"We are limited, not by our abilities, but by our vision."

WELCOME

Thank you for choosing Advanced Eye Care Center as your eye healthcare provider!

On behalf of Dr. Lawrence Shafron, Dr. Rodgers Eckhart, Dr. Paul Middleton and all of our staff, we would like to take this opportunity to welcome you to the Advanced Eye Care Center. We very much look forward to partnering with you to ensure the best care and treatment for your eye sight. We realize your time is valuable and we want to make every effort to ensure we meet your expectations efficiently.

To better serve you, we have provided you with important medical practice and policy information. This information will advise you as to what you can expect from your visit. Please carefully fill out all the required information in your packet. Please keep this information in a convenient location as a reference for you. Your participation in your care and treatment is essential to maximizing desired results.

Please remember to bring with you the New Patient forms completed, along with your insurance information cards and personal identification card. It is only necessary to arrive 15 minutes early to complete your check-in process. Due to the highly specialized nature of advanced eye care, your visit will consist of extensive testing and consultation. You can expect this to be a process of 90 minutes or more. Please allow plenty of time during your day for this visit. We understand that this can be inconvenient at times; however, our primary concern is providing you with the utmost eye care and treatment. Thank you in advance for your understanding and we look forward to your arrival.

We look forward to serving you with your eye care needs. Should you have any questions, please call us at 940-382-8000 so that we may assist you.
Patient Office Policy

Office Hours: Office Hours are Monday through Thursday, 8:00am to 5:00pm and Friday, 8:00am to Noon.

Prescription Refills – As of Monday, September 1, 2008, we no longer handle prescriptions refill requests in person or over the phone. You are required to ask your pharmacy to fax in the request. Requests may be faxed to: (940) 383-2608. Please allow 24 hours from time of receipt from the pharmacy to process the prescription. Your prescription refill will only be processed if it included the correct name of the medicine, dosage, and instructions on how you are taking the medicine. Prescription refills will not be processed outside of normal business hours or after 12:00 pm on Fridays, nor weekends and evenings after the office has closed.

Physician Emergency on Call Policy – when the office is closed a physician is on-call 24 hours a day. The physician is to be contacted when the office is closed for MEDICAL EMERGENCIES ONLY. If you wish to make an appointment, have prescriptions refilled, obtain contacts or glasses you will not be called in over the weekend or when the office is closed. When attempting to contact a physician after office hours please remove any Caller I.D. or Call Interception features that are operating on your phone line. Otherwise the physicians may be unable to contact you. In case of a true life threatening emergency call 911 or seek treatment at the nearest emergency room on weekends and after hours.

15 Minute Late Policy – If you are 15 minutes or later for your appointment you may be asked to reschedule.

Walk-In Appointments – Advanced Eye Care Center is an appointment only office. Examination by a physician cannot be guaranteed if you present to the office without an appointment.

Payment is expected at the time of service. Due to the high cost of billing, patients unable to make payment at the time of service will be rescheduled. Accepted methods of payment include cash, check, credit card, and debit card. We will file any insurance that is properly provided at the time of service. We require a photo ID from the patient in addition to insurance cards to file any insurance.

Form Completion – Please be aware that we need 7-10 business days to complete forms. Patients are required to pay a $25 completion fee for disability forms. There is no charge for completing FMLA papers.
Copying of Medical Records – Patients requesting copies of their medical records will be assessed a $25 fee for the first 20 pages and thereafter $.50 a page. If an abstract is sent to a continuing care provider, there is no charge. An authorization for release of information must be signed and submitted before request for records will be processed.

No Show Policy – Patients who schedule appointments but fail to show up are documented as “no shows.” Patients who continue to “no show” may be charged a $40 fee. In addition, patients with multiple “no shows” may be terminated from the practice. The definition of a “no show” is failing to cancel an appointment within 15 mins of appointment.

Patient Termination Policy -- Although it is an infrequent occurrence, a patient may be terminated from the office. It is at the discretion of the patients’ provider for any dismissal action. Common reasons for dismissal include, but are not limited to, use of foul language, chronic noncompliance with recommended therapy, non-compliance with medications, abusive behavior of staff, physicians, visitors or other patients. Once a patient is dismissed that record will not be re-opened for any provider in the practice.
WHAT TO BRING TO YOUR FIRST APPOINTMENT

BRING SUNGLASSES!

☐ Driver’s License or other photo identification
☐ Insurance card(s) (Policy holder’s information as necessary)
☐ Medical Records from past eye physicians
☐ List of current medications
☐ Insurance Referral (as necessary)

Thank you for choosing Advanced Eye Care for your eye care.
We strive to provide the best possible medical care.
It is our pleasure to welcome you as a new patient.

2210 San Jacinto Blvd., Suite 1 | Denton, TX 76205-7531
Phone: 940-382-8000 | Toll Free: 800-375-4555 | Fax: 940-383-2608
Lawrence A. Shafron, M.D. | Rodgers L. Eckhart, M.D. | Paul G. Middleton, O.D.
ADVANCED EYE CARE CENTER

NEW PATIENT INFORMATION

PERSONAL INFORMATION (PLEASE PRINT)

Name: ___________________________ Date: ___________________________

Date of Birth: __________ M: ___ F: ___ SS#: ___________________________

Mailing Address: _______________________ Street __________ City State Zip

Email: ___________________________

Please choose one preferred phone # for calls:

☐ Phone: ____________ (cell)  ☐ Phone: ____________ (other)

COMPLETE IF UNDER 18 YEARS (Patient must be accompanied by an adult if under 18)

Father: ___________________________ Phone: ___________________________

Address: ___________________________

Mother: ___________________________ Phone: ___________________________

Address: ___________________________

INSURANCE INFORMATION


Primary Insurance:

Policy Holders Name: ___________________________ Employer: ___________________________

DOB: ___________________________ ID: ___________________________ Group: ___________________________

Secondary Insurance:

Policy Holders Name: ___________________________ Employer: ___________________________

DOB: ___________________________ ID: ___________________________ Group: ___________________________

Tertiary Insurance:

Policy Holders Name: ___________________________ Employer: ___________________________

DOB: ___________________________ ID: ___________________________ Group: ___________________________

IN CASE OF AN EMERGENCY, PLEASE CONTACT:

NAME: ___________________________ RELATIONSHIP: ___________________________

PHONE NO. (INCLUDING AREA CODE) ___________________________

MISCELLANEOUS

Have you ever met one of our doctors?  Yes  No  (Dr. Shafron, Dr. Eckhart, Dr. Middleton) circle please.

How/where did you hear about our doctors?  (Dr. Shafron, Dr. Eckhart, Dr. Middleton) circle please.

Friend (Whom may we thank) ___________________________ Relative ___________________________

Insurance/Phone Book ___________________________
NOTIFICATIONS & AUTHORIZATIONS

Financial Policy
Our office is a participating provider for Medicare and most managed care plans. It is the patient’s responsibility to provide their most current insurance card(s) and/or referrals at each visit. If you fail to provide your current insurance information, it may be necessary to reschedule your appointment or we will accept you as a “self-pay” patient and expect you to pay in full at the time of service and we will not file an insurance claim for that date of service.

Payment for any co-pay, deductible, or co-insurance is expected at the time of check-in. If your insurance denies coverage, or does not pay for certain services, you will be financially responsible for these fees. For services rendered to minor patients, we expect payment from the adult accompanying the patient at the time of service.

This office does not file claims for insurance companies that we are not participating providers for and we only file a maximum of two (2) insurance companies. All tertiary insurance policies are the responsibility of the patient. Please know we are not Medicaid providers and cannot file any insurance claims to Medicaid.

I have read and understand the patient office policies, including financial, procedures, Prism, Refraction, self-pay fees along with any co-payments, co-insurances, and/or deductibles will need to be paid at the time of service.

______________________________  Date: __________________________
Patient/Guardian/POA

Assignment of Benefits
I authorize Advanced Eye Care Center to release any information necessary to my insurance carrier(s) to process medical claims. I assign all insurance benefits to be paid directly to Advanced Eye Care Center/Lawrence A. Shafron, MD PA. (A photocopy of this assignment is to be considered as valid as the original.)

______________________________  Date: __________________________
Patient/Guardian/POA

General Consent for Treatment
I have requested medical services from Advanced Eye Care Center for myself and/or my dependent. I give permission to Advanced Eye Care Center to examine and treat myself and/or my dependent as they deem necessary.

______________________________  Date: __________________________
Patient/Guardian/POA
ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgment but, in refusing, we will not be allowed to process your insurance claims.

Date: __________________________

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Advanced Eye Care Center. A copy of this signed, dated document shall be as effective as the original.

Please print your name                               Please sign your name

Last 4 digits of SS# __________________________   DOB __________________________

Legal Representative ______________________________________   Description of Authority ______________________________________

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR MEDICAL INFORMATION:
(This includes step parents, grandparents and any other care takers who can have access to this patient's records):

Name: ___________________________________________   Relationship: ______________________

Name: ___________________________________________   Relationship: ______________________

Name: ___________________________________________   Relationship: ______________________

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY MEDICAL APPOINTMENTS, TREATMENT & BILLING INFORMATION VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Email Confirmation __________________________ Email
☐ U.S. Mail

I AUTHORIZE INFORMATION ABOUT MY MEDICAL HEALTH BE CONVEYED VIA:

☐ Message on Cell Phone
☐ Message on Home Phone
☐ Message on Work Phone

☐ Email Message
☐ U.S. Mail

☐ Any of the above

This Authorization will remain in effect for one year from the date of signature unless changed by patient.

Patient/Guardian/POA __________________________   Date __________________________

Patient/Guardian/POA __________________________   Date __________________________

Patient/Guardian/POA __________________________   Date __________________________

Patient/Guardian/POA __________________________   Date __________________________
MEDICAL HISTORY QUESTIONNAIRE

Name: ________________________________  Nickname: ______________________  Date of Birth: __/__/____

Primary Care Physician: ____________________  Referring /Specialty Dr. ________________________________

Any other specialist (i.e. Endocrinologist, Cardiologist, etc.) ________________________________

Pharmacy: ________________________________  Location (street & city) ________________________________

Race:  
☐ American Indian or Alaska Native  ☐ Asian  ☐ Black or African American  
☐ Native Hawaiian or Other Pacific Islander  ☐ White  

Ethnicity:  
☑ Hispanic  ☐ Not Hispanic  

Preferred Language:  
☐ English  ☐ French  ☐ Italian  ☐ Japanese  ☐ Portuguese  
☐ Russian  ☐ Spanish

Medication Allergies: Reaction Severity  ☐ NONE
_________________________________________ mild / moderate / severe
_________________________________________ mild / moderate / severe
_________________________________________ mild / moderate / severe

Past Eye History: (Please mark all that apply)  ☐ NONE

☐ Overall Healthy  ☐ Cataracts  ☐ Hyperopia (Near sighted)  ☐ Myopia (Near sighted)  
☐ Amblyopia (Lazy eye)  ☐ Diabetic Retinopathy  ☐ Iritis  ☐ Optic Neuritis  
☐ Aphakia  ☐ Dry Eyes  ☐ Keratoconus  ☐ Retinal Detachment  
☐ Astigmatism  ☐ Glaucoma  ☐ Macular Degeneration

Other __________________________________________________________________________

Eye Surgeries: (Please mark all that apply)  ☐ NONE

☐ No prior ocular surgery  ☐ Foreign Body Removal  ☐ Punctal Plugs  ☐ Trabeculectomy  
☐ Blepharoplasty  ☐ Retinal Laser Surgery  ☐ RK (Glaucoma surgery)  
☐ Cataract Surgery  ☐ LASIK  ☐ Strabismus Surgery (eye muscle surgery)  ☐ Vitrectomy  
☐ Corneal Transplant  ☐ PRK  

Other __________________________________________________________________________

Ocular (Eye) Significant Illnesses: (Please mark all that apply)  ☐ NONE

☐ Overall Healthy  ☐ Herpes  ☐ Hypothyroidism  ☐ Sjogrens  
☐ AIDS  ☐ HIV Positive  ☐ Lupus  ☐ Graves Disease  
☐ Diabetes  ☐ Hypertension  ☐ Multiple Sclerosis  ☐ Hyperthyroidism  
☐ Rheumatoid Arthritis

Other __________________________________________________________________________

Current Eye Medications including Over the Counter Eye drops: (Please list)
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________  

Initials ______
Systemic Illnesses: □ NONE
- No history of illnesses
- Anemia
- Arthritis
- Arrhythmia
- Asthma
- Bleeding Disorder
- Cancer
- Thyroid Disease
- Congestive Heart Failure
- COPD
- Diabetes
- Eczema
- Fibromyalgia
- Headache
- Hearing Loss
- Hepatitis
- High Blood Pressure
- High Cholesterol
- HIV
- Kidney Disease
- Kidney Stones
- Liver Disease
- Lung Disease
- Lupus
- Migraine
- Polymyalgia
- Psychiatric Disorder
- Skin Cancer
- Stroke

General Surgeries / Operations: (Please list) □ NONE

Current Other Medications including Over the Counter Medications: (Please list)

Infections: (Please mark all that apply) □ NONE
- Overall Healthy
- Chicken Pox
- Hepatitis A / B / C
- Herpes Simplex
- Herpes Zoster / Shingles
- Histoplasmosis
- HIV / AIDS
- Meningitis
- MRSA
- Toxoplasmosis
- Wound Infection

Family History: □ NONE
- Diabetes
- Cancer
- Heart Disease
- Stroke
- TB
- Kidney Disease
- Blindness
- Cataracts
- Glaucoma
- Macular Degeneration
- Retinal Disease
- High Blood Pressure
- Arthritis
- Lazy Eye

Social History: (Please mark all that apply)

Smoking: □ current every day smoker □ current some day smoker □ former smoker □ never smoked

Alcohol Use: □ Yes □ No If yes how much and how often?

Drug Use: □ Yes □ No If yes what and how often?

Initials ______
Review of Systems: (Please mark all that apply)  □ NONE

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Patient/Representative Signature ___________________________ Date ___________________________