dell children's
medical center of central texas
A member of the Seton Family of Hospitals

DELL CHILDREN'S EYE CENTER
REGISTRATION FORM (PLEASE PRINT)

Pediatrician / Primary Care Doctor:	Today's Date:

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	Age:	❑ Male ❑ Female	Date of Birth: / /

Street Address:	Social Security No.:	Home Phone Number: ( )
City:	State:	ZIP Code:	Cell Phone Number: ( )
		Please check Contact preference: [ ] Home [ ] Cell

Ethnicity: ❑ Hispanic or Latin ❑ Not Hispanic or Latin ❑ Refuse to Report	Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Native Hawaiian ❑ Black or African American ❑ White ❑ Hispanic ❑ Other Race ❑ Other Pacific Islander

Primary Parent / Guardian Name:	Email:	
	Social Security No.:	Date of Birth:
Employer:	Employer phone No.: ( )	
Second Parent / Guardian Name:	Marital Status of Parents: ❑ Married ❑ Divorced ❑ Single	

INSURANCE INFORMATION

Name of Primary Insurance:	Subscriber's Name:	Birth Date: / /	Subscriber's S.S. No.:	Policy No.:	Group No.:
Subscriber Address: *If different than above*			Patient's relationship to subscriber: ❑ Self ❑ Spouse❑ Child ❑ Other		
City:	State:		ZIP Code:		
Name of Secondary Insurance:	Subscriber's Name:	Birth Date: / /	Subscriber's S.S. No.:	Policy No.:	Group No.:
Subscriber Address: *If different than above*			Patient's relationship to subscriber: ❑ Self ❑ Spouse❑ Child ❑ Other		
City:	State:		ZIP Code:		

EMERGENCY CONTACT

Last Name:	First:	Middle:	Home Phone Number : ( ) Cell Phone Number: ( )
Street Address:	Relationship to Patient:	Email:	
City:	State:	ZIP Code:	

APPOINTMENT INFORMATION

Referred by (Full name):	Reason for today's visit:

Consent to Treat

I hereby consent to evaluation, diagnostic procedures, testing, and treatment as directed my physician or his/her designee. I understand that Dell Children's Eye Center includes teaching facilities and therefore I may be attended to by students and residents of various disciplines and affiliated with various educational programs. I understand that I may request and receive information on the specific affiliation(s) of any particular healthcare provider I encounter during my care. I understand that this Consent to Treat will be valid for each visit I make to the Dell Children's Eye Center until revoked by me in writing.

Recalls

Recalls are a courtesy and not guaranteed to be sent out. It is the patient or patient guardian's responsibility to set up all follow up and yearly appointments.

Refraction Wavier

A refraction is performed for blurred vision, misalignment of the eyes is present, headaches, eye strain, excessive blinking, tearing, genetic evaluation, preemie evaluations, and many other conditions. A refraction is considered non medical by most insurance companies, including Medicare even though your physician requires the results to developed a treatment plan. Without a refraction, your doctor can not determine whether glasses are needed to improve vision, alignment or other symptoms. In some cases, your doctor uses the information to determine if surgery will be necessary.
You will be financially responsible for this service if it is not covered by your insurance company.

Contact/ Release of Information

In the event that Dell Children's Eye Center needs to contact you regarding an appointment, lab result, medication or for any other reason, it is permissible to:

- ❑ Leave a message on an answering machine/ Voicemail
- ❑ Other: Name__________________________________
  Relationship to Patient:__________________
- ❑ Speak with spouse/ significant other
- ❑ Speak with other family member

I acknowledge that Dell Children's Eye Center may release my protected health information as necessary for treatment, payment and health care operations and acknowledge that Seton's Notice of Privacy Practice provides information on how my protected health information may be used and/or disclosed for these purposes. I understand that protected health information pertains to my diagnosis and/or treatment, and includes, but is not limited to, information related to my health history, diagnosis, treatment, prognosis, mental illness (excluding psychotherapy notes), use of alcohol or drugs, prescriptions and laboratory test results, including HIV or the diagnosis of AIDS.
I understand that use or disclosure of my protected health information may be necessary before my insurer will pay for the cost of my medical treatment and that if I refuse to consent to this disclosure I may be required to pay the entire cost of medical care provided by Dell Children's Eye Center.
I acknowledge and consent to allow Dell Children's Eye Center to use health information exchange systems to electronically transmit, receive and/or access my medical information, which may include, but is not limited to, treatments, prescriptions, labs, medical and prescription history and other protected health information. I may "opt out" and not have my protected health information disclosed through health information exchange systems by providing the signed Seton "opt-out" form to the practice location where I receive treatment.

Financial Policy

I assign and transfer to Dell Children's Eye Center all rights, title and interest in payments from third-party payors, including but not limited to, health plans, health insurers, Personal Injury Protection (PIP)/Uninsured Motorist/Under Insured Motorist (UIM/UM), auto or homeowner's insurance. I understand that it is my responsibility to know my insurance benefits and whether or not the services I receive are a covered benefit. I understand and agree that I will be responsible for any deductible, co-pay or balance due that Dell Children's Eye Center are unable to collect from my third-party payor for whatever reason. If my account becomes delinquent and it is necessary for the account to be referred to attorneys' or collection agencies, or lawsuit filed, I agree to pay all patient charges, reasonable attorneys fees and collection expenses.
I authorize the release all medical information necessary to process all claims and the release of payment for medical benefits to my physician and Dell Children's Eye Center. I agree to pay any outstanding balance for services not covered by insurance, applicable copays, co-insurance, deductible, and replacement costs for items damaged.

Print Patient Name:____ Patient Date of Birth:______________________

Insurance Card Policy

Please present your current ***Insurance Card*** and ***Photo ID*** at check-in. Both are required to process insurance claims. Your appointment will be rescheduled to our next available opening if you do not bring these documents or if you do not obtain a referral, if required by your insurance. You are responsible for obtaining a referral from your PCP if one is required.

Medicare/Medicaid/Insurance Benefits

If I am eligible for health care benefits under any federal or state program, including, but not limited to Medicare or Medicaid, I certify that the information given by me in applying for payment under any such programs is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or Contractors any information needed for any federal or state program related claims. I request that payment or authorized benefits be made to Dell Children's Eye Center on my behalf. I understand that I am financially responsible for any deductible, co-pay or balance due under these programs.

Acknowledgement of Receipt of the Notice of Privacy Practice

I acknowledge that I have reviewed a copy of Dell Children's Eye Center's Notice of Privacy Practices. I understand how medical information will be used and disclosed. I understand a copy will be given to me upon request.

General Office Policies

-Parents/ Guardians are responsible for supervising their children at all times while in our office.
-Toys and books are provided for entertainment while you wait. Please ensure that your child treats them with respect.
-Climbing or standing on the furniture is not allowed.
-If your child uses any electronic device while waiting, please use headphones or turn the sound off.
-Please arrange child care for siblings if at all possible.
-Cell phones should be turned off once you and your child are placed into an exam room.
-If you are 15 minutes late, the physician reserves the right to reschedule your appointment.
-If you are late, and the physician agrees to see you or your child, you will lose your appointment and be seen after those patients who arrive on time. This may result in a very prolonged wait time. The physician reserves the right to defer dilation or other testing to another visit.
-We ask that you set aside 2 hours for every appointment scheduled.

Consent to Photograph/Digital Imaging

I consent to photographs/digital images for treatment, and to verify identity for payment purposes. I understand that the Seton Healthcare Family will retain the ownership rights to these photographs/digital images, but that I will be allowed access to view them or obtain copies.

Accidental Exposure of Health Care Worker

I understand that Texas Law provides and I give consent that in the event a healthcare worker is exposed to my blood or body fluids, my blood may be tested for the HIV antibody and other communicable diseases at no cost to me.

Policy for Replacing, Repairing, or Cleaning Damaged Items and Medical Equipment

Patients, parents, and all others that accompany them are NOT PERMITTED to touch any of the medical equipment, items on the desktops, or items in the drawer. Some instruments require professional cleaning. If an instrument cannot be used because of fingerprints or smudges you will be held financially responsible for the cleaning fees.
Please do not touch anything on the desktop, including the basket of toys and pencils or anything in the drawers. You will be held financially responsible for repairing or replacing damaged equipment, toys, and furniture.
Dell Children's Eye Center will collect payment in full at checkout. We reserve the right to determine whether to repair, replace, or clean a damaged item. We will provide you a copy of the final bill and will refund any overpayment.

By signing below, you understand and agree to all policies.

____ ________________
Patient Printed Name Patient Date of Birth

____ ________________
Patient/Responsible Party Signature Date