PLEASE PRINT AND COMPLETE ALL ENTRIES

Patient Name: *(Last, First, MI)*	Your Date of Birth: ____ / ____ / ____	☐ Male ☐ Female	Marital Status: ☐ S ☐ M ☐ Minor ☐ D ☐ W
E mail Address:			Your Social Security No:
Address: *Street*			Home Phone: (_____) _____-_____
Address: *City* *State* *Zip*			Patient's Cellular Phone: (_____) _____-_____
San Antonio Eye Specialists is using an automated system to remind you of your upcoming appointments. **Please select all options how we may communicate with you.**			☐ Text Message ☐ E-mail ☐ Automated Phone Call ☐ Live Call
Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ Multiracial ☐ White ☐ Prefer not to answer **Ethnicity:** ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Prefer not to answer			**Preferred Language:** ☐ English ☐ Spanish ☐ Other: _____
WHO IS YOUR PRIMARY CARE PHYSICIAN? _____ WHO IS YOUR **CURRENT** OPTOMETRIST? _____			

ANY CHANGES TO MEDICAL HISTORY OR MEDICATIONS: **YES** OR **NO**

IF YES PLEASE EXPLAIN:

_____

_____

ANY CHANGES IN YOUR HEALTH OR VISION INSURANCE: **YES** OR **NO**

IF YES PLEASE LIST NEW INSURANCE:

_____

_____

ANY CHANGES IN YOUR PHARMACY: **YES** OR **NO**

IF YES PLEASE LIST NEW PHARMACY LOCATION AND PHONE:

_____

_____

FINANCIAL POLICY: We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. In order to reduce confusion and misunderstanding, we have adopted the following policy: we will bill insurance plans with whom we participate, and will only require you to pay the authorized co-payment, coinsurance, and deductible, which is due at the time of service. You are responsible for payment for any unpaid balance by your insurance company. Any returned checks and outstanding balances are subject to collection placement and collection fees. **You are ultimately responsible to know your own insurance policy and its limitations**. We cannot be a party to any disputes regarding coverage or charges between you and your insurance company. **Refractive testing is not covered by Medicare and some other insurance companies. A $60.00 refraction fee will be collected at the time of service.** Kindly give us at least 24 hours if you are unable to keep your appointment. $25 for missed appointments will be billed.

PATIENT AGREEMENT & AUTHORIZATION: I hereby agree to the above policy. I request that payment of authorized insurance benefits be made to Nader G. Iskander, M.D., P.A. DBA San Antonio Eye Specialists for any services rendered to me. I hereby authorize necessary medical information to be released to my insurance company for any information needed to determine benefits, related services, and processing of my claim. Photostat copies of this authorization will be considered as valid as the original.

Patient Signature_____ Date_____

INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time, which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it is best if you make arrangements not to drive yourself.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize the Doctors of San Antonio Eye Specialists and/or such assistants as may be designated by the Doctors to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

_____

Patient Name Printed

_____ _____

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

_____ _____

Witness Signature Date

Disclosure of Patient Information

In Compliance with HIPAA Rules & Regulations

Name _____ Date of Birth: _____

Please check all of the following message delivering methods that are available in case we cannot reach you. Please include your daytime/work telephone number. Please authorize name(s) with whom we may arrange or confirm your appointment information.

- Home Phone _____

May we leave message on this voice mail? □ YES □ NO

- Daytime/Work Phone _____

May we leave message on this voice mail? □ YES □ NO

- Mobile Phone _____

May we leave message on this voice mail? □ YES □ NO

We may arrange or confirm your appointment with:

□ Self Only □ Spouse □ Mother □ Father □ Household Member □ Secretary/Coworker

Other: _____

➢ Medical Information

With whom may we discuss or disclose your medical information?

□ Self Only

Name _____ Relationship _____ Tel _____

Name _____ Relationship _____ Tel _____

Name _____ Relationship _____ Tel _____

I have received a copy of the Notice of Privacy Practices from San Antonio Eye Specialists.

I will inform San Antonio Eye Specialists with any changes of the above disclosure information.

Signature: _____ Date: _____

WRITTEN ACKNOWLEDGEMENT FORM

I am a patient of:

□ NADER ISKANDER, MD, FACS

□ ANDREW COTTINGHAM JR, MD

□ ANTONIO URBINA III, OD

I hereby acknowledge receipt of San Antonio Eye Specialists' Notice of Privacy Practices.

Name [**please print**]: _____

Signature: _____

Date: _____

OR

I am a parent or legal guardian of _____ [patient name].

I hereby acknowledge receipt of San Antonio Eye Specialists' Notice of Privacy Practices with respect

to the patient.

Name [please print]: _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____