ALL EYE CARE, P.A.
VISION, MEDICAL & SURGERY
RAJIV RUGWANI, M.D.
Eye Specialist & Eye Surgeon
2271 N. HWY 77 #100 • Waxahachie, TX 75165 • (972) 937-4433 • Fax (972) 937-4525

PATIENT INFORMATION

Name: First_____MI:_____ Last Name:_____

Address:_____ Apt #:_____City:_____

State:_____ Zip Code:_____ Phone (home):_____ Phone (cell):_____

Email:_____

Sex: F_____ M____Marital Status: Single ____ Married: ____ Divorced:_____ Widowed_____

DOB:_____ SS#_____ Employer:_____ Tel:_____

Primary Doctor:_____ Phone:_____

Preffered Pharmacy:_____ Phone:_____

Emergency Contact:_____ Relationship to Patient:_____

Phone: _____ Patient Reffered By:_____

GUARANTOR/BILLING INFORMATION:

Name:_____ MI:_____ Last Name:_____

Address:_____ City:_____ State:_____Zip Code:_____

Phone:_____ Relationship to Patient:_____

INSURANCE INFORMATION:

Primary Insurance Co:_____ ID #:_____

Group #:_____ Cardholder Name:_____

Employer Name:_____ Relationship to Patient:_____

Secondary Insurance Co:_____ ID #:_____

Group #:_____ Cardholder Name:_____

Employer Name:_____ Relationship to Patient:_____

x_____ Date:_____
Signature (Patient, or if minor parent or legal guardian

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ADVISEMENT OF PATIENT RESPONSIBILTY/POLICY

For our office to file a claim with your insurance we must have a copy of your primary and secondary (if applicable) insurance cards to be placed in your file, along with current picture identification. If the primary insurance requires a referral from your PCP to see a specialist (Dr. Rugwani) we must have the referral in our office prior to your visit . **Patient is responsible to obtain a referral from their PCP.** If we are unable to confirm calid insurance coverage, the entire fee will be due and payable at the time services are rendered.

It is the policy of this office that any co-pay, deductible and/or coinsurance amounts identified by insurance as patient responsibility will be collected at the time services are rendered, unless prior arrangements have been made through our business office. Any patient responsibility for cataract surgery must be paid prior to surgery date. All Eye Care, PA/Dr. Rugwani does NOT offer payment plans.

PAYMENT POLICY FOR REFRACTION

Refraction is a separate test that determines the power needed for your eyeglass prescription. A series of test lenses are carefully presented to determine which power provides the clearest and sharpest vision for you. Unfortunately, Medicare and most medical insurance companies DO NOT cover this expense as part of the examination and as such **we will collect our refraction fee of $25 from the patient at time of service.**

INSURANCE ASSIGNENT/RELEASE OF INFORMATION AND PATIENT RESPONSIBILITY

I hereby authorize All Eye Care, P.A. to release any information concerning my care for the purpose of filing claims to: federal, state, city or town governmental agencies, third party payers of all categories, doctors and hospitals, in accordance with HIPPA (Health Insurance Portability and Accountability Act) regulations.

The person signing below, whether signing as a patient, or legal representative of the patien, agrees that he/she has read and understands the above terms and conditions and individually obligates himself/herself to pay All Eye Care, P.A. for services rendered. The person signing below understands that a quote of benefits from this office is **NOT A GUARANTEE OF PAYMENT** and actual insurance payments will be determined by patient's policy at the time a claim is processed. In the event insurance does not pay the bill within 90 days he/she will be responsible for payment of the balance in full. Should the account be referred to an attorney for collection, the person signing below will be responsible for all atorney's fees and collection expenses.

Relationship to patient: Self Spouse Parent Other:_____
(PLEASE CIRCLE ONE)

_____ Printed Name

_____ Signature

_____ Date

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Authorization to Release Protected Health Information

I acknowledge I have been given the opportunity to review **All Eye Care, P.A.'s** Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

As a covered entity under HIPAA (Health Insurance Portability and Accountability Act), All Eye Care, P.A./ Rajiv M. Rugwani, M.D., is required to maintain the pricacy of your protected health information. We are prohibited by law from disclosing any protected health information to anyone other than you without your written authorization. This agreement authorizes employees of All Eye Care, P.A./Rajiv M. Rugwani, M.D., to disclose protected health information to the person(s) listed below for general disclosure, purposes of treatment, and obtaining payment for our services.

Name	**Relationship**	**Date**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

This authorization is valid until revoked in writing by the patient. The patient has the right to revoke this authorization at any time by submitting a written request. A revocation is not valid and will not apply to disclosures made prior to the date of the written revocation.

All Eye Care, P.A./Rajiv M. Rugwani, M.D., will not be responsible for any disclosures of protected health information made by the recipients of information authorized by this document.

I understand that by signing this document, I hereby authorize All Eye Care, P.A./Rajiv M. Rugwani, M..D., to release my protected health information for the purposes mentioned previously to those persons I have listed above.

_____
Patient Printed Name

Date:_____

x_____
Patient Signature

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MEDICAL INFORMATION

Last Name:_____ Name:_____ Date:_____

Family Physician:_____ Referred By:_____

PATIENT HISTORY

1. Medication Allergies:_____
   _____
2. Past Eye History:_____
   _____
3. Past Medical History:_____
   _____
   _____
4. Past Surgical History:_____
   _____
   _____
5. Current Medications:_____
   _____
   _____

FAMILY HISTORY OF:

YES	NO		YES	NO	
[ ]	[ ]	High Blood Pressure	[ ]	[ ]	Glaucoma
[ ]	[ ]	Heart Disease	[ ]	[ ]	Retinal Detachment
[ ]	[ ]	Diabetes	[ ]	[ ]	Cataracts
[ ]	[ ]	Other:_____	[ ]	[ ]	Eye Disorders
			[ ]	[ ]	Macular Degeneration

SOCIAL HISTORY:

	YES	NO
Tobacco	[ ]	[ ]
Alcohol	[ ]	[ ]
Drugs	[ ]	[ ]

Do You Live:
[ ] Alone [ ] with Spouse
[ ] Other _____

x_____ Date:_____
Patient's or Guardian's Signature

Physician's Signature:_____ Date:_____

Update: Year Initials Update: Year Initials Update: Year Initials

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REVIEW OF SYSTEMS

Any problems in the following areas (past or present)? If "yes", please provide information.

	NO	YES	
CONSTITUTIONAL			
Fever	___	___	_____
Weight Loss/Gain	___	___	_____
EYES			
Blurred Vision	___	___	_____
Double Vision	___	___	_____
Pain	___	___	_____
Discharge	___	___	_____
EARS, NOSE, MOUTH, THROAT			
Nasal Congestion	___	___	_____
Chronic Cough	___	___	_____
Hearing Loss	___	___	_____
CARDIOVASCULAR			
Heart Disease	___	___	_____
High Blood Pressure	___	___	_____
ENDOCRINE			
Diabetes	___	___	_____
Thyroid	___	___	_____
Birth Control	___	___	_____
Pregnancy	___	___	_____
RESPIRATORY			
Breathing Problems	___	___	_____
Asthma/Bronchitis	___	___	_____
HEMOTOLOGIC/LYMPHATIC			
Anemia	___	___	_____
Blood Disorder	___	___	_____
GASTROINTESTINAL			
Kidney Stones	___	___	_____
Gallbladder	___	___	_____
MUSCULOSKELETAL			
Pain/Weakness	___	___	_____
INTEGUMENTARY			
Skin/Breast	___	___	_____
NEUROLOGICAL			
Weakness/Join Pain	___	___	_____
Stroke	___	___	_____
Seizure	___	___	_____
ALLERGY/IMMUNOLOGIC			
Seasonal Allergies	___	___	_____
Hay Fever	___	___	_____
PSYCHIATRIC	___	___	_____

Any Other Problems/Conditions: _____

Please Explain: _____

x _____ Date: _____

Patient Signature

Physician Signature: _____ Date: _____

Update: Year Initials Update: Year Initials Update: Year Initials