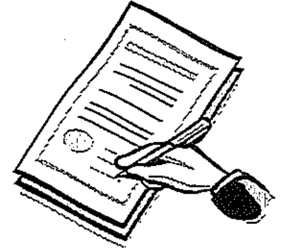
Asad Abbas, MD., PA

In Baytown	In Sugar Land
Phone 281-420-EYES (3937)	Phone 281-552-8900
Fax 281-420-1330	Fax 281-377-3218
1618 W. Baker Rd., Suite A	3531 Town Center Blvd South, Suite 101
Baytown, Texas 77521	Sugar Land, Texas 77479
	We will be moving to Suite 102 in 2017



Welcome to the office of Houston Ophthalmology Associates.

We want you to know what you can expect from us today.

1. If you are a new patient we will have a registration form for you to fill out. All the information we ask for in this form will be very helpful in documenting your visit with us, filing your claim properly and making the paperwork portion of today's visit as painless as possible.
2. If you are a new or returning patient we have several new features that will need your attention:
   a. We now have a privacy policy available for you to pick up, read, and sign. This will explain how we keep your personal information safe and will never share or sell your information. Please sign the notice below after reading the privacy notice and return to the front desk.
   b. We now have a patient portal. If you are a computer geek or not, we have made your chart available only to you or a care taker assigned by you, to view your chart from any computer, in the comfort of your own home. Make sure we have your email address if you would like access to our new Patient Portal.

By signing this document, I am declaring that Houston Ophthalmology Associates, owned by Asad Abbas, MD., PA, has shared a copy of their office ***Notice of Privacy Practices***, with me. I have read and understand the ***Notice of Privacy Practices.***

FOR MINOR CHILDREN PLEASE PRINT PATIENTS NAME____________________

______________________________ ____________

Signature Date

____

Print name here please

____

By entering my **EMAIL ADDRESS** above, I agree to allow Houston Ophthalmology Associates to contact me through email, for all personal communications, including appointment reminders. We have started using a Patient Portal. You can be a part of the Portal by leaving your email address with us. We will print a token with directions on how to use the Portal.

Patient Portal Token created, printed and delivered to patient by ______________ date ______________

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Date ____________ Who is your Primary Physician? (a doctor you go to for a cold) ____________________

We need information about the patient. Please fill in all blanks and print clearly. Thank you.

Last Name	First Name	MI	
Preferred Nick Name	Maiden Name		
Social Security Number	Date of Birth	O Male	O Female
Mailing Address			
City	State	Zip	
Home Phone	Work Phone		

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By entering my **CELL PHONE** below, I agree to allow Houston Ophthalmology Associates to contact me through text messaging, for all personal communications, including appointment reminders.

Circle one answer in each section.

Race	American Indian	Asian	Black	Hispanic	Latino	More than 1	Other	White
Language	Arabic	English	German	Italian	Japanese	Spanish	Urdu	Vietnamese
Marital Status	Annulled	Divorced	Separated	Life Partner	Married	Polygamous	Singled	Widowed
Student Status	Full Time	Not a student		Part Time				

Veteran	YES	NO	**Smoker**	YES	NO	**Diabetic**	YES	NO

Employer Information is only needed if your visit with us is a work related accident

Employer Name	Contact
Mailing Address	Title
City	State / Zip
Office Phone	Office Email
Occupation	Employment Status: Full Part Not Active Military Retired

In case of an emergency – must be completed

If the patient is a minor child, have the parent or guardian fill in below:

Last Name	First Name		

Social Security number only needed for this person if this person will be responsible for the bill.

Social Security Number	Date of Birth	O Male	O Female
Mailing address (if different from patient)			
City	State	Zip	
Home Phone	Cell Phone		
Work Phone	Email		

X ______________________________ X ______________

Patient Signature or Parent/Guardian Date

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Please print the patients last name	**Please print the patients first name and DOB**

Dear Patients, Let us help you understand several things about today's visit….

<u>Please Initial Next to each line</u> to verify that you have <u>read and understand</u> the following:

Insurance Information (each insurance is different)

Medical Plans	We will use your medical insurance to file claims if the doctor performs an eye exam to study the health of your eye ball and for any other medical reason.
X	You may be seeking treatment for glaucoma, cataracts, macular degeneration, diabetic check-up or a number of other eye issues. All of these are considered medical treatments and will be filed on your medical insurance.
Vision Plans	Generally, a vision plan covers the cost of a basic eye exam to obtain a prescription for vision wear, such as glasses or contacts, or to buy the products directly.
X	If you are planning to use only your vision plan while visiting us, and the doctor finds anything medically wrong we will present the option to you and let you decide if you want to be treated today or come back on another day so that you may use your medical insurance. <u>The insurance companies do not allow for these two types of insurance to be used on the same day.</u>

I, X____________________ understand the difference between Medical and Vision Plan insurances.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize The Houston Ophthalmology Associates of Asad Abbas, MD., PA. or insurance company to release any information required to process my claims.

The best medical care can be provided only on the basis of mutual understanding. We encourage you to discuss any questions you may have regarding our policies with our manager.

X______REFRACTION POLICY

Payment for routine eye examinations and refractions are expected at time of service. *When a medical problem is discovered your medical insurance will be billed.* Refraction is the process of determining the eye's refractive error, or need for corrective spectacle and/or contact lenses. It is an essential part of an eye examination, but it is **<u>NOT</u>** a covered service by Medicare or most insurance regardless of the reason for the test being performed.

X______INSURANCE POLICY

We participate in Medicare and a variety of insurance plans and will direct bill your insurance for medical services under these plans of which we have an agreement. In this circumstance you are responsible for applicable deductibles, co-payments, and refractions. We cannot be responsible for negotiating claims with insurance companies. <u>Services not covered by your insurance company are your responsibility regardless of the status of the claim</u>.

X______PRIOR AUTHORIZATION

Most HMO plans require <u>you</u> to obtain authorization for your visit from your primary care physician. It is your responsibility to obtain this authorization. This authorization is required by your insurance company **<u>before</u>** you visit our office, even when the visit is for an urgent problem.

Please continue to next page….

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X______REFERRALS

Referrals are usually required if your Insurance is an HMO policy but can sometimes be required for a specialist visit in general. If you do have an HMO policy and/or your Insurance requires that you have a referral, **IT IS THE PATIENTS RESPONSIBILITY** to request that referral and must be obtained from your primary care physician before the time of your visit. Please request your referral at least **TWO WEEKS** in advance as it takes at least that for the referral to be sent back from the Insurance Company. Referrals are very important and if you're are required to have a referral before being seen your Insurance company **WILL NOT PAY US WITH OUT ONE!** If for any reason you are seen without the referral you **WILL BE RESPONSIBLE FOR THE FULL BILLED AMOUNT OF THE VISIT THAT WAS BILLED FOR THAT DAY!**

X______FORMS OF PAYMENT

For Your convenience, we accept cash, check, and credit cards (MasterCard, Visa, Discover and American express). We also accept Care Credit. If you are struggling with how to pay your large deductable, co-pay or co-insurance, ask to speak to the manager about payment arrangements. We offer many different payment options to help the common person be able to afford quality care.

X______ACKNOWLEDGEMENT

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service. The co-pay is separate from and not included in the refraction fee. The fee for this service is currently $40.00 per prescription.

I have read or have had read to me, and understand and accept Dr. Asad Abbas' payment policies.

____

Patient Signature or Parent/Guardian   Date

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Deductible/Coinsurance Agreement

Health Insurance Deductible

Deductible is the amount of money you pay for eligible medical expenses in a calendar year. After deductible is met, you pay nothing or you share the remaining costs with your Insurance company up to the out-of-pocket maximum.

Deductibles may vary depending on whether medical services are received in or out-of-network. In some cases, services received in medical facilities out of your providers' network are more expensive and fall under a higher deductible.

Coinsurance

Coinsurance is a health care cost sharing between you and your insurance company. The cost sharing ranges from 80/20 to even 50/50. For example, if your coinsurance is 80/20, that means that your insurer covers 80% of annual medical expenses and you pay the remaining 20%. The cost sharing stops when medical expenses reach your out-of-pocket maximum, which usually is between $1,000 and $5,000. If your medical expenses in a calendar year exceed out-of-pocket limit, then your insurer covers all the remaining costs.

There are medical plans with coinsurance 100%, in which case all the medical expenses are covered by insurer after the deductible is paid. Coinsurance rate may also vary in and out of your health care providers' network. Usually it is higher when going out-of-network.

OUT OF POCKET

An **out-of-pocket** maximum is the most you'll have to pay during a policy period (usually a year) for health care services. Once you've reached your **out-of-pocket** maximum, your plan begins to pay 100 percent of the allowed amount for covered services.

I ______________________________, understand that I may have a Deductible on my Insurance. Deductibles are to be paid up front and are the patient's responsibility to make sure payments are made towards Deductible at the time of service and each visit here after until the full Deductible amount is met. I also understand that my Insurance may also have a Coinsurance. This cost share is also due at the time of service. Deductible payments are not negotiable and MUST be paid up front where as Coinsurance amounts are more flexible and we will work with you on payments towards Coinsurances.

Patient Signature: ____ **Date:** ______________

Patient Printed Name: ____

Witness: ____ Date: ______________

Medication List

Patient Name: ____________________ DOB: ____________________

Pharmacy Name: ____________________ Phone #: ____________________

Pharmacy Address: ____

Medication Name	Dosage

Effective DECEMBER 1, 2018

24 Hour Cancellation Policy

Please provide our office with 24-hour notice to change or cancel an appointment.

Patients who do not attend a scheduled appointment or do not provide 24-hour notice to change a scheduled appointment will be responsible for a $25.00 service charge.

This charge will be collected up front before seeing the Physician and cannot be billed to insurance company.

Thank you for providing our office and our patients with this courtesy.

Houston Ophthalmology Associates

Patient signature ______________________ Date ________________