J. Avery Rush, M.D. Sloan W. Rush, M.D.

7308 Fleming Suite A, Amarillo, TX 79106
806-353-0125~FAX: 806-355-0834

Hello LASIK Patient:

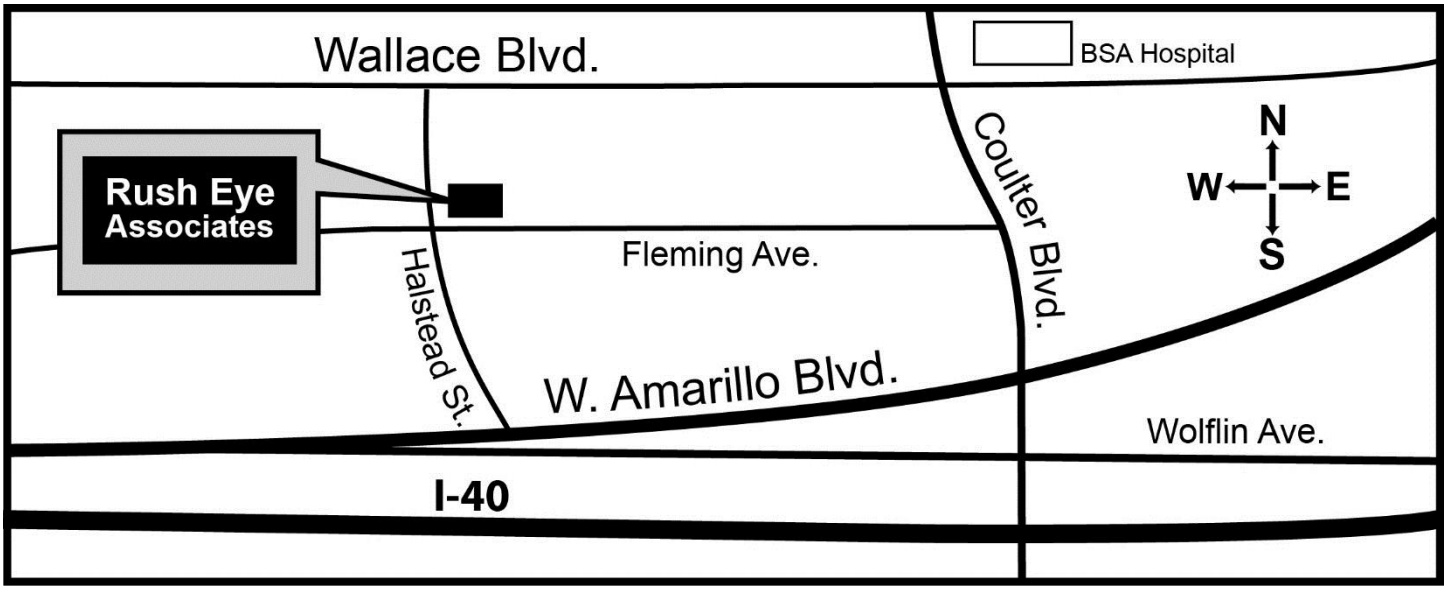
Thank you for making an appointment to see Dr. Rush. Please complete the enclosed paperwork and bring it with you to your appointment. This will help us expedite your check-in process.

Your visit will take about 2 hours and your eyes will be dilated. We will provide sunglasses for your comfort; however, you may wish to make arrangements to have someone drive you. We do not file insurance with vision plans; the cost of the LASIK evaluation is $90. If you schedule LASIK surgery, the $90 will be applied to the surgery charges.

Please bring the completed attached forms and

1) **Your driver's license**
2) **Discontinue soft contact lenses for 1 week, discontinue hard/gas perm contact lenses for 6 weeks.**
3) **Any glasses or contact lens prescription you currently wear.**

We do collect $90 for the LASIK evaluation at check-in. If you are not a LASIK candidate due to eye disease, you may be converted to a medical exam with your consent, in that case we would file your medical insurance. A medical exam is approximately $400 plus the cost of any testing. Please see the map below for your convenience. We are located one block SW of BSA hospital @ 7308 Fleming Avenue. Thank you and we are looking forward to seeing you soon!!



RUSH Eye Associates

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Patient Demographics

Date: _____

Name: _____
Last First Middle

Mailing Address: _____
Street City State Zip

Date of Birth: _____ Age: _____ Sex: M F

Phone: _____
Home Cell Work

Race: _____ Ethnicity: _____ Primary Language: _____

Social Security Number: _____ Email Address: _____

Marital Status: ◯Married ◯Single ◯Divorced ◯Widowed ◯Separated

Name of Spouse: _____ Spouse SS#: ____-___-_____ Spouse DOB: _____

Emergency Contact: _____ Emergency Contact Phone: _____

Relationship to the Patient: _____

Employer: _____ Employer Address: _____

Primary Insurance Coverage: ◯ Y ◯N Name of Insurance: _____
Person Holding Insurance ◯Self ◯Spouse ◯Parent

Secondary Insurance: ◯ Y ◯N Name of Insurance: _____
Person Holding Insurance ◯Self ◯Spouse ◯Parent

Please provide all insurance cards and your driver's license to the front staff each visit

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Is today's visit related to Workers Compensation? ◯Y ◯N Date of Injury: _____

Work Contact Name and Number: _____

Who may we thank for referring you to our office today? _____

What Doctor are you seeing today? _____

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Notice of Privacy Practices

Patient Name: _____ Patient ID: _____

DOB: _____ Social Security Number: _____-___-_____

I hereby acknowledge that a copy of **Panhandle Eye Group** and **Amarillo Cataract and Eye Surgery Center's** Notice of Privacy Practice has been offered to me and I understand that I can request a paper copy at any time. I also understand that I have the right to refuse to sign this acknowledgement if I so choose.

_____ _____

Signature of Patient or Legal Representative Date

_____ ☐ Relationship to Patient (If applicable)

Printed Name or Patient's Representative (if applicable)

- ☐ Parent or guardian of un-emancipated minor
- ☐ Court Appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

For Office Use Only

We attempted to obtain acknowledgement of receipt of our Notice of Privacy Practices on the following date, _____ but acknowledgement could not be obtained for the following reason:

- ☐ Patient/representative refused to sign
- ☐ Emergency situation prevented us from obtaining acknowledgement at this time (we will attempt again at a later date)
- ☐ Communication barrios prohibited obtaining acknowledgement (explain)
- ☐ Other (Specify)

_____

_____

_____

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Assignment of Benefits:

I request payment of authorized Medicare or other insurance benefits for any services furnished to me by **Panhandle Eye Group LLC** and **Amarillo Cataract and Eye Surgery Center**, including physician services to be paid to the provider on my behalf.

_____
Initial

Authorization for Release of Information:

I hereby authorize **Panhandle Eye Group, LLC**, **Amarillo Cataract and Eye Surgery Center,** and any physician who has rendered services to release any and all information pertaining to my (or the patients) treatment to enable collection of benefits for the services rendered. The Authorization includes release of information to insurance companies or healthcare providers, in whole or in part, for payment in exchange for services rendered. A written request provided to **Panhandle Eye Group, LLC and Amarillo Cataract and Eye Surgery** Center in writing will be the only termination of this agreement.

_____
Initial

Authorization for Treatment:

I hereby authorize **Panhandle Eye Group, LLC**, **Amarillo Cataract and Eye Surgery Center,** and any physician the authorization for treatment.

_____
Initial

I hereby have read and agree to the three above statements.

_____ _____
Signature of Patient Or Patient Representative

Date

Vision Correction Consultation

RUSH Eye Associates

7308 Fleming Ave.
Amarillo, TX 79106
Phone: (806) 350-3937

205 E. Llano Estacado
Clovis, NM 88101
Phone: (575) 935-3937

www.rushlasik.com

Today's Date_____

Patient Information

Title: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. Sex: ☐ M ☐ F

Patient: _____
First name

_____
Last Name

DOB: ____/____/_____ Age_____

E-mail: _____

Occupation: _____

Are you currently or have you ever been a member of the armed services? ☐Yes ☐No

Please tell us how you learned about our practice or whom we may thank for referring you to us:

☐ I am an existing or former patient of Rush Eye Associates

☐ Former Patient recommendation _____ Name

☐ Doctor recommendation _____ Name

☐ Family or Friend recommendation _____ Name

☐ Insurance Company recommendation _____ Name

☐ Radio/TV advertisement _____ Name

☐ Internet Search Engine _____ Name

☐ Practice website (www.rushlasik.com)

☐ I heard about Rush LASIK another way _____ Explain

_____

☐ Social Media _____ Which one? (Facebook, Twitter, Instagram)

In the last month, have you seen or heard any of our advertisements? ☐ Yes ☐ No

Primary Care Physician: _____

Eye Doctor: _____

Date of Last Eye Exam: _____

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Eye / Health History

Do you wear glasses? ☐ No ☐ Yes If yes, check all that apply below:

☐ Reading ☐ Driving ☐ Watching TV ☐ All the time

If you wear glasses, do you take them off to read? ☐ No ☐ Yes

Do you wear contacts? ☐ No ☐ Yes If yes, check the type below:

☐ Soft ☐ RGP/Hard ☐ Daily wear ☐ Bifocal

☐ Toric (astigmatism) ☐ Extended wear

☐ Monovision (one distance/one near)

If you wear contacts, do you wear reading glasses over your contacts? ☐ No ☐ Yes

If you wear contacts, what was the last day you wore them? _____

Have you ever been diagnosed with any of the following eye conditions?

Keratoconus ☐ No ☐ Yes

Cataracts ☐ No ☐ Yes

Glaucoma ☐ No ☐ Yes

Macular Degeneration ☐ No ☐ Yes

Dry Eyes ☐ No ☐ Yes

Do you suffer from any of the following conditions?

Diabetes ☐ No ☐ Yes If yes, Type I or Type II? _____

Auto-Immune Disease (rheumatoid arthritis, lupus, HIV, etc) ☐ No ☐ Yes If yes, which?_____

Keloid Former ☐ No ☐ Yes

Have you ever taken any of the following medications?

Accutane ☐ No ☐ Yes

Cordarone (Amiodarone) ☐ No ☐ Yes

Do you take any heart or blood pressure medication? ☐ No ☐ Yes

Have you taken Cortisone or any steroids in last 6 months? ☐ No ☐ Yes

Females:

Are you currently pregnant? ☐ No ☐ Yes

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Eye / Health History

Have you ever been diagnosed with or experienced any of the following conditions?

Heart Disease	☐ No	☐ Yes
Pain in chest when at rest	☐ No	☐ Yes
Pain in chest when exercising	☐ No	☐ Yes
Trouble breathing	☐ No	☐ Yes
Asthma	☐ No	☐ Yes
Bronchitis or a chronic cough	☐ No	☐ Yes
Difficulty climbing a flight of stairs	☐ No	☐ Yes
Do you currently smoke?	☐ No	☐ Yes

If no, have you smoked in the past? ☐ No ☐ Yes

If yes, how many packs/day?_____

If yes, for how many years?_____

Hepatitis or liver disease	☐ No	☐ Yes
Constant back or neck pain	☐ No	☐ Yes
Limb paralysis, numbness or weakness	☐ No	☐ Yes
Muscle or nerve disease	☐ No	☐ Yes
Bleeding problems	☐ No	☐ Yes
Psychiatric, anxiety, depression Alzheimer's/dementia, other psychosis	☐ No	☐ Yes
Mental impairment or learning disability	☐ No	☐ Yes

If yes, please explain:_____

_____

Prior surgery (other than eye)	☐ No	☐ Yes

If yes, please list:_____

_____

_____

Any trouble with anesthesia?	☐ No	☐ Yes

If yes, please explain:

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How interested are you in having LASIK?

□ Just want information and to see if I'm a candidate
□ Interested, but need to think about it
□ I'm ready to have my procedure today!

Have you ever had eye surgery?

□ No □ Yes
If yes: With whom? _____ What type?_____

Have you ever had a LASIK consultation before?

□ No □ Yes
If yes: With whom? _____ When?_____

Have you ever been told you were a good candidate for LASIK?

□ No □ Yes
If no, please explain: _____

If yes, what has stopped you from having the procedure done?

□ Finances □ Fear □ Can't find doctor/practice I'm comfortable with

□ Waiting on new technology

□ Other _____

Are you interested in learning about financing options for LASIK?

□ No □ Yes □ Will arrange my own financing

How soon were you thinking about having LASIK?

□ Within this month
□ 1-3 months from now
□ 3-6 months from now
□ 6-12 months from now
□ Other_____

PLEASE CHECK WHICH OF THESE BEST REPRESENTS YOUR SITUATION

□ I am below the age of 40-45 and I want LASIK to improve my distance vision
□ I am above the age of 40-45, I want LASIK to improve my distance vision and I don't mind wearing reading glasses.
□ I am above the age of 40-45 and I want monovision with LASIK, where one eye sees at distance and one eyes sees at near
□ I am above the age of 40-45 and only wear glasses to read. I am interested in advanced lens implant options so that I may improve my near vision while maintaining my distance vision. I understand LASIK does not correct presbyopia, which is why I need reading glasses.
□ I am above the age of 40-45 and am interested in advanced lens implant options designed to help me see in the distance and at near
□ I am above the age of 40-45 and have already been diagnosed with cataracts and am interested in advanced lens implant options that can help see in the distance and at near