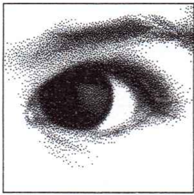

Fernando A. Romero, MD, PA
Pediatric & Adult Ophthalmology

Welcome To Our Practice

Dear Patient,

Welcome to the practice of Dr. Fernando A. Romero. Your visit with us will last approximately 2-2.5 hours. Your time is very valuable to us, and we understand that our visits are long. We make every effort to complete as many tests or procedures that you may require for your condition so that we may reduce the need for additional visits.

Your eyes will be fully dilated to ensure a thorough exam, and may be dilated for several hours afterward. For safety, you may wish to have someone drive you home from each visit.

Please bring the following to each visit:

- Your Drivers' License or Photo ID
- Your current health insurance cards
- Your prescription glasses
- A current list of your medications including dosages and frequency of use
- Sunglasses to wear after your appointment
- Your copay or co-insurance and/or annual deductible is required at the time of each visit.

Please review and fill out the attached forms. You must bring these forms, already filled out, with you on the day of your appointment. We also need to know who your primary physician is, or any other doctors that may need reports.

We have a 24-hour cancellation policy. If you are unable to make your appointment and do not call within 24 hours, you will be charged a missed appointment visit fee.

We strive to make your visit to our office as enjoyable as possible. Please let us know if there is anything we can do to make your visit more pleasant.

Thank you so much!

Fernando A Romero, MD and Staff

Fernando A. Romero, MD, PA
Pediatric & Adult Ophthalmology

Vision and Medical Eye Visit Check-in

PATIENT NAME (printed): ______________________________

A. Patient Visit Types:

- **Medical Eye Exam:**
  These are examinations for diagnosis and treatment of eye diseases. If glasses or contact lenses cannot improve vision, often the cause is related to an underlying medical eye condition. This exam requires dilation of your eyes. Follow-up medical eye exams scheduled throughout the year may not require dilation.

- **Refraction:**
  Refraction is the optical determination of the best possible corrected vision. It is needed to determine if any medical, optical, or surgical treatment may be indicated. It is NOT a covered service by most medical insurance plans. **Our office fee for a refraction is** $ 75.00 and it is collected at the time of service and is in addition to any medical insurance co-payment.

- **Vision Eye Exam (Routine Visit):**
  These examinations (not performed by the ophthalmologist) determine if vision can be improved with glasses and may help identify eye diseases. This visit may or may not require dilation of your eyes. This type of exam is not available for established patients who have diagnosed eye disease or other medical condition that affects the eyes' health.

B. Please check below and sign for the type of exam you have scheduled for today:

☐ **Medical Eye Exam** ☐ **Refraction** ☐ **Routine Vision Eye Exam**

______________________________ ______________________

Patient Signature **Date**

C. Refraction Notice to Patients

Refraction must be performed in order to obtain a prescription. Do you want to receive an eyeglasses prescription today?

☐ **Yes** ☐ **No** **Patient's initials:** ________

Fernando A. Romero, MD, PA
Pediatric & Adult Ophthalmology

Financial Policy

Thank you for choosing Fernando A. Romero, MD as your ophthalmologist. The entire practice is committed to your ophthalmic treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy which you are required to sign prior to any treatment.

All patients must complete our Patient Information Form before seeing Dr. Romero.

We collect all co-payments, deductibles, c-oinsurances and services that are not covered by your medical insurance at the time of service.

We accept cash or credit cards such as VISA, Mastercard, American Express and Discover. We do not accept personal or business checks as payment for services rendered.

Regarding Insurance
We accept assignment of benefits from Medicare, Medicare supplement insurance plans, as well as several insurance companies with which we have managed care contracts. Co-payments, deductibles and fees that are not covered by these insurance companies are your responsibility to pay. In the event that we do accept assignment of benefits with your insurance carrier, we require that you give us your insurance information prior to receiving treatment in order to receive maximum insurance benefit. In the event that you do not allow us to verify your insurance coverage prior to receiving treatment, you are responsible for paying our full charges. You will not receive services at a reduced managed care rate, nor will you receive retrospective reimbursement of the monetary difference between our charges and your insurance carrier's reduced managed care rate.

Regarding insurance plans where we do not have a managed care contract with the insurance carrier, our charges are your responsibility to pay at the time of service, whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.

Usual and Customary Rates
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our geographic area and Dr. Romero's level of expertise as a subspecialist. If you *are not* insured through Medicare or

one of our participatory managed care contracts, you are responsible for full payment regardless of any insurance company's arbitrary determination of usual and customary rates.

In the event that you are approved to pay our charges on an extended payment plan, you must provide a credit card with authorization to bill that account for the balance.

If your insurance company has not paid any portion of your account within 90 days, the balance will be automatically transferred to you.

Appointment Cancellations
We require a 24-hour notice for all appointment cancellations so that patients needing appointments can be put into the schedule upon your cancellation. If you fail to give proper notice, you will be charged a no-show fee of $25.00 for any appointment missed after the first missed appointment. No-show fees cannot be billed to your insurance company.

Medical Records
If you are requesting a copy of your medical record or you would like for us to send them to someone else, we require your authorization and we charge a fee for copying the records. We use the guideline set forth by the Texas State Board of Medical Examiners for our fees for copying medical records.

We charge $15.00 for completing all **health forms,** this includes but is not limited to school health forms, disability forms, work health forms and vision discount plan forms. We do not charge for the simple return to work/school form that is provided for office visits.

Minor Patients
The adult accompanying a minor and the parents (or the guardians of the minor) are responsible for payment at the time of service. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit card, or payment by cash at the time of service has been verified.

Future Appointments
Your signature below allows any member of this practice or our automated patient communication software program to leave messages at your home or office in your absence regarding confirmation of future appointments with Dr. Romero.

Patient Statements
We send patient statements for all balances due after your insurance processes your claim. All payments are due within 25 days of the date on the statement. If we send multiple statements there is a late fee assessed on each statement after the first statement. *If you cannot pay within 25 days, please contact our office to keep your account in good standing.*

Collections

In the event that past due accounts are turned over for collection, charges for rebilling, collection services and attorney's fees will be your responsibility to pay.

I certify that the information I have provided is accurate and I agree to pay all balances due at the time of service plus any additional balance my insurance deems my responsibility once my claims have been processed. I also certify I have read and understand the financial policies of Fernando A. Romero, MD, PA.

______________________________ ____________

Signature of Patient or Responsible Party Date

Print Name: ______________________

______________________________ ____________

Signature of Co-Responsible Party Date

Print Name: ______________________

Fernando A. Romero, MD, PA
Pediatric & Adult Ophthalmology

Patient Information

Refraction

Refraction is the process of determining the eye's refractive error, or need for corrective spectacle lenses. It is part of a medical eye examination, but is ***not*** a covered service by Medicare or most managed care plans. Dr. Romero's charge for a refraction is $75.00 This refraction fee is in addition to a patient's co-pay / co-insurance which must be paid at the time of the visit. If the result of your vision screening is not 20/20, a refraction will be required and you will be assessed the refraction fee.

Acknowledgment

I have read the above statement and understand that a refraction is a non-covered service. I accept full financial responsibility for the cost of this service. The co-pay / co-insurance is separate from and not included in the refraction fee.

______________________________ ______________________
Patient Signature (Parent for Minor) Date

PATIENT REGISTRATION B

PHARMACY INFORMATION:

Preferred Pharmacy	Street Address	City	State	( ) Phone #

PHYSICIAN INFORMATION:

Primary Care Physician	Street Address	City	State	( ) Phone #
Other Physician's Name and Specialty	Street Address	City	State	( ) Phone #
Other Physician's Name and Specialty	Street Address	City	State	( ) Phone #

AUTHORIZATION FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION:

I authorize the physician and/or administrative and clinical staff of **Fernando A. Romero, MD PA** 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., your spouse, son, daughter, sibling, caretaker, friend)

Name of Person or Entity:	Relationship:

I have been provided a copy of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to read and understand and consent to use and disclosure of protected health information about myself for treatment, payment and health care operations.

______________________________ Signature of the Patient or Patient Representative

I have been provided a copy of the Financial Policy to read. I understand, that I, the patient or the patient's representative, am/is responsible for payment of all charges for service rendered. I also acknowledge that non-payment of my account may result in collections proceedings and dismissal from the practice.

______________________________ Signature of the Patient or Patient Representative

I authorize the release of any medical information necessary to process all claims and I authorize the release of payment for medical benefits to ______________________

______________________________ Signature of the Patient or Patient Representative

Name: ______________________________________ DOB: __/__/_____ Appt Date: __/___/______

Are you allergic to any medications? N Y please list: ________________________________

Is the reason for your visit: Annual Dilated Medical Eye Exam Follow-up Visit Eye Problem

If the reason for your visit is due to an eye problem, when did it begin? ________________________

Have you been treated for this condition by another health care provider? ________________________

Did he/she prescribe any medication for your condition? ________________________

Did anything make it better or worse? ________________________

Which eye -- Right Left Both?

Describe the pain if any – Dull Sharp Constant Short-lived Fleeting Intermittent

What makes the pain better or worse? ________________________

Do you have blurry vision? Y N Is it blurry at distance at near both?

Are you currently or have you previously experienced any problem listed below? Please circle Y for yes, and N for no.

Blurred Vision	Y/N	Hypertension	Y/N	Gastrointestinal	Y/N
Eyes Burning	Y/N	Diabetes	Y/N	Kidney	Y/N
Double Vision	Y/N	Thyroid	Y/N	Bladder/Reproductive	Y/N
Dry Eyes	Y/N	Other Endocrine	Y/N	Neurological	Y/N
Eye Pain	Y/N	Hayfever / Allergies	Y/N	Other Psychiatric	Y/N
Itching	Y/N	Sinusitis	Y/N	Skin	Y/N
Loss of Vision	Y/N	Ear/Nose/Throat	Y/N	Cancer	Y/N
Red Eyes	Y/N	Headache / Migraine	Y/N	General (fatigue, fever, weight loss	
Swollen Eye Lids	Y/N	Muscles/Joints/Bones	Y/N	malaise, etc.)	Y/N
Foreign Body Sensation	Y/N	Autoimmune	Y/N	Cardiovascular	Y/N
Sjogren's Syndrome	Y/N	Cholesterol	Y/N	Depression / Anxiety	Y/N
Bleeding Disorders	Y/N	Stroke	Y/N	Seizure Disorders	Y/N

If you circled "Y" to any of the above, please explain: ________________________

____

Are you currently pregnant? Y N Possibility

Have you ever had a blood transfusion? N Y (list dates)________________________

Please list all your medications, dosage and frequency (If you have a list pre-printed you may attach it to this form). Please include vitamins and supplements, if any.

Medication	Dosage	Frequency

Please list all of your eye drops and the frequency of their use: ________________________

____

Please list all surgeries you have had over the past five years: ________________________

____

 Reviewed By: .... Date: ....

COORDINATION OF BENEFITS ACKNOWLEDGEMENT

Doctor Name: DR. FERNANDO ROMERO

Patient Name: ______________________________

Date of Service: ______________________________

Coordinating benefits can help you maximize your coverage and lower your out-of-pocket costs.

I, ______________________________ (patient name) acknowledge that

- The doctor will submit a claim to VSP® for all covered vision services that have been provided.
- The doctor will coordinate coverage with my VSP benefit and other VSP benefits or other insurance plan(s) that I have coverage with.
- This will use my VSP vision benefit for the current eligibility period.

Patient signature: ______________________ Date: ______________________

If you have questions about your VSP benefit, please call VSP Member Services at **800.877.7195.**

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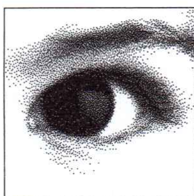

Fernando A. Romero, MD, PA
Pediatric & Adult Ophthalmology

Refraction Reimbursement

Refraction is the process of determining the eye's refractive error or the need for corrective spectacle lenses. While it is a part of the medical eye examination, it is a routine vision service which is not covered by most medical insurance plans.

In order to assist our patients with their vision plans, we will file a claim to your vision plan for the reimbursement of the refraction. At the time of your visit, you will be asked to pay the $75.00 refraction charge. Based on your vision plan's allowed benefit for this service, you will be reimbursed according to the fee schedule of the vision plan.

If you would like our office to file your claim, we will need the following information* in order to submit it to the vision plan. Please PRINT all information below:

VISION PLAN: ____

ID#: ______________________________ GROUP#: ______________

POLICY HOLDER Name and Date of Birth: ______________________________

Social Security #: _______________________ Employer: ______________

Email: ____

PATIENT Name and Date of Birth: ______________________________

*If you wish not to provide this information, it will be your responsibility to file the claim in order to receive any reimbursement.

If you have any questions regarding your vision plan benefits, please call the number located on the back of your plan's membership card.

For Office Use Only DX Code: ______________________