Patient Demographic Form

KLEIMAN | EVANGELISTA
EYE CENTERS OF TEXAS

Please Print **Date** _____

PATIENT INFORMATION

Last Name: **First Name:** **Middle Initial :** **Nickname/AKA:**

Date of Birth : **Social Security Number:** **Birth Gender** ☐ Male ☐ Female **Current Gender** ☐ Male ☐ Female ☐ Undifferentiated

_____/_____/_____ **Gender Identity** ☐ Male ☐ Female ☐ Choose not to disclose _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Life Partner ☐ Separated ☐ Widowed ☐ Other

Race: ☐ Black-Non-Hispanic ☐ American Indian/Alaskan Native ☐ Hispanic ☐ Asian/Pacific Islander ☐ White-Non-Hispanic ☐ Other **Language:** *other than English* _____

Home Address: **Apt#:** **City:** **State:** **Zip Code:**

Home Phone: **Cell Phone:** **Other Phone:**

Email Address: **Employment Status :** ☐ Active Duty Military ☐ Employed Full-time ☐ Not Employed ☐ Student-Full-time ☐ Child ☐ Employed Part-time ☐ Retired ☐ Student Part-time ☐ Disabled ☐ Homemaker ☐ Self Employed ☐ Other

Employer: **Employer Phone :**

PHYSICIAN REFERRAL INFORMATION

How did you hear about us?

☐ Billboard ☐ Friend ☐ Magazine ☐ Physician ☐ Website ☐ Other_____
☐ Employer ☐ Health Fair Event ☐ Optometrist ☐ Radio ☐ Yellow Pages
☐ Family Member ☐ Insurance ☐ News ☐ Television

PCP:_____
Optometrist: _____
Pharmacy: _____
Were you referred by a physician? Yes___ No__ If yes, Who? _____

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient ☐ Self (if self, skip to Emergency Contact) ☐ Spouse ☐ Parent ☐ Other

Last Name **First Name** **Middle Initial**

Date of Birth **Social Security Number**

Home Address **Apt#** **City** **State** **Zip Code**

Home Phone **Work Phone** **Other phone** ☐ Cell ☐ fax

Employer **Employment Status** ☐ Active Duty Military ☐ Employed Full-time ☐ Not Employed ☐ Student-Full-time ☐ Child ☐ Employed Part-time ☐ Retired ☐ Student Part-time ☐ Disabled ☐ Homemaker ☐ Self Employed ☐ Other

Employer Phone

EMERGENCY CONTACT INFORMATION

Last Name **First Name** **Relationship to patient**

Address **Apt#** **City** **State** **Zip Code**

Home Phone **Work Phone** **Other Phone** ☐ Cell

PLEASE PROVIDE THE FRONT DESK WITH YOUR INSURANCE CARDS

_____
Patient/Responsible Party Signature

_____
Date

HEALTH HISTORY

Patient Name:_____ **Date of Birth:**_____

EYE HISTORY

Do you wear contacts/glasses? □ *YES* □ *NO* How many years have you worn them?

What kind of contact lenses do you wear? □ *Soft* □ *Hard* When (if at all) did you stop wearing them?

Have you had any eye surgery, laser treatment or any other ocular procedure? □ *YES* □ *NO*
If *yes*, please list:

REASON FOR TODAY'S VISIT:

Are you currently experiencing, or have experienced, any of the following? Select all that apply.

□ Blurry Vision □ Double Vision □ Redness □ Dryness □ Floaters or Spots □ Light Flashes □ Eye Infection
□ Light Sensitivity □ Headaches □ Eye Pain or Soreness □ Discharge □ Itching □ Sandy or Gritty Feeling

MEDICAL HISTORY

Height: Weight:	Are you pregnant? □ *YES* □ *NO* Are you breastfeeding? □ *YES* □ *NO*
Do you smoke? □ *Current* □ *Former* □ *Never* Tobacco use? □ *Current* □ *Former* □ *Never* Would you like info on quitting? □ *YES* □ *NO*	
Do you use alcohol? □ *YES* □ *NO* How much?	Have you had a fall in the last year? □ *YES* □ *NO*
Have you had the influenza immunization? □ *YES* □ *NO*	Have you had the pneumonia vaccine? □ *YES* □ *NO*

List all the medications you are taking, including eye medications:

Are you allergic to any medications? □ *YES* □ *NO* If *yes,* please list:

SURGICAL HISTORY Please list any surgeries you have had:

Have you and/or a family member experienced, or been treated for any of the following?

CONDITON	PATIENT	*FAMILY*	CONDITION	PATIENT	*FAMILY*
Cataracts	□ YES □ NO	□ YES □ NO	**Heart Disease/Attack**	□ YES □ NO	□ YES □ NO
Crossed Eye / Lazy Eye	□ YES □ NO	□ YES □ NO	**High Blood Pressure**	□ YES □ NO	□ YES □ NO
Macular Degeneration	□ YES □ NO	□ YES □ NO	**Atrial Fibrillation**	□ YES □ NO	□ YES □ NO
Retinal Detachment	□ YES □ NO	□ YES □ NO	**Seizures**	□ YES □ NO	□ YES □ NO
Glaucoma	□ YES □ NO	□ YES □ NO	**Stroke**	□ YES □ NO	□ YES □ NO
Keratoconus	□ YES □ NO	□ YES □ NO	**Kidney Disease**	□ YES □ NO	□ YES □ NO
Hearing Loss	□ YES □ NO	□ YES □ NO	**Liver Disease**	□ YES □ NO	□ YES □ NO
Asthma	□ YES □ NO	□ YES □ NO	**Diabetes**	□ YES □ NO	□ YES □ NO
COPD	□ YES □ NO	□ YES □ NO	**Cancer**	□ YES □ NO	□ YES □ NO
Lung Disease	□ YES □ NO	□ YES □ NO	**Blood Disorder**	□ YES □ NO	□ YES □ NO
Thyroid Disease	□ YES □ NO	□ YES □ NO	**HIV/AIDS**	□ YES □ NO	□ YES □ NO
BPH (enlarged prostate)	□ YES □ NO	□ YES □ NO	**Depression**	□ YES □ NO	□ YES □ NO

Other:

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PATIENT FINANCIAL POLICY

We require that all patients complete our Patient Financial Policy prior to seeing the physician and upon each annual visit thereafter. It is your responsibility to notify our office of any patient information changes (i.e., address, name, insurance information, etc.)

INSURANCE

I authorize payment to Kleiman Evangelista Eye Centers of Texas and the release of any information necessary to process my payment for insurance. It is the patient's responsibility to provide our office with current insurance information. We will ask for your insurance card at your every visit and will copy for our records. If current information or referral authorization is not obtained at the time of services, it will become the patient's responsibility to pay the entire balance. Your insurance policy is a contract between you and your insurance company. As a courtesy, and pursuant to contractual obligations, we file your claims on your behalf. However, we will not become involved in disputes between you and your insurance carrier. This includes, but is not limited to, deductibles, co-payments, non-covered charges and "usual and customary" charges. We will supply information as necessary. You are ultimately responsible for the timely payment of your account.

CO-PAYS

Co-payments are due at the time of service.

We have an office fee for refractions that is collected at the time of service. The refraction fee is in addition to any co-payment your insurance plan may require. We do not file the charge for a refraction with any insurance insurance plans, as they do not cover it.

DEDUCTIBLES and CO-INSURANCE and ESTIMATES for ALL procedures:

Balances related to unmet deductibles and estimations of co-insurance, as per the contract you have with your insurance, are to be paid at the time of service. For all procedures, an estimation of patient responsibility will be provided to you and is to be paid in full PRIOR to services being rendered. Additional balances due, if applicable, will be billed to you after the insurance carrier has processed the claim. If the health insurance company listed denies payment to Kleiman Evangelista Eye Centers of Texas because I am no longer insured, I agree to pay for all medical services provided. I will be responsible for all co-pays, co-insurance and deductibles as determined by my insurance company.

PAID/OUTSTANDING BALANCES

I understand I am responsible for all costs if my account is sent to an outside collection agency including collection fees of 30%, all attorney fees and court costs. I understand that any unpaid balance could be assessed an interest at the rate of 18.00% (1.5% monthly). I hereby authorize this provider and its employees, agents, and assignees to contact me via phone, text messaging, e-mail, and Automated Telephone Dialing Systems (ATDS). I consent and authorize your office or facility to make calls and/or send messages containing important information about my account including marketing information and past-due notifications through an automated telephone dialing system.
We ask that full payment to be made at the time of service unless prior arrangements have been made through the billing office. If your insurance company has not paid the balance in full, you will receive a statement notifying you of the amount due. You may call our billing office at 817-381-1166 or billing@keec.com to set up payment arrangements if necessary. Any overdue balances may be considered for further collection activity.

RETURNED CHECKS

The charge for a returned check is $25.00 payable by cash, money order or charge (no checks accepted.) This will be applied to your account in addition to the insufficient funds amount.

_____ _____

Patient Printed Name Patient Date of Birth

_____ _____

Patient/Responsible Party Signature Date

KLEIMAN | EVANGELISTA
EYE CENTERS OF TEXAS

Notice of Privacy Practices

Effective Date 10/14/2006; Revised Date 6/25/2023

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

Your Health Information is personal, and we are committed to protecting it.

This Notice of Privacy Practices (this "Notice") describes how EVP EyeCare and the members of its Affiliated Covered Entity ("we" or "our") may use or disclosure your protected health information. An Affiliated Covered Entity is a group of health care providers under common ownership or control that designates itself as a single entity for purposes of compliance with the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (collectively, "HIPAA"). For a list of the health care providers in our Affiliated Covered Entity, please refer to the online version of EVP EyeCare's Affiliated Covered Entity document, or ask the receptionist at your respective EVP location.

If you have any questions please contact our HIPAA Privacy Officer (contact information below). We are required by law to: maintain the privacy of your protected health information, give you this notice of our duties and privacy practices regarding health information about you, and follow the terms of our notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION:

Described as follows are the ways we may use and disclose health information that identifies you ("Health Information", or "PHI"). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to us and stating that you wish to revoke permission you previously gave us.

As described below, your Health Information may be used and disclosed to treat you, to obtain payment for services provided to you and to conduct "health care operations":

Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment. We may use and disclose Health Information so that we may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment. However, if you pay for your services yourself (e.g. out-of-pocket and without any third party contribution or billing), we will not disclose Health Information to a health plan if you instruct us to not do so.

Health Care Operations. We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information for care coordination or quality improvement/assurance activities. Subject to the exception above if you pay for your care yourself, we also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operations.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you. We will not, however, send you communications about health-related or non-health-related products or services that are subsidized by a third party without your authorization.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we mays hare Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contracts with them.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSES THAT MAY BE MADE WITHOUT YOUR CONSENT, AUTHORIZATION OROPPORTUNITY TO OBJECT:

We may use or disclose your PHI in the following situations without your consent, authorization, or an opportunity to object:

As Required by Law. We will disclose Health Information when required to do so by federal, state or local law.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to: prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through an approval process. Even without approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Fundraising and Marketing. Health Information may be used for fundraising communications, but you have the right to opt-out of receiving such communications. Except for the exceptions detailed above, uses and disclosures of Health Information for marketing purposes, as well as disclosures that constitute a sale of Health Information, require your authorization if we receive any financial remuneration from a third party in exchange for making the communication, and we must advise you that we are receiving remuneration.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may help prevent the threat.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye or tissue donation; and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Lawsuits. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or

medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION:

Other uses and disclosures of Health Information not contained in this Notice or required by law may be made only with your written authorization. For example, most uses and disclosures of psychotherapy notes, the use or disclosure of PHI for marketing purposes, any use or disclosure of PHI that constitute a sale of that information, and uses and disclosures other than those described in this Notice, require your authorization. You may revoke this authorization at any time in writing, except to the extent that we have taken an action in reliance on the use or disclosure indicated in the prior authorization.

YOUR RIGHTS: You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to our office.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our office.

Right to an Accounting of Disclosures. You have the right to receive an accounting of our disclosures of your Health Information other than disclosures for treatment, payment, health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our office.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our office. **We are not required to agree to all such requests.** If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment. We must agree to requests to restrict disclosures of Health Information about you to a health plan if: (A) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and (B) the Health Information pertains solely to a health care item or service for which you, or a person other than the health plan on behalf of you, has paid us in full.

Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work, or that we send mail to a different address. To request confidential communication, you must make your request, in writing, to our office. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of this Notice. You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. You may also obtain a copy of this notice at our web site www.iconlasik.com.

Right to Electronic Records. You have the right to receive a copy of your electronic health records in electronic form.

OUR RESPONSIBILITIES: Our responsibilities include the following:

Maintain the Privacy of Health Information. We are required by law to maintain the privacy and security of your Health Information.
Notice of Privacy Practices. We must follow the duties and privacy practices described in this notice and give you a copy of it.
Notification of Breaches. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your Health Information.

CHANGES TO THIS NOTICE: We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office and will provide it to you upon request. The notice will contain the effective date on the first page.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with our HIPAA Privacy Officer by calling (720) 442-0249 or with the Secretary of the Department of Health and Human Services. You will not be penalized or retaliated against for filing a complaint.

In the event of a family member or caregiver accompanies me at the time of my evaluation and/or treatment, I give my permission to discuss freely my condition, treatment, or diagnosis with that person.

Please list with whom we may discuss your treatment and diagnosis with?:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Please list with whom we may discuss any financial questions with?

Name:_____ Relationship:_____

Name:_____ Relationship:_____

I acknowledge having been provided this Notice.

_____ _____
Patient Printed Name Patient Date of Birth

_____ _____
Patient/Responsible Party Signature Date