Zarmeena Vendal, MD
Natalie Stanciu, MD
Stanley Saulny, MD
Kurt Andreason, MD
Michael Tschoepe, MD

PLEASE FILL OUT ALL BLANKS COMPLETELY

PATIENT INFORMATION

Name:_____Date of Birth: _____ Age: _____

Address: _____ City: _____ State: ____ Zip:_____

Home #:_____ Work #:_____ Cell #:_____

Email: _____ Social Security #:_____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Race: ☐African American ☐Asian Pacific ☐Caucasian ☐Hispanic ☐Native American ☐Other:_____

Occupation:_____ Employer: _____

Employer's Address: _____

Emergency Contact Name:_____ Phone #: _____

_____

Primary Care Physician Name Address Phone # Fax #

_____

Date of Last Eye Exam Name of Previous Eye Care Provider

REASON FOR TODAY'S VISIT

☐Cataract Evaluation ☐Routine Eye Exam ☐Surgery to reduce your dependency on glasses/contacts

Other:_____

Please let us know about your history and family history of eye related problems and indicate whom below.

☐Diabetes_____

☐Glaucoma_____

☐Age Related Macular Degeneration_____

HOW WERE YOU REFERRED TO US

Friend/Family/Acquaintance, Name:_____

Were you referred by a doctor? Name:_____ Specialty_____

_____

Address City, State, Zip Phone # Fax#

☐TV, Channel _____ ☐Radio, Station _____ ☐Magazine_____ ☐Internet ☐Paper

Other:_____

PLEASE TURN OVER, READ AND COMPLETE THE BACK OF THIS FORM

ATTENTION ALL PATIENTS:

Payment is due at the time of service.
Method of payment: □ Cash □ Check □ Credit Card: MC/Visa/AMEX/Discover □ Care Credit

PATIENT AUTHORIZATION – ASSIGNMENT OF MEDICARE AND INSURANCE BENEFITS AND ACKNOWLEDGEMENT OF OUR NOTICE OF PRIVACY PRACTICES

I request that payment of authorized Medicare, Medigap or any other insurance be made on my behalf to the Knolle & Young Associates dba Westlake Eye Specialists for any services furnished to me by a physician of the group. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Serves (CMS) and other insurers and its agents any information needed to determine these benefits payable for related services. In Medicare assignment cases, or insured contracts, the provider agrees to accept the charge determination of the Medicare carrier or insurance and I am responsible for the deductible (Medicare deductible - $183), co-insurance (or the 20% Medicare) or insurer does not pay, and for non-covered services (such as the $50 refraction fee not covered by Medicare and most other insurances). I understand that I am responsible for my bill in the event Medicare or my insurer denies my claim. I authorize release of my medical records to my primary care physician or other physicians associated with the continuity of my care.

My signature below further verifies that I have not joined an HMO or other entity which my designated insurance (Medicare or Insurance card) benefits have been relinquished.

I authorize Knolle & Young Associates dba Westlake Eye Specialists, its assignees, and third party collection agents to utilize all contact information I have provided to communicate with me. This includes, but is not limited to, home telephone, cellular telephone, and employment telephone. I hereby grant permission and consent to Knolle & Young Associates dba Westlake Eye Specialists, its assignees, and third party collection agents to place calls to my home telephone, cellular telephone, and employment telephone; leave messages (whether voice or text); and utilize pre-recorded/artificial voice messages and/or automatic dialing devices in connection with any communication to me. Additionally, I understand that some procedures/services performed by the physician(s) may not be covered by my insurance plan. If services are not covered, I understand and agree to be financially responsible for payment for such services.

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Knolle & Young dba Westlake Eye Specialists Notice of Privacy Practices. By signing below I am only giving acknowledgment that I have had the opportunity to receive the Notice of our Privacy Practices.

Signature _____ Date _____

NOTICE CONCERNING COMPLAINTS:

Complaints about physicians as well as other licensees and registrants of the Texas State Board of Medical Examiners, including physician assistants and acupuncturists, may be reported for investigation at the following address: Texas State Board of Medical Examiners, Attention: Investigations, 1812 Centre Creek Dr., Suite 300, P.O. Box 149134, Austin, TX 78714-9134, 1-800-201-9353.

Complaints regarding Knolle & Young dba Westlake Eye Specialists may be registered with the Department of State Health Services Facility Licensing Group, 1100 West 49th St., Austin, TX 78756, 1-888-973-0022.

TDI's Consumer Protection Program helps consumers with insurance questions and problems. The program can be reached toll-free at (800) 252-3439. In addition, the TDI Web Site offers a wealth of information, including a complete listing of licensed agency, agencies and insurers, and records of enforcement and disciplinary actions by TDI as the regulator of the insurance industry.

Consumers with questions and/or complaints about their own insurance claims, agents and/or insurance companies should call the consumer protection line at TDI and can file complaints with TDI. TDI can investigate individual concerns and answers questions. We encourage consumers to also file complaints with the Office of the Attorney General, but please understand that this agency cannot advise you about your specific situation or explain the law. We are prohibited by law from providing these services to private individuals.

The Office of Public Insurance Counsel (OPIC) represents the interests of Texas consumers in matters such as insurance rates and rules. OPIC is required by law to represent all consumers as a group. Individual complaints that suggest a widespread pattern of practices, or which indicate that a large number of consumers are affected, may lead to action by the agency. Therefore, consumers may wish to complain to the OPIC as well.

Patient Record of Disclosure

The HIPAA privacy rule gives individuals the right to request a restriction on notes and disclosure of their protected health information (PHT). The individual is also granted the right to request confidential communications, or that a communication be made by alternative means.

I wish to be contacted in the following manner: (check all that apply)

_____By my home telephone, my number is:_____

_____It is ok to leave me a message with detailed information.

_____It is NOT ok to leave me a message with detailed information.

_____It is ok to contact me at work and my number is:_____

_____It is ok to leave me a message at work with detailed information.

_____It is NOT ok to leave me a message at work with detailed information.

_____It is ok to leave a call back number only at my work number.

I authorize you to discuss my medical history and release any and all medical information to the following individuals: (fill in all that apply)

_____My spouse, whose name is:_____ Phone:_____

_____My parent, whose name is:_____ Phone:_____

_____No one other than myself

_____Fill in any other name you desire:_____

Patient Signature:_____

Printed Name:_____

Date of Birth: _____

Name of legal guardian/caretaker: _____

Westlake: 5656 Bee Cave Road, Suite F-200; Austin, TX 78746
Kyle: 20871 North IH-35, Suite 100; Kyle, TX 78640
Round Rock: 501 East Palm Valley Blvd.; Round Rock, TX 78664
Phone: (512) 472-4011; Fax: (512) 472-5057

INFORMATION ABOUT REFRACTIONS & WHY THEY ARE TYPICALLY NOT COVERED BY INSURANCE

Federal insurance programs, like Medicare and Medicaid, and even private insurance contracts cover most medical and surgical eye exams, but they typically do not cover the eye service called "refraction".

What is Refraction?

Refraction is a testing procedure that measures how much optical (focusing) error an eye has. Certain eye measurements are taken using a variety of instruments. Based on these measurements, a series of trial lenses are placed in front of your eyes, and you are asked to compare one lens with another to determine which lens combination offers you better vision. This leads to a determination of how well you see.

When Does Insurance NOT Pay for a Refraction?

Most health insurance was not designed to pay for non-emergency or routine procedures. Thus, Medicare, Medicaid, HMOs, and most private policies will not pay for refraction. Almost all insurance payors consider a refraction merely to obtain a prescription to improve vision as a routine procedure and will not reimburse it.

When DOES Private Insurance Pay for Refraction?

Most health insurance will pay for medical examinations. If you have a sudden eye problem or visually threatening medical or surgical eye condition, refraction will be performed as part of your eye evaluation. Refraction in this instance is necessary to learn your eye's best vision capability at the time of the examination. That "best vision" becomes a baseline for checking for any changes that may occur as your eye condition is treated. It is a necessary part of the exam for both medical and legal purposes. In this case, it is possible that the refraction may be covered by your insurance. However, Medicare will not cover refraction under any circumstances.

Who Has Made This Distinction for Insurance Coverage?

It is our government (for Medicare and Medicaid) or your own insurance company that determines exactly which clinical services are covered by their policies, and not your individual physician. Therefore if you have any questions or concerns regarding your coverage, you will need to address these with your specific insurance carrier.

What is Our Policy?

We are dedicated to providing our patients with the very best medical and surgical eye care in the region. Therefore, refraction will be performed when medically necessary (typically this includes all new patients, those presenting with decreased vision and on a yearly basis thereafter). Additionally, we are happy to perform refraction during any visit at your request. However, please keep in mind that most of the time this service will not be covered, and you will be responsible for this charge. We appreciate your understanding in this matter.

Our fee for the refraction is $50.00, and is collected at the time of your visit, in addition to any co-payments or deductible amounts due for the medical portion of your examination.

I have been informed, I have read the above and I understand the above policy regarding refractions.

Signature_____ Date_____

Witness_____ Date_____

Westlake Eye Specialists
The Art of Eye Surgery

PATIENT HISTORY

NAME _____**OCCUPATION**_____ **RACE** _____**DATE**_____
DOB_____**AGE** _____ **HEIGHT**_____ **WEIGHT**_____(as stated by pt) **SEX** □ Male □ Female

MEDICAL HISTORY:

□ Anemia	□ ENT Problems	□ Mumps
□ Anxiety	□ GI Problems	□ Psychiatric Problems
□ Arthritis	□ Glaucoma	□ Pacemaker
□ Asthma	□ Gyn Problems	□ Palpitations
□ Back/Neck Problems	□ HIV	□ Prostate Problems
□ Bleeding Disorder	□ Hard of Hearing	□ Restless Leg Syndrome
□ Bronchitis	□ Heart Attack	□ Retina Problems
□ Cancer	□ Heart Disease	□ Shingles
□ Chest pain	□ Heart Murmur	□ Seizures
□ Chicken Pox	□ Hepatitis Type	□ Sinus Problems
□ Congestive Heart Failure	□ High blood pressure	□ Sleep Apnea
□ COPD	□ High Cholesterol	□ Stroke
□ Depression	□ Kidney/Bladder/Urinary Problems	□ Thyroid Problems
□ Diabetes	□ Liver Disease	□ Ulcers
□ Emphysema	□ Measles	□ Other_____

□ **HISTORY OF HEAD OR EYE TRAUMA** (please describe)_____

SURGICAL HISTORY: (list all prior surgeries to the best recollection)

_____

_____

_____

Complications with anesthesia? □ Yes □ No If yes, what is the complication? _____

FAMILY HISTORY OF OCULAR DISEASE:

□ Macular Degeneration Whom: _____
□ Glaucoma Whom: _____
□ Diabetes Whom: _____

DRUG ALLERGIES: □ No known allergies □ Latex allergy □ Sulfa allergy □ Adhesive tape
□ Medication allergy_____Reaction_____

PHARMACY NAME_____**Location**_____**Phone**_____

MEDICATIONS: If you need to add more medications, please add to the back of this form.

Drug Name	Dosage	Times per day

SOCIAL HISTORY:

Do you smoke? □ Yes □ No PPD_____ Years_____
Do you drink alcohol? □ Yes □ No Drinks per week _____
Substance Abuse? □ Yes □ No Additional details: _____

Westlake Eye Specialists
The Art of Eye Surgery

Name:_____

Date:_____

Healthcare Provider Form

Referring Provider

Physician/Provider Name	**Phone**
Group or Association	**Fax** or Direct Messaging Address
Address	Condition(s) under management

Primary Care Physician, Internist or Family Doctor

Name	**Phone**
Group or Association	**Fax** or Direct Messaging Address
Address	Condition(s) under management

Rheumatologist

Name	**Phone**
Group or Association	**Fax** or Direct Messaging Address
Address	Condition(s) under management

Endocrinologist

Name	**Phone**
Group or Association	**Fax** or Direct Messaging Address
Address	Condition(s) under management

Other Provider(s)

Name	**Phone**
Group or Association	**Fax** or Direct Messaging Address
Address	Condition(s) under management

Westlake Eye Specialists
The Art of Eye Surgery

Acknowledgment of Information

Patients Rights and Responsibilities

I have been given copies of the Patient Rights and Patient Responsibilities of Westlake Eye Specialists. I fully intend to uphold my responsibilities as a patient of this facility, and expect my rights as a patient to be upheld.

Advanced Directives

I have been made fully aware of this facility's policy regarding advanced directives. I have also been made aware of and given information on how to receive information regarding advanced directives.

Disclosure of Ownership

I have been made fully aware that the physician performing my procedure may have an ownership interest in this facility. A schedule of typical fees of services provided by this facility is available upon request. These procedures are performed at hospitals and other outpatient facilities in the community. I have the right to choose where to receive services, including a facility where my physician does or does not have an ownership interest. I have chosen to be treated at this facility.

Assignment of Insurance Benefits

Medicare/ Other Insurance

I hereby assign benefits to be paid, on my behalf, to Westlake Eye Specialists. I understand and agree to be financially responsible for charges not paid within a reasonable time by insurance or other third party payer. I certify the information given with regard to insurance coverage is correct.

Notification:

I have received the Patient Rights, Advanced Directives and Disclosure of Ownership information prior to the date of my procedure at the Westlake Eye Specialists.

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Witness Date

PATIENT'S RIGHTS

1. Patients undergoing surgical procedures in the facilities used by Westlake Eye Specialists have the right to be treated with all due respect, consideration, and dignity. Patients shall be provided appropriate privacy.
2. The patient has the right to be free from all forms of abuse or harassment.
3. Patients have the right to confidentiality. Confidentiality of records of all treatment/procedures performed in the facilities used by Westlake Eye Specialists is the right of each patient. Except as required by law, no patient's medical information will be disclosed to any source without prior legal authorization for approval or refusal from the patient or the patient's legal guardian.
4. Patients have the right to expect proper information. To the best of the knowledge of the Westlake Eye Specialists medical staff, all information concerning the patient's diagnosis, treatment, and prognosis will be provided to the patient. When concern for a patient's health makes it inadvisable to give such information to the patient, such information is made available to an individual designated by the patient or to a legally authorized individual.
5. Westlake Eye Specialists patients are given the opportunity and are encouraged to participate actively in the decision-making process concerning their need for medical and surgical care. Language barriers are dealt with on case by case basis through interpreters provided for the patient, language line, and resources available.
6. Patients have the right to expect all procedures and treatments be explained, and the informed consent provided for each surgical procedure be explained prior to being signed by the patient, or patient's legal guardian, and witnessed. Patients are given ample time for discussion and/or questions of the medical staff regarding their treatment. Postoperative instructions are provided, and complication and/or consequences if pre-op and post-op instructions are not followed completely, are discussed with each patient and/or his legal guardian.
7. Patients have a right to request information regarding advanced directives or present their own advanced directive. The patient has a right to the Westlake Eye Specialists policy regarding advanced directives. It is our policy that the advanced directive will be taken to the Medical Director and after discussion, the Medical Director will explain that we do not follow advanced directives in our surgery center. A copy of the directive will be placed in the patient's chart, but it will be ignored. A patient receiving treatment here will always be given emergency, life saving measures if necessary and/or transferred to a hospital with the advanced directive.
8. All patients of Westlake Eye Specialists have the right to address their physician and/or Westlake Eye Specialists administrator should any problems or questions arise relating to the medical-nursing care provided and/or subsequent billing for services rendered, without compromise to the patient's future access to care. Each concern so expressed will receive a response and consideration will be given to appropriate corrective action channeled through the Quality Management Committee, Patient Safety Committee, and/or the Board of Directors as needed. Grievances will be addressed within 30 days.
9. Patients have a right to be treated regardless of race, color, creed, gender or national origin. Requirements for patients' use of the Westlake Eye Specialists facilities are based solely on the medical needs of the patient without regard to race, color, creed, or national origin. All persons having occasion either to refer patients for admission or recommend Westlake Eye Specialists must do so without regard or the patient's race, color, creed, gender or national origin.
10. Patients have the right to change providers if qualified providers are available. The patient must make request known immediately so an arrangement for rescheduling can be made if necessary.
11. Patients have a right to file any complaints with the Department of State Health Services Facility Licensing Group, located at 1100 West 49th Street, Austin, Texas 78756 1-800-973-OO22.

    They also file complaints with Medicare by using the website for the Ombudsman: http://www.medicare.gov/Ombudsman/resources.asp or they may simply call 1-800-Medicare for help.

WestlakeEyeSpecialists
The Art of Eye Surgery

PATIENT RESPONSIBILITES

The patient and/or his family members have the following responsibilities to Westlake Eye Specialists in order to ensure the best possible results of surgical intervention:

1. The patient has the responsibility to provide accurate and complete information about present chief complaints, allergies and reactions, illnesses, hospitalizations, medications and dosages, and other matters relating to their health. This includes presenting advanced directives to staff prior to surgery or treatment.
2. The patient has the responsibility to report unexpected changes in condition to the responsible practitioner. Also, the patient should express concern regarding inability to comply with a planned course of treatment, and every effort should be made to adapt the treatment plan to the patient's specific needs and limitations.
3. The patient is responsible for requesting additional information or voicing any concern either prior to the day of surgery or while in the preoperative area prior to anesthesia.
4. The patient is responsible for requesting any information regarding their physician's credentials and/or malpractice coverage. Physicians with no malpractice coverage are not granted privileges in this facility.
5. The patient is responsible for reporting clear comprehension of a contemplated course of action and what is expected of him/her and is responsible for following the treatment plan that is developed with the health care provider.
6. The patient is responsible for keeping appointments and, when unable to do so for any reason, notifying us at (512) 472-4011.
7. The patient is responsible for their own actions if refusing treatment or not following the practitioner's instructions. Noncompliance with the proposed course of treatment may lead to further complications or illness.
8. The patient is responsible for following all preoperative instructions, and for leaving valuables at home and is responsible for providing a responsible adult to transport him or her home from the facility after surgery/treatment.
9. The patient is responsible for being respectful and considerate of the rights of other patients and Westlake Eye Specialists personnel and for assisting in the control of noise and distractions, as well as being respectful of property of others, including the facility.
10. The patient is responsible for adhering to and assisting in the enforcement of the no smoking policy throughout the building.
11. Patients can access all services available using our website, www.westlakeeyes.com, or merely by asking for the information. It is the patient's responsibility to ask any questions on information they need clarified.
12. Fees for services will be addressed with each patient before surgery. It is the patient's responsibility to make payment prior to surgery for what is owed out of pocket. The patient is responsible for all expenses not covered by the insurance company, which will be completely assessed after insurance is billed.
13. Patients have the responsibility to inquire about any questions they have located on post-operative instructions.

Westlake Eye Specialists
The Art of Eye Surgery

SPEED II Questionnaire

Date:____/____/____

Name:_____, _____
(Last) (First)

Date of Birth:____/____/_____ Sex: M F (circle one)

(Office Use Only)
Total SPEED Score: _____
(Frequency + Severity)

---

*Report the **FREQUENCY** of any dry eye symptoms you are experiencing using the grid below.*
Please check (✓) one box per line.

SYMPTOMS	Never (0)	Sometimes (1)	Often (2)	Constant (3)
1. Dryness, Grittiness or Scratchiness				
2. Soreness or Irritation				
3. Burning or Watering				
4. Eye Fatigue				

---

*Report the **SEVERITY** of any dry eye symptoms you are experiencing using the grid below.*
Please check (✓) one box per line.

SYMPTOMS	No Problem (0)	Tolerable (1)	Uncomfortable (2)	Bothersome (3)	Intolerable (4)
5. Dryness, Grittiness or Scratchiness					
6. Soreness or Irritation					
7. Burning or Watering					
8. Eye Fatigue					

---

9. Please mark if you have experienced any of the above symptoms:
___Today ___Within the past 72 hrs ___Within the past 3 months

10. Do you have fluctuating vision problems that improve if you blink?
___Never ___Sometimes ___Frequently ____A Lot or Always

11. Do your symptoms affect your daily activities? ___Yes ___No

12. Which activities seem to make your symptoms worst?
___Reading _____Computer Use ___Close-Up Work ___Watching TV

___Outdoor Activities_____Other

13. How long can you do the activity before your eyes start bothering you? _____

Eye drops and/or ointments used: Y N Today? Y N Past 4 hrs? Y N How long are they effective?
Name of drops / ointments / gels: _____
Any moisturizers, lotions or facial creams today? Y N
Any make-up today? Y N
Any history of blepharitis or stye? Y N
Are you a CL's Wearer? SCL's RGP's How long have you been suffering with Dry Eye Symptoms?