BRAZOSPORT EYE INSTITUTE
FRANK J. GRADY, M.D. / JONATHAN P. GRADY, M.D.
PATIENT INFORMATION

NAME ____ DATE ____________
LAST FIRST MI

MAILING ADDRESS ____ APT# __________

CITY __________________________ STATE _______ ZIP ____________

PHONE (HOME) _________________ (CELL) _________________ (WK) _________________

EMAIL _____________________________

BIRTHDATE ____________ SSN ______________ ☐ MALE ☐ FEMALE ☐ SINGLE ☐ MARRIED ☐ OTHER

EMPLOYER _________________ SPOUSE NAME _____________________

PREFERRED PHARMACY _____________________ CITY ________________

FAMILY PHYSICIAN _____________________ REFERRING DOCTOR FOR YOUR VISIT _______________

PERSON TO CONTACT IN EMERGENCY _________________________ PHONE# _________________

WHOM MAY WE THANK FOR RECOMMENDING OUR PRACTICE? ☐ INSURANCE PLAN ☐ INTERNET ☐ YELLOW PAGES
☐ FRIEND (NAME) _______________ (WE WOULD LIKE TO THANK THEM)

NOTICE OF PAYMENT POLICY

PAYMENT POLICY: It is customary to pay for professional services when rendered. For your convenience we accept major credit/debit cards, personal checks and cash. **IF YOU ARE UNPREPARED TO PAY FOR YOUR VISIT IN FULL TODAY, PLEASE INFORM THE FRONT DESK SO WE CAN RESCHEDULE YOUR VISIT.**

INSURANCE: Please read and sign below if you have insurance with: Medicare, Medicaid, an HMO/PPO/POS or State Agency or Worker's Compensation, and our physician is contracted with your carrier. Present your insurance card along with any required referrals/authorizations to the Front Desk. You are responsible for **any** deductible, copay, coinsurance or non-covered amounts as determined by your insurance carrier.

NON-COVERED SERVICES: The filing of a claim for any services rendered DOES NOT GUARANTEE PAYMENT from your insurance carrier. You will be financially responsible for these services. Our office has a **90 day** policy in regards to the payment of **any** balance on your account.

EYE EXAM: I agree to and understand that my eyes must be dilated in order for the doctor to thoroughly check the retina of the eye. I understand that if my pupils are dilated or my eye is patched after the exam, I may not be able to safely operate a motor vehicle and am solely responsible for evaluating the need for alternate transportation.

The contents of this document will remain in force unless revoked by me in writing.

______________________________ ______________________________
Signature of Patient (or Legal Guardian) Name and Relationship if other than Patient

No Show Policy Form

Brazosport Eye Institute
103Parking Way
Lake Jackson, TX. 77566

No Show Policy

Our goal is to provide quality medical care to all of our patients in a timely manner. In order to be able to accommodate our other patients with appointments, we request that you please notify the office 24 hours in advance to reschedule or cancel if you are not able to keep your appointment.

Our No Show Policy is as follows:

- A 24-hour notice is required to reschedule or cancel your appointment.
- Late cancellations are considered a "No Show". Calling at the last minute before your scheduled appointment is not acceptable.
- First No Show appointment: You will get a courtesy phone call to remind you of the missed appointment and you have the possibility to reschedule at that time.
- No Show appointment: You, NOT your insurance company, may be charged $25.00 for the time slot we were not able to fill when you were a NO Show.

I ________________________, have reviewed and understand the above **No Show Policy.**

Signature ______________________________ Date________________________
Signature of Patient or Responsible Party

INSURANCE INFORMATION

PATIENT NAME ________________________________ CHART# ________________

*** PLEASE PRESENT THE FRONT DESK WITH ALL CURRENT CARDS***

PRIMARY INSURANCE COMPANY: ________________________________

INSURED'S NAME (POLICY HOLDER) ________________________ EMPLOYER ______________

INSURED'S DATE OF BIRTH ____/____/____ ☐MALE ☐FEMALE

PATIENT'S RELATIONSHIP TO INSURED ☐SELF ☐SPOUSE ☐CHILD ☐OTHER______________

ADDRESS OF INSURED *IF DIFFERENT* FROM PATIENT: ________________________________

____

SECONDARY INSURANCE COMPANY: ________________________________

INSURED'S NAME (POLICY HOLDER) ________________________ EMPLOYER ______________

INSURED'S DATE OF BIRTH ____/____/____ ☐MALE ☐FEMALE

PATIENT'S RELATIONSHIP TO INSURED ☐SELF ☐SPOUSE ☐CHILD ☐OTHER______________

ADDRESS OF INSURED *IF DIFFERENT* FROM PATIENT: ________________________________

____

THIRD INSURANCE COMPANY: ________________________________

INSURED'S NAME (POLICY HOLDER) ________________________ EMPLOYER ______________

INSURED'S DATE OF BIRTH ____/____/____ ☐MALE ☐FEMALE

PATIENT'S RELATIONSHIP TO INSURED ☐SELF ☐SPOUSE ☐CHILD ☐OTHER ______________

ADDRESS OF INSURED *IF DIFFERENT* FROM PATIENT: ________________________________

ASSIGNMENT OF BENEFITS: I hereby authorize any insurance company to pay the proceeds of any benefits due me directly to Frank J. Grady, M.D., Assoc.

AUTHORIZATION FOR DISCLOSURE: I hereby authorize the release of information deemed necessary to determine benefits payable under my insurance policy. A copy of this can be considered an original for insurance purposes.

________________________________ ________________

Signature of Patient or Representative Date

PATIENT NAME: ______________________________ CHART# ______________

REFRACTION POLICY

During your annual (or more often as necessary) visit, a refraction will be performed to determine your need for glasses or to evaluate if any further visual improvement can be achieved. This is a necessary and essential portion of your eye exam. The refraction is considered NON-COVERED by Medicare and most private insurances. It is the responsibility of the patient to pay for the refraction when it is not billed to their insurance. Our office currently charges $98 for this vision test, but provides a prompt pay price of $35.00 to the patient when paid at the time of service. This fee is in addition to the patient's copay, coinsurance and/or deductible amounts.

I have read and understand I may be charged a prompt pay price of $35 at the time of service for the refraction.

CONSENT TO TREATMENT

I hereby authorize and permit Frank J. Grady, M.D., Assoc to examine and to perform any necessary medical or laboratory tests as is deemed necessary to treat my illness/condition.

______________________________ ______________

Signature of Patient or Representative - Date

NOTICE OF PRIVACY POLICY

In accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, this office has in place a policy to protect your private health information. A copy of the complete policy is available upon request. By signing below, you acknowledge receiving information regarding Dr. Frank J. Grady's privacy policy.

______________________________ ______________

Signature of Patient or Representative Date

In accordance with this privacy policy, please list below anyone (other than physicians) whom you wish to have verbal or written information regarding your medical records.

NAME ______________________________ RELATIONSHIP ____________________

NAME ______________________________ RELATIONSHIP ____________________

NAME ______________________________ RELATIONSHIP ____________________

Medical Information

Date______________________________

Name_____________________________

Referred by______________________

Family Physician_________________

I. Past History

1) **Medication Allergies:**

2) **Past Medical History:**

3) **Past Surgical History:**

4) **Current Medications.** (Name & Purpose)

II. Family History of:

Cataracts_________________________

Glaucoma_________________________

Retinal Detatchments__________

Eye Disorders:__________________

Diabetes__________________________

High Blood Pressure__________

Heart Disease___________________

Other:______________________________

III. Social History:

Drugs____________________

Alcohol___________________

Tobacco__________________

Do you live ☐ alone, ☐ with spouse, ☐ other-____________________

PFSH + ROS Updated:

FOR OFFICE USE ONLY - PLEASE DO NOT WRITE BELOW THIS LINE

Year	Initials
____________	______
____________	______
____________	______
____________	______
____________	______
____________	______
____________	______
____________	______

IV. Review of Systems:

System	Symptom	
NORMAL ☐ 1) CONSTITUTIONAL	*Fever*	☐
	Weight loss	☐
	Other	☐ ____________
NORMAL ☐ 2) EYES	*Blurred vision*	☐
	Double vision	☐
	Pain	☐
	Discharge	☐
	Other	☐ ____________
NORMAL ☐ 3) EARS, NOSE, MOUTH, THROAT	*Pain*	☐
	Mass	☐
	Discharge	☐
	Hearing loss	☐
	Smell	☐
	Other	☐ ____________
NORMAL ☐ 4) CARDIOVASCULAR	*Chest pain*	☐
	Shortness of breath	☐
	Irreg Heart Beat	☐
	Other	☐ ____________
NORMAL ☐ 5) RESPIRATORY	*Short of breath*	☐
	Cough	☐
	Asthma	☐
	Other	☐ ____________
NORMAL ☐ 6) GASTROINTESTINAL	*Bowel habits/change*	☐
	Diarrhea	☐
	Constipation	☐
	Stomach pain	☐
	Ulcers	☐
	Other	☐ ____________
NORMAL ☐ 7) HEMATOLOGIC/LYMPHATIC	*Anemia*	☐
	Blood disease	☐
	Free bleeder	☐
	Swollen lymph nodes	☐
	Other	☐ ____________
NORMAL ☐ 8) MUSCULOSKELETAL	*Weakness*	☐
	Joint pain	☐
	Decreased ROM	☐
	Other	☐ ____________
NORMAL ☐ 9) INTEGUMENTARY (SKIN/BREAST)	*Masses*	☐
	Tumors	☐
	Pigmented lesions	☐
	Rash	☐
	Other	☐ ____________
NORMAL ☐ 10) NEUROLOGIC	*Weakness*	☐
	Tingling	☐
	Numbness	☐
	Other	☐ ____________