Please Print

Patient Information (Circle one: Mr. Mrs. Ms. Dr. Fr. Str.)

Kozlowsky Dolan & Winter Eye Consultants, LLC

Name: _____ Date: _____
First MI Last

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

Home Phone _____ Work Phone _____ Cell Ph _____

E-Mail _____ Soc Sec # ___-___-___ Birth Date _____

Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If College Student FT / PT Name of School _____ City _____ State _____

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Referring Physician _____ Primary Care Physician _____

Person to Contact In Case Of Emergency? _____ Phone _____

Responsible Party

Name Of Person Responsible For This Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Drivers License # _____ Birth Date _____ Soc. Sec. # ___-___-___

Employer _____ Work Phone _____

Is This Person Currently A Patient In Our Office? ☐ Yes ☐ No

Insurance Information

Name Of Insured Person _____ Relationship To Patient _____

Birthdate _____ Soc. Sec. # ___-___-___ Date Employed _____

Name Of Employer _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Phone _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

How Much Is Your Deductible? _____ How Much Have You Used _____ Max Annual Benefit _____

Do You Have Any Additional Insurance ☐ Yes ☐ No If Yes, Complete The Following

Name Of Insured Person _____ Relationship To Patient _____

Birthdate _____ Soc. Sec. # ___-___-___ Date Employed _____

Name Of Employer _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Phone _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

How Much Is Your Deductible? _____ How Much Have You Used _____ Max Annual Benefit _____

Signature of Patient Or Parent/Guardian Of Patient X _____ Date _____

Kozlovsky Delay, & Winter Eye Consultants, LLC

An Alliance of Professional Associations

Medical History Record

Patient Name (please print)_____

Date of Birth _____ Exam Date _____

Employer _____ Occupation _____

Emergency Contact _____ Emergency Contact Phone _____

Date of Last Eye Exam _____ Name of Previous Eye Doctor _____

Referring Physician _____ Primary Care Physician _____

Do you have any of the following eye conditions? If yes, please check box.

- ❑ Dry Eyes
- ❑ Blurred Vision
- ❑ Eye Surgeries
- ❑ Eye Injuries
- ❑ Wear Glasses
- ❑ Wear Contacts

Please explain any eye problems _____

_____

Do you have family history of any of the following? If yes, Please check box.

- ❑ Cataracts
- ❑ Diabetes
- ❑ Glaucoma
- ❑ High Blood Pressure
- ❑ Macular Degeneration
- ❑ Retinal Detachment

Please explain any boxes you have checked _____

_____

Personal Medical Information: Do you have problems with any of these systems? If Yes, please check box

- ❑ Gastrointestinal
- ❑ Ear/Nose/Throat
- ❑ Cardiovascular
- ❑ Respiratory
- ❑ Headaches
- ❑ High Cholestoral
- ❑ Nervous System
- ❑ Genitourinary
- ❑ Musculoskeletal
- ❑ Skin
- ❑ Blood Pressure How Long? _____
- ❑ Mental
- ❑ Diabetes/Endocrine How Long? _____
- ❑ Blood/Lymph
- ❑ Allergic/Immunologic
- ❑ Surgeries (what type & when) _____

_____

List Medications _____

_____

Any allergic reactions to medications or other substances? ❑ Yes ❑ No

If yes, please list allergies _____

_____

Please Check Yes or No

Do you smoke? ❑ Yes ❑ No How Much? _____

Do you drink alcohol? ❑ Yes ❑ No How Much? _____

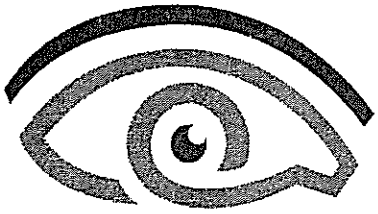
Are you interested in Contact Lenses? ❑ Yes ❑ No

Are you interested in laser vision correction? ❑ Yes ❑ No

Please sign below if you have reviewed all information above and it is correct to the best of your knowledge.

Signature _____ Date _____

FINANCIAL ASSIGNMENT AND AGREEMENT



Kozlovsky Delay & Winter
Eye Consultants, LLC
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1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-pay, co-insurance, or any other balance not paid for by your insurance.
2. In order to control the cost of billing, payment of all charges for which the patient is responsible will be made at the conclusion of each visit unless prior arrangements have been made.
3. I - the patient - request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.
4. This assignment will remain in effect until revoked be me - the patient - in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.
5. Payment of all balances is expected within 30 days of the statement date. In the event of default, for any reason, patient or responsible party will be responsible for any and all attorney fees, court costs, and collection fees.
6. Checks which are returned for insufficient funds will result in a $30 charge to the patient account.

Signature of patient or responsible party Date

Thank you for choosing us as your healthcare provider. We are committed to providing you the best possible medical care and will continue to do so with your assistance and cooperation.

Since we are contracted providers with many different insurance companies and contracts are constantly changing, we ask that you please verify with your insurance company to insure that we .are current providers with them. We feel that it is ultimately the patient's responsibility to know their insurance benefits.

We will verify insurance benefits however, "Verification of benefits is not a guarantee of payment. All benefits are subject to terms, conditions and exclusions of the patient's healthcare contract." Please br aware that some, and/or perhaps all, of the services provided may be non-covered services and therefore your responsibility. Thank you for your cooperation in this matter.

Signature of patient or responsible party Date

NOTICE OF PRIVACY PRACTICES

Kozlovsky, Delay & Winter Eye Consultants, LLC
(An Alliance of Professional Associations)
2929 Mossrock Suite 104
San Antonio, TX 78230
210-377-0350 Voice 210-377-2982 Fax

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we will ask you for special written permission.

We will ask for special written permission in the following situations; any request for medical records.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;
- [specify other uses and disclosures affected by state law].

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your eye care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of [*Kozlovsky, Delay & Winter Eye Consultants*] Notice of Privacy Practices.

Patient name _____

Signature _____ Date _____

Kozlovsky Delay & Winter
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2929 Mossrock
Suite 104
San Antonio, TX 78230
210-377-0350

INFORMATION REGARDING THE EYE EXAM AND REFRACTIONS

The normal healthy eye can "refract" or focus light without the help of any other lenses such as glasses or contacts. If the eye cannot focus an image sharply and requires another lens to assist it, then the eye is said to have a "refractive error."

The procedure to determine a prescription for eyeglasses or contact lenses is called a refraction. **However, a prescription for glasses or contact lenses is not the only purpose for performing a refraction. It is medically important for your eye doctor to know if any changes are occurring in your vision or prescription and to follow these changes over time.** The way to determine if any changes are occurring is by performing a refraction.

Unfortunately, most medical insurance companies have unilaterally determined that they do not pay for the refractive portion of the exam. This is a decision which the insurance companies have made in much the same way that they determine the cost of the co-pay, the cost of co-insurance and services which are applied to the deductible. We all wish this were not so.

If you are being seen under the benefit of a vision plan, such as VSP or Spectera, the refraction will be paid by the insurance company. However if you are using the benefit of a medical insurance, the cost of the refraction will almost always be the patient's responsibility.

Please keep in mind that the refraction is one of the most time consuming portions of the eye exam. The average time needed to perform a refraction is about 10 - 15 minutes but may be as much as 20 – 25 minutes for more difficult prescriptions. It is expensive for us to train and maintain the staff necessary for this to be done properly and accurately. For this reason we must ask the patients to pay for the refraction.

The cost of the refraction is $35.

Thank you for your understanding.

_____ _____

Patient (or person authorized to sign for patient) Date

Revised 10/2007

Kozlovsky Delay & Winter
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2929 Mossrock
Suite 104
San Antonio, TX 78230
210-377-0350

INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the eye doctor to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your eye doctor to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Dr. John Kozlovsky, Dr. Richard Delay or Dr. Bruce Winter and/or such assistants as may be designated by them to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

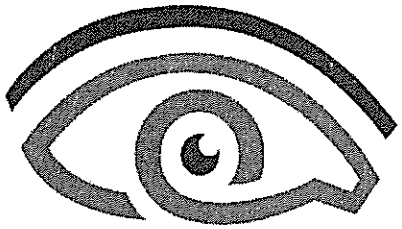
_____ _____

Patient (or person authorized to sign for patient) Date

_____ _____

Witness Date

Revised 12/2002



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Cancellation Policy/No Show Policy

For Doctor Appointments and Surgery

1. Cancellation/ No Show Policy for Doctor Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment.

Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a forty dollar ($40) fee; this will ***not*** *be covered by your insurance company.*

2. Scheduled Appointments

We understand that delays can happen however we must try to keep the other patients and doctors on time. If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.

3. Account balances

We require that patients with "self pay" or "patient responsible" balances do pay their account balances to zero (0) prior to receiving further services by our practice.

Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns.

Patients with balances over $100 must make payment arrangements prior to future appointments being made.

Patient Name	Patient/Responsible Signature	Date