# BRAZOS VALLEY EYE PHYSICIANS

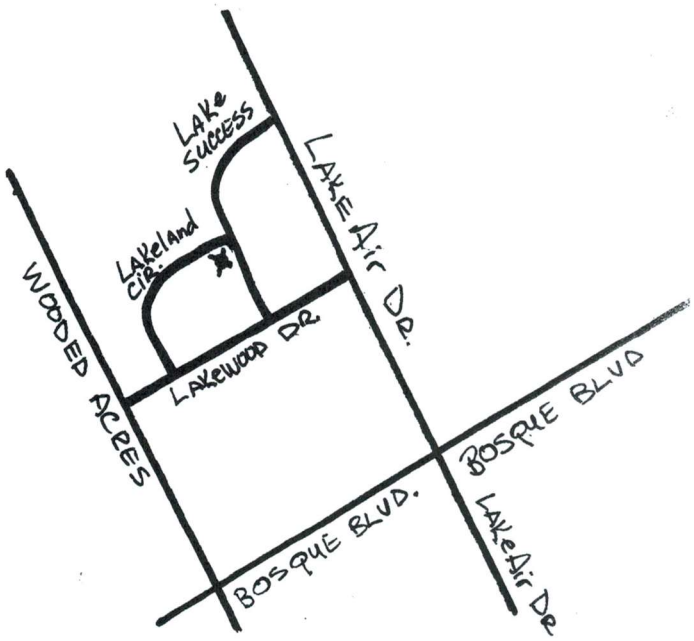
## SCOTT SMITH, M.D.

5002 LAKELAND CIR. STE. A
WACO, TEXAS 76710
TELPEPHONE (254) 752-2571 * FAX (254) 752-0699

Thank you for contacting **Brazos Valley Eye Physicians** for your eye care needs. Please complete the enclosed patient registration paper-work, front & back and return it to us as soon as possible so we may pre-pare your medical record for your upcoming appointment.

You may fax it back to us at number **(254)752-0699**, mail it or bring it to the office at the above address.

We thank you and look forward to assisting you with your eye care needs.
Thank you



BRAZOS VALLEY EYE PHYSICIANS

# "NO SHOW/MISSED APPOINTMENT POLICY"

We, at Brazos Valley Eye Physicians, understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (preferably within 24 hours). You can cancel appointments by calling the following number: 254-752-2571

An appointment reminder call to you is made/attempted one (1) business day prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

PLEASE REVIEW THE FOLLOWING POLICY FOR NO SHOW/NO Call/ MISSED APPOINTMENTS

1. We would prefer that you reschedule your appointment with at least a 24 hours' notice: There is a waiting list to see Dr. Smith at Brazos Valley Eye Physicians and we like to take care of these patients as soon as possible..

2. If no call is received this will be documented as a "No-Show" appointment.

3. If you do not present to the office for your appointment, this will be documented as a "No-Show" appointment.

4. After the first "No-Show/Missed" appointment, you will receive a phone call or letter reminding you of our "No-Show" policy. Brazos Valley Eye Physicians will assist you in rescheduling this appointment if necessary.

5. If you have 2 "No-Show/Missed" appointments within a one-year time period, you will receive a warning letter from our office and will be assessed a $25.00 no show fee.

6. If you have 3 "No-Show/Missed" appointments within a one-year time, you will receive a second $25 no show fee assessment. Dismissal from the practice will be considered. A letter will be sent upon coming to the decision of your dismissal as one of our patients.

# Contact Lens Policy

## Dr. Smith does not measure, fit or dispense contact lenses.

To assist our patients Dr. Smith has agreement with a Waco, certified dispensing optician who can measure and fit, dispense, provide follow-ups and product for the contact lens patient.

***Rick Spinn Optical @ 254-751-1161**
2024 N Valley Mills Dr, Waco, Tx 76710

Brazos Valley Eye Physicians will provide you with a refractive prescription, which you can then take over to "RICK SPINN OPTICAL". He will, for a fee, measure, fit, dispense and provide follow-ups. ***He is your point of contact for all things related to your contacts.**

**In addition, if you wish/intend to purchase contact lenses online, since we are not involved with the fitting, measuring and dispensing of contacts, we are unable to confirm ANY contact lens information. "Rick Spinn Optical" will have all of that information.**

***Please do not have online contact lens order requests sent here.**

Brazos Valley Eye Physicians

**Scott Smith M.D**

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**PATIENT REGISTRATION (please print)**

First Name _____ Middle Initial _____ Last Name _____

Home Address _____

City, State, Zip _____

Primary Phone (_____) _____Alternate (_____) _____

Date of Birth _____ SS# _____

**Ethnicity**: ❑ Hispanic or Latino ❑ Not Hispanic or Latino **Gender:** ❑ Male ❑ Female

**Race**: ❑ White ❑ American Indian or Alaska Native ❑Asian ❑ Black or African American

❑ Native Hawaiian or Other Pacific Islander **Marital Status**: ❑ S ❑ M ❑ D ❑ W ❑ Other

Primary Care Physician: _____

Pharmacy_____

Emergency Contact _____Relationship_____

Phone _____

Sign up for patient portal? ❑ No ❑ Yes Please provide email:_____

Insurance(s) Name &/ ID#:_____

_____

_____

Referred by:_____

All professional services rendered are the responsibility of the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. If it is necessary to turn this service over to collection for non-payment after 90 days, then the patient is responsible for the bill, the interest, and collection and attorney fees.

AUTHORIZATION TO PAY BENEFITS TO PROVIDER: I hereby authorize payment directly to the Provider for my charges.

AUTHORIZTION TO RELEASE INFORMATION: I hereby authorize the undersigned Provider to release any information acquired in the course of my examination or treatment to my insurance company in writing or fax.

Signature (Patient, Guardian, or Parent of Minor) _____Date:_____

Brazos Valley Eye Physicians

**Scott Smith M.D**

## PATIENT MEDICAL HISTORY

Please complete this form and bring it with you to your appointment. Add pages if you need space.

_____ _____

Patient Name Date of Birth

**1. Do you have now, or have you ever had the following:**

| **PROBLEM** | | | **DATE OF ONSET** |
|---|---|---|---|
| Diabetes Mellitus | ❒Yes | ❑No | _____ |
| Treatment: ☐ Diet Control ☐ Oral Agents ☐ Insulin | | | |
| Name of Treating Physician _____ | | | |
| Heart Attack | ❒Yes | ❑No | _____ |
| Chest Pain or Angina | ❒Yes | ❑No | _____ |
| High Blood Pressure | ❒Yes | ❑No | _____ |
| Stroke or "Shock" | ❒Yes | ❑No | _____ |
| Anemia | ❒Yes | ❑No | _____ |
| Hepatitis | ❒Yes | ❑No | _____ |
| Asthma | ❒Yes | ❑No | _____ |
| Emphysema | ❒Yes | ❑No | _____ |
| Bronchitis | ❒Yes | ❑No | _____ |
| Pneumonia | ❒Yes | ❑No | _____ |
| Tuberculosis | ❒Yes | ❑No | _____ |
| Liver Disease | ❒Yes | ❑No | _____ |
| Ulcer | ❒Yes | ❑No | _____ |
| Overactive Bladder | ❒Yes | ❑No | _____ |
| Prostate Treatment | ❒Yes | ❑No | _____ |
| Kidney Disease, Stones | ❒Yes | ❑No | _____ |
| Arthritis | ❒Yes | ❑No | _____ |
| Type: ☐ Osteo ☐ Rheumatoid | | | |
| Cancer or Tumor | ❒Yes | ❑No | _____ |
| Type, Location and Treatments: | | | |
| _____ | | | |
| Thyroid Disease | ❒Yes | ❑No | _____ |
| ☐ Underactive ….. Treatment _____ | | | |
| ☐ Overactive ……. Treatment _____ | | | |
| Seizures | ❒Yes | ❑No | _____ |
| Varicose Veins, Clots | ❒Yes | ❑No | _____ |
| Transfusions | ❒Yes | ❑No | _____ |
| Have you tested positive | ❒Yes | ❑No | _____ |
| For AIDS or HIV | ❒Yes | ❑No | _____ |
| Other medical problems | ❒Yes | ❑No | _____ |

**2. Are you allergic to any medications or foods?**

❒Yes ❑No

Please list _____

_____

_____

_____

_____

**3. What eye medications are you using at present?**

Name and Dosage _____

_____

_____

_____

_____

**4. What other medications do you take regularly (including "social drugs")?**

Name, Dosage & Frequency

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

5002 Lakeland Circle, Ste A ♦ Waco, TX 76710 ♦ Tel: (254) 752-2571 ♦ Fax: (254) 752-0699

Brazos Valley Eye Physicians

**Scott Smith M.D**

**PATIENT MEDICAL HISTORY** Patient Name_____DOB_____

5. **When was you last professional eye exam and by whom?**
   Date _____Name of Doctor_____
   Type of doctor ☐ Ophthalmologist, M.D. ☐ Optometrist, O. D.
   **Were any existing or future eye problems mentioned by the doctor during this last exam?** ❒Yes ❑No
   If yes, please list: _____
   _____
   **Do you wear Contact Lenses?** ❒Yes ❑No
6. **Have you had any previous eye surgery, laser surgery, or eye injuries?** ❒Yes ❑No
   If yes, types and dates: _____
   _____
   _____
7. **Reason for today's visit?** _____
   _____
   _____
8. **What non-eye operations have you had?**
   Types / Dates _____
   _____
   Date of last General anesthesia _____
   Complications? Explain: _____
   _____
9. **Among you and your blood relatives, is there a history of any of the following?**

| PROBLEM | YOU | | BLOOD RELATIVES | |
|---|---|---|---|---|
| Glaucoma | ❒Yes | ❑No | ❒Yes | ❑No |
| Cataracts | ❒Yes | ❑No | ❒Yes | ❑No |
| Lazy Eye | ❒Yes | ❑No | ❒Yes | ❑No |
| Retinal Disease | ❒Yes | ❑No | ❒Yes | ❑No |
| Macular Disease | ❒Yes | ❑No | ❒Yes | ❑No |
| Night Blindness | ❒Yes | ❑No | ❒Yes | ❑No |
| Color Blindness | ❒Yes | ❑No | ❒Yes | ❑No |
| Unexplained Vision Loss | ❒Yes | ❑No | ❒Yes | ❑No |
| Bleeding Disorder | ❒Yes | ❑No | ❒Yes | ❑No |
| Diabetes Mellitus | | | ❒Yes | ❑No |
| High Blood Pressure | | | ❒Yes | ❑No |
| Heart Disease | | | ❒Yes | ❑No |
| Tumor or Cancer | | | ❒Yes | ❑No |

10. **Do you smoke?** ❒Yes ❑No
    How many packs per day? _____
    **If you smoked in the past**, when did you stop and how long had you smoked?
    _____
    _____
11. **Do you drink alcoholic beverages?**
    ❒Yes ❑No
    How many drinks (beer, wine, liquor) per day? _____
    Avg per week? _____
    If you drank in the past, when did you stop and how long were you drinking?
    _____
    _____
12. **In your line of work, hobby, or lifestyle are your eyes exposed to chemical or air pollutants?**
    ❒Yes ❑No
    Name and frequency _____
    _____
    _____
    _____
13. **If applicable, are you pregnant?**
    ❒Yes ❑No
14. **Please identify you family or primary medical doctor(not eye doctor)?**
    Name _____
    Clinic _____
    Address _____
    _____
    City, ST _____
    Phone _____

## HIPAA PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information and that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have been informed by you of your Notice of Privacy Practices (in the New Patient Welcome Packet) containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used and disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name _____

Signature _____

Relationship to Patient _____

Date _____

## Authorization for Release and/or Discussion of Information to Family Members

Patient Name:_____

Date of Birth:_____

Declined: _____ ( If declining, check here then sign at bottom)

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Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released or discussed with family members you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Brazos Valley Eye Physicians/ Dr. Scott Smith to release my medical and/or billing information to the following individual(s):

1._____ Relation to Patient:_____

2._____ Relation to Patient:_____

3._____ Relation to Patient:_____

**Patient Information**

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed. I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient. You have the right to revoke this consent in writing.

Patient Name:_____

Signature:_____

Date:_____