K. Randy Pierce, MD
Peter T. Wollan, MD
Haumith Khan-Farooqi, MD

Mark A. Plunkett, MD
Eric Dai, MD
Peter Ryg, MD

EYE PHYSICIANS OF AUSTIN
Advanced Eye Care

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, wear a face covering 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.

Patient Information Form
(PLEASE PRINT)

EYE PHYSICIANS OF AUSTIN
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Patient's Name_____
(First) (MI) (Last)

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

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

Responsible Party: _____ **Phone:** (____) _____

Phone Contacts:		**Circle One**	**Preferred Method of Contact**
Home: (____) _____	Okay to leave message?	YES NO	☐
Cell: (____) _____	Okay to leave message/text?	YES NO	☐
Work: (____) _____	Okay to leave message?	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: Cell (____) _____ Home (____) _____ Work (____) _____

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

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

Insurance Subscriber's name: _____

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

_____ _____
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 either you or your health insurance carrier, full payment is due at the time of service.

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When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account as soon as the same day you make your payment, and you will not receive your check back from your bank.

Non-covered Services- In the event that your health plan determines a service to be **"not covered"** you will be 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 is conducted to measure the prescription strength you may need for glasses. It is also an important tool that aids in the diagnosis and treatment of many eye conditions. **However, most insurers, including Medicare, classify this as a Non-Covered Service and require that patients be responsible for payment.** Federal guidelines require that refractions be billed separately for all patients.
If you are aware that your insurance does not cover this, you may pay our refraction "prompt pay" rate of $52 at the time of service, and we will not file insurance. If you choose not to pay, your insurance will be billed our normal charge of $65. If there is a remaining balance after insurance processing, it will be billed to you.

I certify that the information I have reported with regard to my insurance coverage is correct. I authorize the release of any necessary information, including medical records, to determine insurance benefits to which I may be entitled.

Referral Policy- HMOs and some other insurances require an official referral/authorization number or form. If authorization has not been received by our office at time of service, you will be asked to sign a Referral Waiver that states you will be financially responsible at time of service.

Minor Patients- For services rendered to minor patients, we expect the adult accompanying the minor to settle charges for services. 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 of your prescription will be available in the office upon request.

Notice of Privacy Practices and TCPA- 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. Our Notice of Privacy Practices is posted in our lobby and available to you on your patient portal. You have the right to restrict personal health information to your health plan if disclosure is for payment and pertains to a service for which you have paid out of pocket and in full. By signing this, you agree to allow us to contact you at the phone numbers you have provided, including leaving a message on your voice mail/answering machine.

I acknowledge the receipt of Notice of Privacy Practices of Eye Physicians of Austin and the acceptance of the financial policy.

_____
Print patient's name

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

EPA

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