2019 - PATIENT INFORMATION: (PLEASE PRINT)

WHO SHOULD WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

PATIENT FULL NAME: _____ **CURRENT AGE**_____

MARITAL STATUS: **SINGLE** **MARRIED** **DIVORCED** **WIDOWED** **GENDER:** **MALE** **FEMALE**

ADDRESS:_____ **CITY:**_____ **STATE:** _____

ZIP: _____ **EMPLOYED BY:** _____ **OCCUPATION:**_____

****

PREFERRED COMMUNICATION: Please CIRCLE at least one option **May we leave a message? (Name and number only)**

HOME
PHONE:_____ **YES** **NO** **Leave a message** **YES** **NO**

DAYTIME
PHONE: _____ **YES** **NO** **Leave a message** **YES** **NO**

CELL
PHONE:_____ **YES** **NO** **Leave a message** **YES** **NO**

YOU WILL RECEIVE TEXT MESSAGES FOR APPOINTMENT REMINDERS AND CONFRIMATONS AND OTHER NON-PROTECTED HEALTH INFORMATION. **Texting** **YES** **NO**

I authorize the use of my email address for PATIENT COMMUNICATION only.

EMAIL: _____

I AUTHORIZE THE RELEASE OF MY MEDICAL AND/OR FINANCIAL INFORMATION TO THE FOLLOWING INDIVIDUAL(S): ***I.E. SPOUSE, PARENTS, KIDS*)**

_____

Please list Name(s) and relationship to patient **– PARENTS, SPOUSE, CHILDREN OR ENTER NONE**

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WHOSE NAME IS THE INSURANCE UNDER? **RELATIONSHIP TO PATIENT?**

***FULL NAME:** _____ **SELF** **SPOUSE** **PARENT** **GUARDIAN**

SAME BILLING ADDRESS AS ABOVE? **YES** **NO** **EMPLOYER:**_____

If different from patient:
Insured's Address: _____

2019 PRIMARY MEDICAL INSURANCE CARRIER: _____

SECONDARY INSURANCE CARRIER:_____

VISION INSURANCE:_____

REVIEWED BY PATIENT: _____

******MUST BE COMPLETED IN ORDER TO FILE INSURANCE – IF NOT COMPLETE WE ARE UNABLE TO FILE YOUR INSURANCE!!***
This information will be shredded after being entered in our computer system.

PATIENT'S DATE OF BIRTH: **PATIENT'S SS#:** _____

Patient's DRIVER'S LICENSE#:_____ **EXPIRES:** _____ **STATE:**_____

EMPLOYEE/PRIMARY INSURED'S DATE OF BIRTH: **SS#:** _____

HEALTH HISTORY

PLEASE FILL OUT COMPLETELY, THANK YOU!

PATIENT NAME:_____

PAST MEDICAL HISTORY: HAVE YOU EVER HAD (PAST MEDICAL CONDITIONS) ANY OF THESE CONDITIONS?

NONE ____

Diabetes	Heart Problems	Thyroid	Rheumatoid
Cholesterol	Stroke	Asthma	Alzheimer's
Hypertension	Parkinson's	Lupus	COLD SORES/FEVER BLISTERS/Herpes

****

EYE HISTORY: HAVE YOU EVER HAD ANY OF THESE EYE CONDITIONS? **NONE____**

Glaucoma Cataracts Floaters Macular Degeneration Flashes

Other: _____

****

SURGICAL HISTORY: **NONE____**

CATARACT	LASIK	APPENDECTOMY	HERNIA
AFTER CATARACT LASER	PRK	BREAST	HYSTERECTOMY
EYE MUSCLE	RK	GALLBLADDER	KNEE
RETINAL		HEART	PROSTATE

PLEASE LIST ANY OTHER SURGICAL PROCEDURES: _____

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ALLERGIES: List all medications you are allergic to (i.e. Penicillin) **NONE___**

_____

****

PATIENT SOCIAL HISTORY:

Use of Tobacco	No	Yes
Use of Alcohol	No	Yes

DIABETIC PATIENTS – WE NEED YOUR DIABETIC DR'S NAME AND FAX NUMBER TO SEND REPORT.

_____

MEDICATIONS: (Prescription and Over the Counter) and reason for the medication AND DIRECTIONS (Attach a copy of a list of medications – please include your name and date) (i.e. Lipitor – Cholesterol 20MG DAILY) INCLUDE ANY EYE DROPS, VITAMINS OR SUPPLEMENTS YOU ARE USING.

SEE ATTACHED LIST_____ **NONE_____**

Medication	Strength	Dosage	Medical Condition

FAMILY MEDICAL HISTORY: Does anyone in your family have any of the following medical conditions:

UNKNOWN_____ Adopted_____ No family history_____

Family Members	Diabetes	Glaucoma	Macular Degeneration	Hypertension
Mother				
Father				
Sister				
Brother				
Aunt/Uncle				
Mat. Grandmother				
Mat. Grandfather				
Pat. Grandmother				
Pat. Grandfather				

REVIEW OF SYSTEMS – CURRENT MEDICAL CONDITIONS: Please indicate your present/current medical conditions below.

NONE_____

Cardiovascular
High Blood Pressure
Stroke
Cholesterol
Heart Disease

Ears, Nose, Throat
Hearing Loss
Sinus problems

Endocrine
Diabetes
Thyroid Disorder
Renal Disease

Gastrointestinal
Hepatitis
Acid Reflux

Hematologic/Lymphatic
Blood Clots
Leg/Muscle Cramps
Anemia

Immunologic
Sarcoidosis
Shingles
Cold Sores/Fever Blisters

Integumentary/Skin
Lupus
Raynaud's Disease
Rosacea

Respiratory
Asthma
COPD

Genitourinary
Menopause
Prostate Disorder

Musculoskeletal
Rheumatoid Arthritis
Arthritis
Osteoporosis

Neurological
Migraines
Headaches

Psychiatric
Alzheimer's
Memory Loss

Constitutional
Weight changes

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Other conditions not listed above: _____

_____

To the best of my knowledge, the questions on this form have been **answered completely and accurately**. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform Dr. Goffman of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____

Signature of Patient or Responsible Party Date

_____

Printed Patient Name

REVIEWED BY PATIENT: _____

Dear Patient:

We are committed to providing you with the best possible care. If you have medical or vision insurance, we are committed to helping you receive your maximum allowable benefits.

When verifying benefits through our online clearinghouses, the information we receive from your insurance company is sometimes not always accurate. We encourage our patients to be familiar with their own insurance benefits.

Patients are responsible for payment at the time of service. An estimate of your out-of-pocket expenses will be given to your prior to your appointment. **You are responsible for any unmet deductible, coinsurance or copays, and any non-covered services at the time services are rendered**.

In order for us to file your claim in a timely manner a copy of your Medicare and/or insurance card will be needed as well as your referral from your primary care physician, if required by your insurance carrier. **For patients with secondary insurances, we only file to your primary insurance carrier. You will need to file for reimbursement to your secondary insurance. Medicare patients, your secondary will be accepted only if Medicare forwards the claim to your secondary policy directly.**

For our Out-of-Network patients, you will be given an itemized receipt to file with your insurance company.

Normal processing time takes 4-6 weeks for most insurance companies. We will make every attempt to work with your insurance company should they require additional information to process your claim; however, if your insurance company fails to make a payment within a reasonable length of time, issues a denial notice, and/or goes into receivership, the balance will then be billed to you directly. A reasonable length of time is approximately 5-6 weeks.

We must emphasize that, as a medical care provider, my relationship is with you, not your insurance company. While filing of insurance is a ***courtesy*** *we extend to our patients, all charges are your responsibility from the date the services are rendered.*

I agree to assume any financial obligation involved in the full payment of services, which include all outstanding balances not covered by Medicare and/or my insurance company. I authorize any holder of medical information to release to the Social Security Administration or its intermediaries or carriers, or to the billing agents of the insurance companies listed on my patient information record, or to my employer or worker's compensation carrier. Any information needed for this insurance or Medicare claim to be processed.

DR. GOFFMAN RECOMMENDS CERTAIN SCREENING DIAGNOSTIC TESTS WHICH ALLOW HIM TO PERFORM A MORE COMPREHENSIVE AND THOROUGH EXAMINATION.

THESE TESTS INCLUDE: TOPOGRAPHY, RETINAL PHOTOS, MACULAR DENSITY, PACHMETRY AND OPTICAL COHERENCE TOMOGRAPHY – OCT. REFRACTIONS MAY OR MAY NOT BE COVERED BY YOUR MEDICAL/VISION PLAN. CONTACT LENS SERVICES, CONTACT LENSES, GLASSES, LASER VISION CORRECTION AND THE PREMIUM IMPLANTS FOR CATARACT SURGERY ARE NOT COVERED BY YOUR MEDICAL OR VISION PLANS.

- **I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES AND BEEN PROVIDED AN OPPORTUNITY TO REVIEW IT.**
- **I UNDERSTAND THAT MY INSURANCE BENEFITS MAY OR MAY NOT COVER ANY OR ALL SERVICES.**
- **I authorize the release of any medical or other information necessary to process any insurance claim. I also authorize payment of medical benefits to Joel H. Goffman, M.D., P.A.**
- ***CANCELLATION OF AN APPOINTMENT LESS THAN 48 HRS PRIOR WILL RESULT IN A $25. NO SHOW FEE.***
- ***CANCELLATION OF A SURGICAL PROCEDURE LESS THAN 2 WEEKS PRIOR WILL RESULT IN A $200. NO SHOW FEE*.**

X_____ **X**_____

PATIENT OR RESPONSIBLE PARTY SIGNATURE **DATE**

Joel H. Goffman, M.D.
8588 Katy Frwy, #101
Houston, Texas 77024

Estimated Patient Out-of-Pocket Charges

Medical and Vision insurance do not cover all services. Dr. Goffman recommends these diagnostic screening tests for a thorough and complete examination. Refractions are not always covered by insurance. Contact lenses and contact lens services are not covered by your insurance. Non-covered charges are not billed to your insurance.

These services may include the following:

ROUTINE VISION Copay or deductible are additional to the amounts below UHC Vision/Spectera/Optum Vision		
Patients under 25	$39 Topography	Copay or Deductible + 39 + contact lens services if applicable (see below)
Patients 26 and over	$89 Topography, Fundus Photos, OCT	Copay or Deductible + 89 + contact lens services if applicable (see below)

OR

MEDICAL INSURANCE Copay or deductible are additional to the amounts below (Refractions might be covered depending on your plan)		
Patients under 25	$89 Refraction, Topography	Copay or Deductible + 89 + contact lens services if applicable (see below)
Patients 26 and over	$139 Refraction, Topography, Fundus Photos, OCT	Copay or Deductible + 139 +contact lens services if applicable (see below)
CONTACT LENS SERVICES		
Contact Lens Fit	Under 21 $175, Standard Fit $225, Monovision $275	Based on the type of contact lenses the doctor recommends
Contact Lens Evaluation or Modification	$95-$150	Update contact lens prescription for existing contact lens wearer
Medicare Patients – NON-COVERED SREVICES		
Spectacle wearers	Refraction	$139 + deductible/copay /coinsurance
Contact lens wearers	Refraction + Contact Lens Evaluation	$234 + deductible/copay/coinsurance
Exam fees Cash Price (No Insurance)		
	New Patient – non-contact lens wearer	Established Patients – non-contact lens wearer
Patients under 25	$229	$195
Patients 26 and over	$255	$245
	New Patient – contact lens wearer	Established Patient – contact lens wearer
Patients under 25	$324	$290
Patients 26 and over	$350	$340
OTHER SERVICES		
Corneal Thickness	$25	Post laser surgery patients
PD Measurement	$25	Pupillary measurement to order glasses elsewhere
Macular Density	$35	Measures the macular pigment layer
APPT NO SHOW	$25	LESS THAN 48 HRS NOTICE
NO SHOW SURGERY	$200	LESS THAN 2 WEEKS NOTICE

The above pricing is an estimate only. If additional testing is required by Dr. Goffman, it will be added to your services. I have received, read and understand this notice. If you have any questions, please contact the staff prior to your visit to clarify your charges prior to your Date of Service. Payment is due at the time of service.

Signature:_____ Date:_____

IF YOU HAVE ANY QUESTIONS ABOUT YOUR ESTIMATED OUT-OF-POCKET COST, PLEASE CALL THE OFFICE PRIOR TO YOUR APPOINTMENT TO DISCUSS YOUR BENEFITS WITH THE OFFICE STAFF. THANK YOU!

JOEL H. GOFFMAN, M.D., P.A.
8588 KATY FREEWAY, SUITE 101 HOUSTON, TX 77024
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(713) 467-0990 Fax (713) 464-6989

INFORMATION REGARDING DILATING EYE DROPS

Dilation is a procedure which allows the doctor to use eye drops to temporarily enlarge your pupils for a more extensive view of the retina (back of the eye). Like looking into a room through an open door instead of a keyhole. with dilation, the doctor can evaluate and diagnosis eye health problems before symptoms occur. Examples include Diabetes, Cataracts, Glaucoma, Retinal Detachment, Macular Degeneration, High Blood Pressure, Cancer, etc.

Dilation is an important part of a complete eye exam. It is recommended that all patients receive a comprehensive dilated every year.

Some patients may experience blurred vision up close and light sensitivity for 2-6 hours. In most cases distance vision will be minimally affected. If you do not have a pair of dark sunglasses for your ride home, we will provide you with a disposable pair. Typically, you will be able to drive following your exam, however if you feel more comfortable being driven please decide ahead of time. You should not operate heavy equipment or drive an automobile unless you are comfortable with your vision. Please note there is not addition charge for having your eyes dilated.

It is not possible for your Dr. Goffman to predict how much your vision will be affected.

I hereby authorize Dr. Goffman, and/or such assistants as may be designated by him to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

Patient Name: _____ Date: _____

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