Drs. T. Jeff Russell, Heather H. Winslow, and Slayt W. Ebeling
Medical Information Privace Notice Summary

This notice is required by law to inform you of the ways in which we may use your confidential and protected health information.

1) For treatment – we may release your medical information to other physicians for consultations, referrals, and coordination of your health care.
2) For payment – we may release your medical information to an insurance company or third party about your treatment so we may be reimbursed for your care or to obtain prior approval or to determine if your insurance company will cover the treatment.
3) Appointment reminders – we may use and disclose medical information to contact you as a reminder that you have an appointment for medical care or to change an existing appointment.
4) Individuals involved in your care or payment for your care – we may release medical information about you to a friend or family member who is involved in your medical care or payment of your medical care.
5) Workers compensation – we may release your medical information about you for workers compensation or similar programs.

You have the right to inspect and copy your medical information. You must submit your request in writing to the Privacy Officer. We may charge a fee for the costs of copying, mailing, or other supplies associated with your request. You have the right to request that we amend your medical information if you feel the information is incorrect or incomplete. The request must be in writing and must include the reason you wish to amend your information.

This is a summary of part of the Privacy Practices for InfinityVision. If you would like the complete privacy notice form, please notify the receptionist or one of our staff.

_____ _____

Signature of Patient Printed Name and Date

Drs. T. Jeff Russell, Heather H. Winslow, and Slayt W. Ebeling

Name _____ **Date of Birth** _____ **Date** _____

MEDICAL/OCULAR HISTORY

Drug Allergies: _____

Surgical History: _____

_____

_____

Current Medications: _____

_____

_____

Smoking History: □ Current smoker □ Former smoker □ Never smoker

Medical Conditions that Apply to You:

□ Arthritis □ Asthma □ Cholesterol □ Headaches □ Heart Disease □ High Blood Pressure

□ HIV □ Lung Disease □ Rosacea □ Seasonal Allergies □ Seizures □ Shingles/Fever Blisters

□ Stroke □ Thyroid □ Cancer (please specify type) _____

□ Diabetes (if yes, most recent blood sugar count _____ and date taken _____)

□ Other: _____

Eye Conditions that Apply to You (past and present):

□ Cataract □ Color Blindness □ Corneal Disease □ Diabetes □ Double Vision □ Dry Eye

□ Glaucoma □ Lazy Eye □ Macular Degeneration □ Retinal Detachment or Tear

□ Glasses – how long_____ Other Conditions: _____

Eye Surgery:

□ LASIK/PRK □ RK □ Cataract □ Glaucoma □ Retina □ Cornea Transplant

Surgery Details: _____

Eye/medical conditions of your immediate family:

□ Cataracts □ Glaucoma □ Diabetes □ Blindness □ Macular Degeneration □ Cornea

Any other type of ocular disease _____

Contact Lens History

Type of contact lenses you are wearing: □ Soft □ RGP □ Toric □ Multifocal □ Monovision

How long to you wear one pair of contact lens: □ 1 day □ 1-2 weeks □ 1-2 months □ other ____

Type of cleaning solutions used _____

Any allergies to contact lens solutions _____

Any allergies or other problems with contact lenses _____

Drs. T. Jeff Russell, Heather H. Winslow, and Slayt W. Ebeling
3535 Travis St, Ste 170, Dallas, TX 75204

Last_____First_____Middle_____

Address_____City_____St_____

Zip_____Home Phone_____Cell Phone_____

Work Phone_____D.O.B____/____/____Age_____Sex: □ M □ F

Email address:_____

Marital Status: □ Single □ Married □ Widowed □ Other SSN_____

Occupation_____Employer_____

Emergency Contact_____Phone_____

Relationship of emergency contact to patient_____

New Patients Only: Name of doctor or referring party_____

INSURANCE INFORMATION

Primary Insurance Carrier_____

Secondary Insurance Carrier_____

Responsible Party (if patient is a minor)_____

ALL PATIENTS: PLEASE READ & SIGN THE FOLLOWING

To allow us to file for your medical insurance benefits and/or accept Medicare assignment, please sign the following release:

I request that medical insurance benefits be paid directly to InfinityVision for services rendered. I authorize the release of medical information to my insurance carriers for determination of benefits.

*****IF YOU BELONG TO AN HMO OF ANY TYPE AND DO NOT HAVE A CURRENT REFERRAL, OR IF YOU ARE UNABLE TO PROVIDE PROOF OF INSURANCE AT TIME OF SERVICE, YOU WILL BE RESPONSIBLE FOR TODAY'S PAYMENT IN FULL.*****

SIGNED_____DATE_____

T. Jeff Russell, MD | Heather H. Winslow, MD | Slayt W. Ebeling, OD

3535 Travis St, Ste 170

Dallas, TX 75204

214-522-2661 phone 214-522-5469 fax

Authorization to Release Medical Information

I,_____, hereby authorize my medical records to be released:

□ to □ from

InfinityVision
3535 Travis St, Ste 170
Dallas, TX 75204

□ from □ to

the office of:

NAME:_____

ADDRESS:_____

CITY, ST, ZIP:_____

FAX:_____

X_____ X_____
Signature Patient Date of Birth

X_____ X_____
Date Witness

FINANCIAL/INSURANCE POLICY

We have contracted with many insurance carriers or managed care networks to be providers on their plan. Contractually, both the provider and the patient have certain obligations under these plans. If you have medical insurance, we are anxious to help you receive your maximum benefits allowed. In order to achieve that goal, we need your assistance and your understanding of our payment policies.

• All payments for services not covered by your insurance plan, or services being filed on an insurance plan, are due at the time of service.

• We must have a copy of your current insurance card at the time of your visit in order to file a claim for you. If we do not have proof of valid insurance, you will be responsible for the full amount of services rendered.

• We will collect all co-payments/or deductibles due at the time of service.

• Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract and are not responsible for knowing the specific benefits of your plan.

• Verification of your benefits does not guarantee payment.

• Not all services are a covered benefit in your insurance contract. Some insurances companies select certain services they will not cover or set maximum limitations. Any services identified as such will be your responsibility and payment will be due at the time of service.

We must emphasize that filing of claims is a courtesy we extend to all our patients. All charges are your responsibility from the date services are rendered. It is understood that temporary financial problems may affect timely payment of your account. If such problems arise, please contact us promptly for assistance in the management of your account.

PLEASE ACKNOWLEDGE YOUR UNDERSTANDING AND AGREEMENT TO THESE TERMS BY SIGNING BELOW: I hereby authorize Infinity Vision, to furnish my insurance company, its representatives or any other insurance company or attorney, the customary medical information requested about me. I understand that Infinity Vision will file my insurance on my behalf and I will be responsible for following up with my insurance company for timely payment of services rendered. I agree to pay in full all balances due that are not paid by the insurance company.

Signature _____ Date_____

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Refraction and Contact Lens Policy

One of the most important parts of your eye exam is the refraction. That is the part of the exam by which we determine the best possible acuity for your eyes, which is an essential piece of medical information that is used to assess your eyes and search for medical conditions and other vision problems. It is NOT a covered service by Medicare and many other insurance plans. The refraction fee is collected at the time of service. This is in addition to any co-payment, co-insurance, or deductible your plan may require. Should your insurance plan pay us for the refraction, we will reimburse you. Additionally, please note that contact lenses used for refractive purposes (i.e. for vision correction) are considered cosmetic by Medicare and most medical insurance plans, and are therefore not covered by insurance.

Yes, I have read the above information and understand that the refraction, contact lens exams, and contact lenses are a non-covered service. I accept full responsibility for the costs of these services and understand they are due at the time of service. I understand that any co-payment, co-insurance, or deductible I may have is separate from and not included in these fees.

_____ _____

Patient Signature Date

Should you choose NOT to have a refraction and should you break or lose your glasses, we will NOT be able to provide you with a glasses prescription. You will be asked to schedule a return appointment and charged another office visit along with the refraction fee.