7625 Fleming Ave, Amarillo, TX 79106
806-353-0125~FAX: 806-355-0834

Hello LASIK Patient:

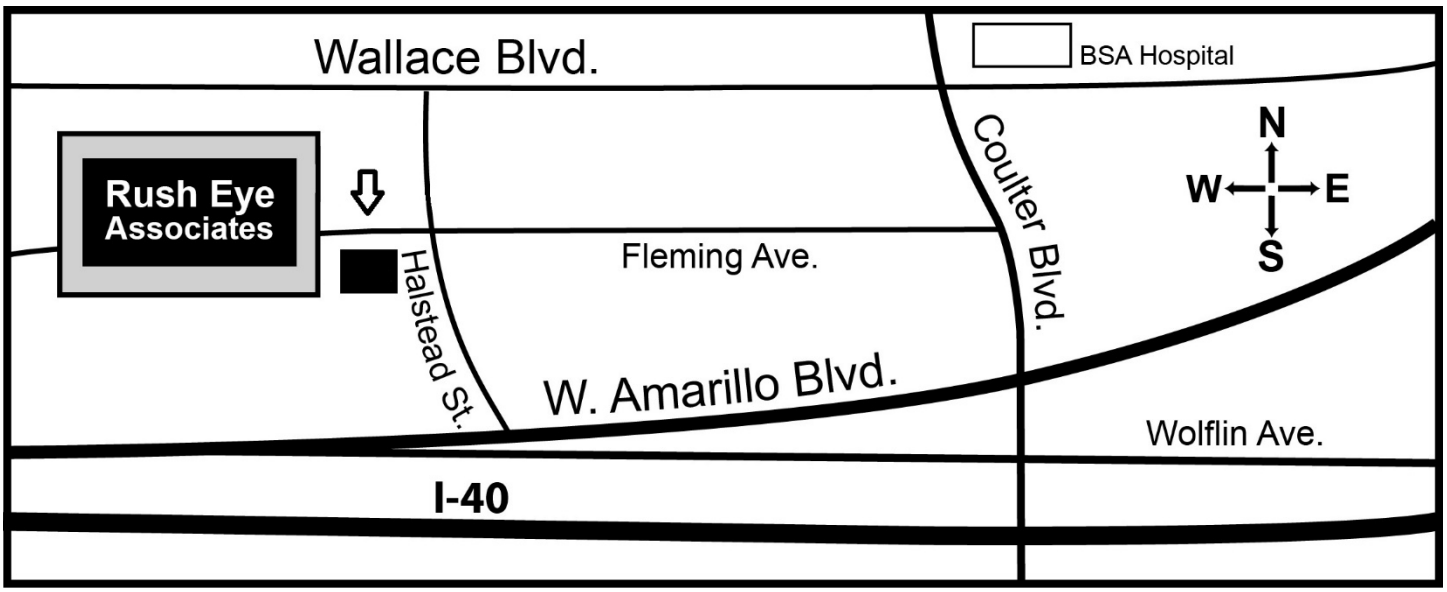
Thank you for making an appointment to see Dr. Rush. Please complete the enclosed paperwork and bring it with you to your appointment. This will help us expedite your check-in process.

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.

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. Please see the map below for your convenience. We are located one block SW of BSA hospital @ 7625 Fleming Avenue. Thank you and we are looking forward to seeing you soon!!



RUSH Eye Associates

7625 Fleming Ave, Amarillo, TX 79106
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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? _____

RUSH Eye Associates

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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

_____
Printed Name or Patient's Representative (if applicable)

☐ Relationship to Patient (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

Eye / Health

History Patient Name: _____ Date_____

Date of Birth: _____Age: _____ Drug Allergies: _____

Primary Care Physician: _____Eye Doctor:_____

Date of Last Eye Exam: _____

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

Have you ever taken any of the following medications?

Accutane	☐ No	☐ Yes
Cordarone (Amiodarone)	☐ No	☐ Yes

Please list any medications you take and dosage: _____

_____

_____

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

Females: Are you pregnant? ☐ No ☐ Yes

Are you nursing a baby at this time? ☐ No ☐ Yes

Do you have any of the following conditions?

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

Keloid Former ☐ No ☐ Yes

Auto-Immune Disease (rheumatoid arthritis, lupus, HIV)? ☐ No ☐ Yes_____

Heart trouble? ☐ No ☐ Yes

Pains in your chest when you exercise? ☐ No ☐ Yes

Pains in your chest at rest? ☐ 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 (or did you) smoke? (Packs per day___? How many years? ___) ☐ No ☐ Yes

Have you had 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? (please explain)_____

_____

Have you had surgery before? ☐ No ☐ Yes

Procedures_____

_____

_____

Did you have any trouble with your anesthesia? ☐No ☐ Yes

Explain:_____

_____

Please Answer If Age 40 or Older

LASIK is a procedure that reduces or eliminates the need for glasses for distance vision. For patients above the age of 40 experiencing near vision difficulties (presbyopia), LASIK will neither cause nor eliminate the need for reading glasses. Are you interested in other alternatives that may enhance your entire range of vision?

☐ No, I want LASIK to improve my distance vision without glasses. I'm OK with reading glasses.

☐ I'm interested in monovision or blended vision with LASIK