

Patient Information and Consent

How did you find us?

- Established patient
- Community Impact Magazine
- Direct Mail Postcard/Flyer
- Drove by
- ER Patient
- Family / Friend Referral
- Internet Search
- Hays Free Press Paper
- Health Fair
- Home & Lifestyle Magazine
- Howerton Website
- San Marcos Daily Record
- Yellow Pages
- Yelp

Doctor Referral

Referring Physician: _____

Phone: _____

Reason for Referral: _____

Social Media

- Facebook
- Instagram
- Twitter

Patient Consent for Treatment

1. I voluntarily consent to health care treatment and diagnostic procedures provided by Howerton Eye Clinic, Howerton Surgical Center and its associated physicians, clinicians, and other personnel. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand no guarantee has been or can be made as to the results of the treatments or examinations at Howerton Eye.
2. I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, the treatment and health care operations consistent with the Howerton Eye Notice of Privacy Practices.
3. I agree to be contacted via email or SMS with information related to my visit, such as: a patient portal invitation, post-visit satisfaction surveys, and/or appointment reminders.
4. I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for me medical treatment.

I have received a copy of the Notice of Privacy Practice and Financial Policy Notice. **Initial** _____

Patient or Authorized Person's Signature

Date

Authorization for Use of Disclosure of Protected Health Information

I authorize my physician and/or administrative and clinical staff of Howerton Eye Clinic & Howerton Surgical Center to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices.

Name and relationship of person(s) who you wish to allow access: (e.g. spouse, son, daughter, sibling, caretaker, friend)

Name of Person or Entity:	Relationship:	Phone:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient or Authorized Person’s Signature

Date

Financial Policy Notice

Thank you for choosing Howerton Eye Clinic, PLLC and/or Howerton Surgical Center, LLC. Please understand that the services that you elect to participate in imply a financial responsibility and you are ultimately responsible for payment of your bill. If you have any financial questions about your visit, please contact our Front Desk or Billing Department as soon as possible (512-443-9715, Option 3) as we may have deadlines to resolve discrepancies. We accept cash, checks, credit card and care credit.

Private Pay (Self-Pay): I understand that if I do not have health insurance, full payment is due at the time of service, as well as, payment for any past due balances or bills.

Policy Benefits/Non-Covered Charges: I understand it is my responsibility to know my insurance policy coverage and benefits and to notify Howerton Eye Clinic of any insurance changes in a timely manner. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurance. Services rendered may be considered non-covered by insurance and/or may be subject to a deductible in addition to a copay. I understand I have the right to refuse any services before they are rendered if I think they are non-covered services or not payable by my insurance. We will not become involved in disputes between you and your insurance company regarding non-covered charges, diagnosis, copays, cost-shares, or deductibles. Please refrain from asking our office to change a diagnosis or procedure code in order for the visit to be covered by your insurance company.

Out of Network Insurance Plans: I understand that full payment is required if I choose to be seen using an out of network insurance plan.

In-Network Insurance Plans: I understand I must provide a copy of my current insurance card in order to file an insurance claim. If I do not have my insurance card, full payment may be due at the time of service. I authorize release of my medical information necessary to process an insurance claim on my behalf. I understand that I am financially responsible for all charges and I understand and agree to this financial policy. I request that my medical insurance carrier make any payment to Howerton Eye Clinic, PLLC for services rendered to me.

Managed Care (HMO) Plans of Health Select: I understand it is my responsibility to obtain any and all necessary referrals including referrals for follow up visits if my plan requires one. We will strive to keep you informed of how many visits are remaining on a referral and/or the expiration date, but it ultimately the responsibility of the patient to know this information and to make the necessary arrangements through their primary care physician. If you do not have a current referral on file, you may be asked to reschedule your appointment.

Past Due Accounts: I understand that all outstanding accounts will be turned over to a collection agency after three statements have been mailed out.

Patient Responsibility: I acknowledge it is my responsibility as the patient (or responsible party) to pay my insurance deductible, co-insurance, co-payment, or any other balance not paid by my insurance plan at the time of service. If I am a self-pay patient (or responsible party), I understand that I am responsible for any balances /past due bills at time of service. I hereby authorize Howerton Eye Clinic, PLLC and/or Howerton Surgical Center, LLC to release any/all information necessary to secure payment and request that payment of authorized Medicare and insurance benefits be made on my behalf for all services provided.

Patient or Authorized Person’s Signature

Date

Refraction Policy

A refraction is the process we use to determine your best possible vision or visual acuity, this is an essential part of your exam, which helps your physician asses your overall eye health and functioning. A refraction is NOT a covered test by Medicare and many other insurance plans that consider refractions as a “vision” service, not a “medical” test.

Our office fee for the refraction is \$50.00. If the refraction is performed during your visit, this fee will be collected at the time of service, in addition to any co-payment your plan may require. Should your insurance plan pay us for the refraction we will reimburse you accordingly.

Glasses and contact lens vision rechecks are offered up to 30 days from the date of your paid refraction exam at no charge. After 30 days from your paid refraction exam, any refraction rechecks will be charged. However, your glasses or contact lens coverage or warranties should be discussed with the optical shop where they are purchased. We are not a party to that agreement.

By signing below I acknowledge that I have read the above information and understand that the refraction is a non-covered test by Medicare and many other insurance plans. I accept full financial responsibility for the cost of service and understand it is due at the time of service. I understand that any co-payment, co-insurance or deductible I may have are separate from and not included in the refraction fee.

Patient or Authorized Person’s Signature

Date

Medical Power of Attorney/Guardian

Do you have a Medical Power of Attorney (POA) or Guardian that makes medical decisions on your behalf? _____ YES (Initials) _____ NO (initials)

- If yes, we will need to obtain verbal consent from your POA/Guardian for your examination today. Please provide the contact information for your POA/Guardian under the section below 'Authorization for Medical Information' and we will be happy to contact them on your behalf to obtain verbal consent to proceed with today's exam.
- We will need legal documentation showing you have POA/Guardian, please provide a copy of this to the front desk. If you do not have a copy of this information, would you like us to request this for you? _____ YES (Initials) _____ NO (initials)

Patient or Authorized Person's Signature

Date

Medical vs. Vision Insurance

If you are here for an exam that is being billed under your MEDICAL insurance and no medical diagnosis is found, please be aware that you may be liable for the full cost of the visit.

If you are only here for a glasses or non-medically necessary contact lens prescription and have no other medical diagnosis or complaint for your visit (such as glaucoma, cataracts, diabetes, headaches, etc.) please let our front desk know this prior to your appointment (512-443-9715, Option 3) so that we can make sure we have the correct insurance on file, are able to provide you with an accurate estimated cost for your appointment and collect the correct co-pay upon arrival.