K. Randy Pierce, MD
Peter T. Wollan, MD
Eric Dai, MD

EYE PHYSICIANS OF AUSTIN
Advanced Eye Care

Haumith Khan-Farooqi, MD
Peter Ryg, MD
Jack Li, MD

Dear Patient:

Thank you for choosing Eye Physicians of Austin for your eyecare needs. We look forwarding to meeting you during your upcoming appointment.

To expedite your check-in process, please complete the enclosed patient information form and bring it with you to your appointment. If your insurance plan requires an authorization or referral to be seen, please secure it prior to your appointment. We will collect payment at the time of your visit, so please bring your preferred method of payment with you to the office.

Annual eye exam appointments typically last 90 minutes and normally require dilation of your eyes, bringing your sunglasses may make you feel more comfortable.

If you're sick or have been exposed to COVID-19, please contact our office at (512) 583-2020 prior to your appointment to discuss rescheduling options. Please arrive no earlier than five minutes prior to your appointment, and bring the below items with you.

- Insurance cards and picture ID.
- If you wear glasses or contact lenses, please bring them to your appointment.
- List of medications you're currently taking.

Again, thank you for choosing Eye Physicians of Austin! If you have any questions prior to your appointment, please give our friendly staff a call or reach out to us via the CONTACT link on our website at epaustin.com.

Sincerely,

Eye Physicians of Austin, P.A.

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Patient Information Form

Patient's Name: _____
(First) (MI) (Last)

Gender: M F **Date of Birth:** _____ **Social Security #:** _____

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

		Circle One		**Preferred Method of Contact**
Phone: (_____) _____	Okay to leave message/text?	YES	NO	☐
E-mail Address: _____				☐

***I understand that email is not a secure method of communication and that personal health information sent via email may not be private. Eye Physicians may occasionally send promotional information via email.*

Patient's Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Race: ☐ African American ☐ American Indian ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Other

Primary Language: _____

Emergency Contact Name: _____ **Relationship:** _____

Emergency Telephone: Phone: (____) _____

Patient's Primary Care Physician: _____ **Phone:** (_____) _____

Patient's Referring Physician: _____ **Phone:** (_____) _____

Insurance Subscriber's Name: _____

Subscriber's DOB: _____ **Relationship to Subscriber:** _____

Responsible Party: _____ **Phone:** (_____) _____
(if other than self)

_____ _____
Patient/Parent/Legal Guardian Signature **Date**

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Financial Policy & Notice of Privacy Practices

Unless other arrangements have been made in advance by you or your health insurance carrier, full payment is due at the time of service.

Financial Responsibility Agreement — I authorize this office to apply for benefits on my behalf for services rendered and request that insurance payments be made to Eye Physicians of Austin. I understand my insurance is an agreement between my insurance provider and me, not between the insurance provider and this office. Regardless of insurance status, I am ultimately responsible for the balance of my account and medical services rendered. I understand I may also be billed by a third-party provider, such as a lab, for services rendered at Eye Physicians of Austin. If we use information from your check to make an electronic fund transfer, funds may be withdrawn as soon as the same day, and you will not receive your check back from your bank.

Non-covered Services — If your health plan determines a service is "not covered," you are responsible for the complete charge. Payment is due upon receipt of a statement from our office. If you disagree with your insurance company's determination, you must contact your insurance company.

Refraction — A refraction measures the prescription strength you may need for glasses and assists in diagnosing and treating many eye conditions. Most insurers, including Medicare, classify refraction as a non-covered service and require patient payment. Federal guidelines require refractions to be billed separately for all patients. If you know your insurance does not cover refraction, you may pay our $60 prompt-pay rate at the time of service, and we will not file insurance. If you choose not to pay at the time of service, insurance will be billed our normal charge of $75, and any remaining balance after insurance processing will be billed to you.

I certify that the insurance information I have provided is correct. I authorize the release of necessary information, including medical records, to determine insurance benefits.

Referral Policy — HMOs and some other insurance plans require an official referral or authorization. If authorization has not been received by our office at the time of service, you will be asked to sign a Referral Waiver accepting financial responsibility.

Minor Patients — For minor patients, the accompanying adult is expected to settle charges at the time of service. Payment arrangements must be made in advance for unaccompanied minors.

Eyeglass and Contact Lens Prescriptions — If eyeglasses and/or contact lenses are prescribed, you consent to receive your prescription electronically through our patient portal. A physical copy is available in the office upon request.

Notice of Privacy Practices, TCPA, and AI-Assisted Documentation — We take appropriate steps to safeguard medical and personal information provided to us. As required by HIPAA, we maintain the privacy of your medical information, provide notice of our legal duties and privacy practices, and follow our current Notice of Privacy Practices, which is posted in our lobby and available through your patient portal. You have the right to restrict disclosure of your personal health information to your health plan if the disclosure is for payment purposes and the service was paid out of pocket and in full. By signing, you agree that we may contact you at the phone numbers provided, including leaving messages on your voicemail/answering machine. We may use secure AI-assisted technology to document medical visits; all documentation is reviewed and approved by your healthcare provider, and you may opt out at any time.
I acknowledge receipt of the Notice of Privacy Practices of Eye Physicians of Austin and accept the financial policy.

_____

Print patient's name

_____ _____

Patient Signature (or person authorized to sign for patient) **Date**