Cynthia Phelps, O.D

Informed Consent & Treatment Authorization

The law requires that we make every effort to inform you of your rights related to your personal health information.

- *I have read or had explained to me the Notice of Privacy Practices for Cynthia Phelps, O.D and agree to continue my care with Cynthia Phelps, O.D under said terms.*
- *I was given the opportunity but declined to read the Notice of Privacy Practice, for Cynthia Phelps O.D but wish to continue my care with Cynthia Phelps O.D under the terms of her privacy policies.*
- *I have read or had explained the Notice of Privacy Practices for Cynthia Phelps O.D and do not wish to continue my care with Cynthia Phelps under said terms.*
- *The Notice of Privacy Practices could not be read due to the emergent nature of the care or the reason described as:*

  _____
- *I (do)____(do not)____ authorize Cynthia Phelps O.D; or her staff to leave a message with available persons at my home phone number, on my answering machine or with the emergency contact listed above.*
- *I (do)___ (do not)___ authorize Cynthia Phelps O.D; or her staff to leave a message at my place of employment.*

Patient or Legal Guardian Signature_____Date_____

Financial & Insurance Filing Policy

- *All charges are your responsibility, whether or not your insurance company pays. Not all services are covered in all contracts. Some insurance companies arbitrarily select certain services they will not cover. We cannot become involved in disputes between you and your insurer regarding covered charges, deductible, or copay.*
- *If your insurance company doesn't pay your claim within 30 -45 days it is your responsibility to contact them to expedite payment. We will require you to pay the balance by cash, check, money order or credit card.*
- *Payment for copay and/or deductible is due at the time services are rendered.*
- *In the event that refraction is not covered by your insurance you will be charged a fee in addition to your copay and/or deductible.*

Authorization To Release Health Information & Assign Benefits

I hereby authorize Cynthia G. Phelps, O.D to provide diagnosis & optometric treatment to my child or me. I further authorize the release of Protected Health Information to additional physicians or optometrist in order to facilitate continuity of care.

I _____, authorize the release of all necessary Protected Health Information & assign all medical & vision benefits to Cynthia Phelps O.D. I also request that payment of authorized Medicare (if applicable) benefits be made on my behalf to Cynthia Phelps, O.D for any services furnished to me by Cynthia Phelps, O.D. I authorize any holder of medical information related to me to release to the Centers for Medicare & Medicaid Services (CMS) & its agents, any information needed to determine these benefits or the benefits payable to related service. I understand that my signature requests that payment be made & authorizes release of medical information necessary to pay the claim. If item 12 of the CMS 1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the supplier agrees to accept the charge determination of the Medicare carrier as the full charge, & the patient is responsible only for the deductible, copay, & non-covered services. I understand that I am ultimately responsible for any bill incurred in this office. Should this account become delinquent, I will be responsible for any & all legal fee, court costs & collection charges .There will be a service charge for each returned check. The authorization & assignment will remain in effect until revoked me in writing, A photocopy of this authorization & assignment is to be considered as valid as the original. I request that you file my insurance & I have agreed to & completed all of the conditions listed above. I accept financial responsibility for all charges. I have read & understood this information & I am signing voluntarily.

Patient or Legal Signature_____ Date_____

Dr. Cynthia G. Phelps, O.D.
Therapeutic Optometrist
1321 N. Loop 1604 E. Ste. 100A
San Antonio, TX 78232
VisionTech 20/20 (p) 210-782-8205
(f) 210-545-2147

Patient Information Form

Cynthia G. Phelps, O.D., P.A.
& Associates
Doctors of Optometry

DATE: _____

_____ Parent/Guardian _____
Last Name First Name MI

DOB _____ M/F Occupation/Grade _____ Pharmacy: _____

Employer _____ SSN # _____ Email: _____

Home # _____ Work # _____ Cell # _____

Mailing Address _____ Apt# _____ City _____ State _____ Zip _____

Referred by: _____ Date of Last Exam _____

Have you ever worn contacts? Yes / No What type? (Disposable, Gas Perm, Toric, Bifocal, Daily Wear, Colored)
Are you interested in Lasik surgery or Refractive surgery? Yes / No

PLEASE CIRCLE AS NEEDED BELOW

General Health	Patient		In Family
Diabetes	Y	N	Y or N
High Blood Pressure	Y	N	Y or N
Heart Problems	Y	N	Y or N
Lung Problems	Y	N	Y or N
Kidney Problems	Y	N	Y or N
Thyroid Problems	Y	N	Y or N
Arthritis	Y	N	Y or N
Major Operations	Y	N	
Medical Allergies	Y	N	See below
Presently Pregnant	Y	N	

Eye History	Patient		In Family
Glaucoma	Y	N	Y or N
Cataract	Y	N	Y or N
"Lazy Eye"	Y	N	Y or N
Eye Injury	Y	N	Y or N
Eye Surgery	Y	N	Y or N
Eye Diseases:			

Current Vision Problems	
Blur @ Dist. w/o glasses	Y or N
Blur @ Dist. w/glasses	Y or N
Blur @ Near w/o glasses	Y or N
Seeing Double	Y or N
Seeing 'flashing lights'	Y or N
Eyes burn, itch, or tear	Y or N
Problems seeing @ night	Y or N
Frequent Headaches	Y or N

Allergies _____ Smoker: Yes or NO

Medications Currently Being Taken _____

Vitamins or Supplements: _____

Please note that the following are additional tests you may choose to do and are an *extra fee.*

1. FUNDUS PHOTOGRAPHY: The ***latest technology in retinal imaging.*** It allows the doctor to see the back of the eye without dilation. To limit any concerns about retinal problems including MACULAR DEGENERATION, GLAUCOMA, RENTINAL HOLES or DETACHMENTS, and SYSTEMIC DISEASES such as DIABETES, STROKE, and HIGH BLOOD PRESSURE, this test is ***highly recommended***. It is a permanent record that would serve as an accurate baseline for future comparison, i.e. more reliable than a doctor's drawings. This additional test is **$25**. (Circle one of the choices below.)

I DO want the Fundus Photography. YES NO I would like to discuss with Doctor.

AS A COURTESY, WE WILL FILE MOST INSURANCE CLAIMS WHEN YOU COMPLETE THE SECTION BELOW AND PROVIDE THE FOLLOWING:

Primary Medical Insurance: _____ Phone#: _____

In order to better serve our patients if you present with a **MEDICAL CONDITION** such as red, dry, itchy eyes we offer the right to file to the appropriate payor for such conditions. This will prompt our staff to file a claim according to the plan provisions for your Primary Medical Insurance.

Vision plans can then be used to file for your glasses or contacts. This will maximize your benefit and minimize your out of pocket cost. I have read and understood this information and I am signing voluntarily. Please note that contact lens benefits will be filed unless patient states otherwise. Please indicate whether you would like your benefits filed for your exam and contact lenses. YES NO

_____
Patient/Guardian's Signature and Date