, we ask that you assist us in providing this information by making the most appropriate selection regarding race and ethnicity from the choices listed below:

ETHNICITY (select one)

- ◯ Hispanic: a person who identifies with or is of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin.
- ◯ Non-Hispanic: any possible options not covered in the above category.
- ◯ Unknown: a person who cannot or refuses to declare ethnicity.

RACE (select one)

- ◯ White: a person having origins in or who identifies with any of the original Caucasian peoples of Europe, North Africa, or the Middle East.
- ◯ Black: a person having origins in or who identifies with any of the black racial groups of Africa.
- ◯ Native American/Eskimo/Aleut: a person having origins in or who identifies with any of the original peoples of North America, and who maintains cultural identification through tribal affiliation or community recognition.
- ◯ Asian/Pacific Islander: a person having origins in or who identifies with any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. Includes Hawaii, Laos, Vietnam, Cambodia, Hong Kong, Taiwan, China, India, Japan, Korea, the Philippines and Samoa.
- ◯ Unknown: any possible options not covered in the above categories. Includes patients who cite more than one race.

CARTER EYE CENTER

HIPPA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH CARE INFORMATION

By signing this form, I, _____ , authorize the use and disclosure of my health information as described below:

1. Description of information: disclosure of my condition, prognosis and treatment plan.

2. Name or class of person(s) authorized to make the use or disclosure: Employees and Authorized Agents of Carter Eye Center.

3. Name or identification of person(s) or class of person(s) authorized to receive the information: (PLEASE LIST ALL FAMILY MEMBERS, SPOUSE NAME, FRIENDS OR REPRESENTATIVES WITH WHOM WE MAY DISCUSS YOUR MEDICAL CONDITION).

   _____

   _____

   _____

4. Date or event when authorization expires. This authorization does not expire unless listed below.

   _____

   _____

5. Description of each purpose of the requested use or disclosure: (1) participation in the medical care of the patient, or (2)

   _____

   _____

I understand that I have the right to revoke this authorization, in writing, at any time, except (1) where uses or disclosures have already been made based upon my original permissions or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back to revoke this authorization. I must do so in writing and send it to Carter Eye Center at the address listed below.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the Federal Privacy Standards.

_____ *(initials of patient or guardian)* I understand that Carter Eye Center may not place conditions regarding any treatment on my signing of this authorization and that I have a right to refuse this authorization.

Signature of Patient or Guardian** _____ Date_____

Print Name of Patient _____ Print Name of Guardian _____

***If authorization is signed by an individual's personal representative the representative's authority is based on:*

_____

_____

(e.g., state law, court order, etc.)

CARTER EYE CENTER

MEDICAL QUESTIONNAIRE

Name _____ Account # _____ Date _____

Age _____ Sex ◯ Male ◯ Female Ht _____ Wt _____ lbs (state by patient)

NKA _____

Latex allergy/sensitivity? ◯ Yes ◯ No _____
If yes, describe reaction.

Adhesive allergy/sensitivity? ◯ Yes ◯ No _____
If yes, describe reaction.

Complications with anesthesia? ◯ Yes ◯ No _____
If yes, describe reaction.

History of fainting at the sight of blood? ◯ Yes ◯ No Other known allergies? ◯ Yes ◯ No *If yes, please list below.

_____
Please list all known allergies or aversions.

Have you ever taken the following medications?

Flomax (Tamsulosin HCL)	◯ Yes ◯ No	Uroxatral (Alfuzosin HCL)	◯ Yes ◯ No
Minipress (Prazosin HCL)	◯ Yes ◯ No	Rapaflo (Silodosin)	◯ Yes ◯ No
Cardura (Doxazosin Mesylate)	◯ Yes ◯ No	Hytrin (Terazosin)	◯ Yes ◯ No

CANCER ◯ Yes ◯ No
Location _____
Mastectomy ◯ Right ◯ Left

CARDIOVASCULAR
Angina	◯ Yes ◯ No
Arrhythmia	◯ Yes ◯ No
Congestive Heart Failure	◯ Yes ◯ No
Pacemaker	◯ Yes ◯ No
High Blood Pressure	◯ Yes ◯ No
Heart Attack	◯ Yes ◯ No

When _____

DIABETES
Insulin Dependent	◯ Yes ◯ No
Oral Dependent	◯ Yes ◯ No
Diet Controlled	◯ Yes ◯ No
Dialysis	◯ Yes ◯ No
Shunt Location	◯ Yes ◯ No

HEMATOLOGIC/LYMPH
Use Blood Thinners	◯ Yes ◯ No
HIV/AIDS	◯ Yes ◯ No
History of Hepatitis	◯ Yes ◯ No

When _____

EYES
Double Vision	◯ Yes ◯ No
Floaters or Spots	◯ Yes ◯ No
Flashes of Light	◯ Yes ◯ No
Dry Eyes	◯ Yes ◯ No
Decreased Vision	◯ Yes ◯ No
Sandy/Gritty Feeling	◯ Yes ◯ No
Excessive Tearing	◯ Yes ◯ No
Glaucoma/Suspect	◯ Yes ◯ No

ALLERGIC / IMMUNOLOGIC
Seasonal/Hay Fever ◯ Yes ◯ No

SKIN CONDITIONS ◯ Yes ◯ No
List: _____
_____

ENDOCRINE
Thyroid Disorder	◯ Yes ◯ No
Pregnant/Breastfeeding	◯ Yes ◯ No
Prostate Problems	◯ Yes ◯ No

RESPIRATORY
O^2/C-Pap Use	◯ Yes ◯ No
Emphysema	◯ Yes ◯ No
Asthma	◯ Yes ◯ No
COPD	◯ Yes ◯ No
Bronchitis	◯ Yes ◯ No

MUSCULOSKELETAL
Arthritis	◯ Yes ◯ No
Paralysis	◯ Yes ◯ No

Where? _____

Prosthesis ◯ Yes ◯ No
Where? _____

PSYCH/NEUROLOGICAL
Oriented	◯ Yes ◯ No
Seizure/Epilepsy	◯ Yes ◯ No
Anxiety/Depression	◯ Yes ◯ No
Claustrophobia	◯ Yes ◯ No
Alzheimer's	◯ Yes ◯ No

If yes, who is POA? _____
Stroke ◯ Yes ◯ No
Physical Limitations? _____

OTHER
Dentures	◯ Yes ◯ No
Alcohol	◯ Yes__/wk ◯ No
Walking Aid	◯ Yes ◯ No
Smoking	◯ Yes__/ppd ◯ No
Hearing Aid	◯ Yes ◯ No

Technician _____ **Harvey L. Carter, MD** _____

CARTER EYE CENTER

MEDICATIONS AND SURGERIES

Patient Name _____ DOB ____/____/____

Medical Record _____

Pharmacy of Choice _____ Pharmacy Phone _____

Pharmacy Address _____ City _____

FAMILY MEDICAL HISTORY
Please check if you have any of the following in your family history:

◯ Cataracts ◯ Glaucoma ◯ Macular Degeneration ◯ Retinal Detachment

If yes, please please let us know which family member below:

_____

_____

_____

Please list all medications you currently take:

_____

_____

_____

_____

_____

_____

_____

_____

Please list all previous surgeries (even surgeries not pertaining to the eye):

_____

_____

_____

_____

_____

_____

CARTER EYE CENTER

VISUAL ACUITY QUESTIONNAIRE

PATIENT NAME _____ ACCT # _____

DATE OF EXAM _____ DATE OF PROCEDURE _____

Activity of daily living complaint: _____

_____

_____

SCHEDULED PROCEDURE:

- ○ Cataract Surgery
- ○ Pterygium Excision Surgery
- ○ Other_____

- ○ YLPC s/p Cat. Sx.
- ○ YLPC s/p AIOL
- ○ Other_____

Eye	Distance VA	Best Corrected Snellen VA	Near VA	BAT or Glare Symptoms
OD	sc / cc 20/	20/	sc / cc J	20/
OS	sc / cc 20/	20/	sc / cc J	20/

VISUAL FUNCTIONAL STATUS AND VISUAL SYMPTOMS:

1. Do you have difficulty seeing street signs and/or driving (halos/glares around light, seeing curbs/exits)?	○ Yes ○ No
2. Do you have difficulty seeing the TV/movie screen (faces, numbers or print on screen)?	○ Yes ○ No
3. Do you have difficulty reading small print with good light and proper glasses? (newspaper, books)	○ Yes ○ No
4. Do you have difficulty performing handwork (sewing, knitting, fine tasks)?	○ Yes ○ No
5. Do you have difficulty with personal correspondence (writing checks, reading bills, filling out forms)?	○ Yes ○ No
6. Do you have difficulty with leisure activities (playing cards, bingo, golf, sporting activities)?	○ Yes ○ No
7. Do you have visual difficulty with navigation around the house (climbing steps, dialing phone numbers)?	○ Yes ○ No
8. Are you able to recognize faces of people?	○ Yes ○ No
9. Do you have double or distorted vision?	○ Yes ○ No
10. Do you have difficulty with color perception?	○ Yes ○ No
11. Do you have difficulty with depth perception?	○ Yes ○ No
12. Are you able to care for yourself with your present vision?	○ Yes ○ No
13. Do you live alone and wish to remain independent?	○ Yes ○ No

CARTER EYE CENTER

PATIENT QUESTIONNAIRE

The sole purpose of this questionnaire is to assist our physicians and staff in your evaluation, diagnosis and to recommend treatment.

Patient Name _____ Patient DOB ____/____/____

Present or Past Occupation _____

Have You Previously Been Seen by Doctor: ◯ Carter ◯ John

How Did You Hear About Carter Eye Center? _____

Who Did You Bring with You Today? _____

Have Any of Your Family Members Ever Had Surgery with Carter Eye Center? ◯ Yes ◯ No

If Yes, What Kind of Surgery? _____

Do You Wear Contacts? ◯ Yes ◯ No If Yes: ◯ Soft ◯ Toric ◯ RGP Date Last Worn _____

Do You Have Prism in Your Glasses? ◯ Yes ◯ No

Do You Experience Double Vision? ◯ Yes ◯ No

I Struggle with the Following Activities With or Without Glasses:

◯ Reading Fine Print
◯ Driving in Daytime
◯ Watching TV
◯ Reading Traffic Signs
◯ Playing Golf
◯ Driving at Night/Evening
◯ Doing Computer Work

I Currently Have Problems With:

◯ Glare/Halos
◯ Hazy/Blurry Vision
◯ Blurred Vision
◯ Seeing in Poor/Dim Lighting

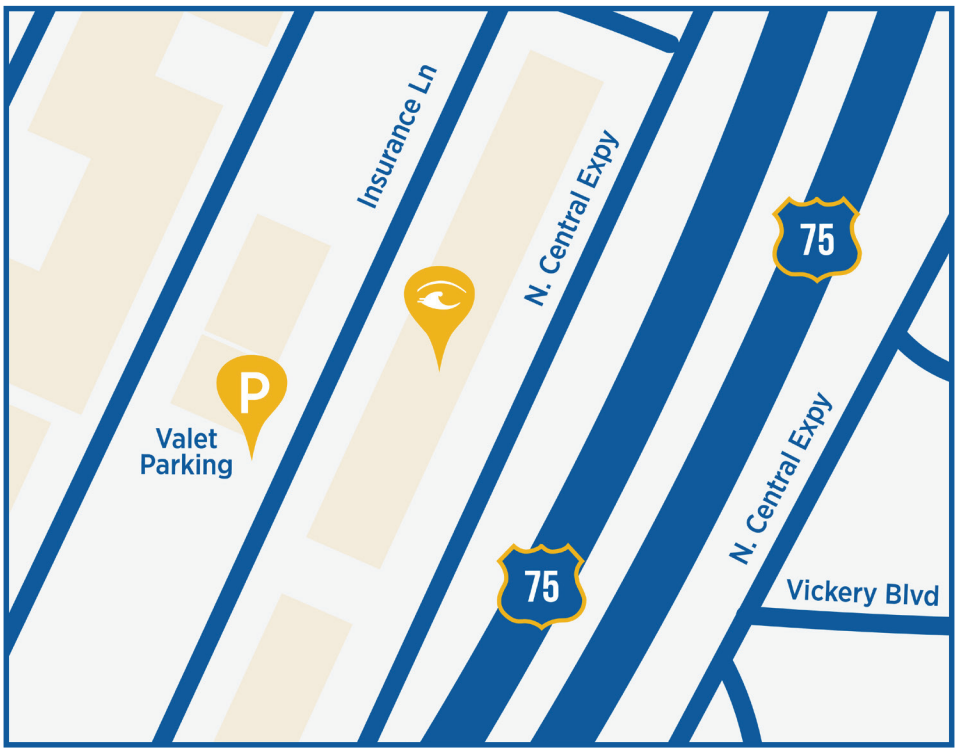
My Hobbies Include:

◯ Crafts/Sewing/Painting
◯ Piano/Music
◯ Sports
◯ Computer/Tablet
◯ Reading
◯ Shooting/Hunting
◯ Boating/Fishing
◯ Swimming/Water Activities
◯ Golf

Fill in the Circle on the Scale Below that Would Best Describe Your Personality.

EASY GOING **PERFECTIONIST**

CARTER EYE CENTER



4633 N. Central Expressway, Suite 300
Dallas, TX 75205
214.750.1962