Welcome New Patient:

Thank you for choosing Clear Vision San Antonio for your eyecare needs. We have several locations to serve you.

SAN ANTONIO

- 8002 West Ave, San Antonio, TX 78213
- 1314 E Sonterra Blvd, Suite 2103, San Antonio, TX 78258

EAGLE PASS

- Eagle Pass at 2149 El Indio Hwy, Ste 2, Eagle Pass, TX 78852

Our mission is to provide exceptional patient care and customer service. In order to meet those standards, please take time to review the enclosed New Patient paperwork which include;

- Patient Registration and Consent Forms
- Patient Medical Questionnaire
- Notification for Patient's Rights and Responsibilities/Notice of Privacy Practices
- Patient Financial Responsibility Acknowledgement Form/Credit Card on File
- Refraction Policy

On the day of your appointment please bring the following:

- Completed forms in New Patient Packet
- Insurance card(s)
- Picture ID or Driver's License
- Your medication bottles (prescribed or over the counter)

At Clear Vision San Antonio our goal is to provide quality patient care in a timely manner. Please be courteous and call our office if you are unable to keep your appointment or if you are running late. This time will be reallocated to someone who is in urgent need of treatment. Please note failure to give a 48 hour cancellation notice may result in a fee being assessed to your account, fee will be determined based on appointment type. This fee is not billed to your insurance and you will be responsible to pay it out of pocket.

As a courtesy you will receive a phone call reminding you of your appointment time unless prior arrangements have been made with our business office, all payments are due at the time of your visit.

If you have any questions or concerns about your upcoming visit, please don't hesitate in calling our office at (210) 904-2020. We look forward to seeing you soon.

Clear Vision San Antonio

Clear Vision San Antonio

Diplomat of the American Board of Ophthalmology

Date:_____ ☐New Patient ☐Annual Update ☐New Information

TODAY'S VISIT

What is the reason for your visit today? _____

Referring Provider: _____ PCP Provider :_____

PATIENT INFORMATION

Last Name:_____ First Name:_____ MI: _____

Home Address:_____

City State Zip

Mailing Address:_____

City State Zip

Patient Phone Numbers (Please check the box after the phone numbers where we may leave detailed messages):

Home: ☐ (_____)_____ Cell: ☐ (_____)_____ WK: ☐ (_____)_____

Personal Information

Age:_____ Date of Birth: _____ Social Security #: _____

Email: _____ Employer:_____

Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Full-time Student? ☐ No ☐ Yes

GOVERNMENT REQUIRED FOR ELECTRONIC HEALTHCARE REPORTING ALL PATIENTS MUST COMPLETE THIS SECTION

☐ African American ☐ American Indian / Alaskan Native ☐ Asian ☐ Hispanic

☐Native Hawaiian / Pacific Islander ☐ White ☐ Other Race ☐ Would rather not respond/report

☐ English Speaking ☐ Non-English Speaking

Spouse or Parent/Guardian Information

Last Name:_____ First Name:_____ MI:_____

Address, if different: _____ City, State, Zip: _____

Home: ☐ (_____)_____ Cell: ☐ (_____)_____ WK: ☐ (_____)_____

Age:_____ Date of Birth: _____ Social Security #: _____

Employer:_____ Occupation: _____

Emergency Contact Last Name:_____ First Name: _____

Home: ☐ (_____)_____ Cell: ☐ (_____)_____ WK: ☐ (_____)_____

Relationship: ☐ Spouse ☐ Parent ☐ Friend ☐ Co-worker ☐ Other:_____

Clear Vision San Antonio

Diplomat of the American Board of Ophthalmology

Patient Name: _____ DOB: _____

Clinical Information:

Preferred Pharmacy: _____ Telephone:_____

Preferred Laboratory: _____

How did you hear about us? ☐ Physician ☐ Internet ☐ Insurance Carrier ☐ Friend/Family ☐ Website ☐ Hospital

☐ Other_____

INSURANCE INFORMATION

*****Are you under the age of 65 and eligible for Medicare due to disability? ☐ YES ☐ NO**

MEDICARE/MEDICAID PATIENTS

Have you recently enrolled with a replacement policy? If yes, please identify _____

Are you covered under a HMO/PPO policy which makes Medicare your secondary insurance? ☐ NO ☐ YES, PLEASE COMPLETE MSP YEARLY QUESTIONNAIRE FORM IF NOT DONE SO FOR THIS OFFICE.

PRIMARY INSURANCE

Name of Insurance: _____

Name of Subscriber:_____ Subscriber's DOB:_____

Subscriber's SSN # _____ Sex:_____ Employer: _____

Patient Relation to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy Effective Date:_____ Policy #_____ Group # _____

SECONDARY INSURANCE

Name of Insurance: _____

Name of Subscriber:_____ Subscriber's DOB:_____

Subscriber's SSN # _____ Sex:_____ Employer: _____

Patient Relation to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy Effective Date:_____ Policy #_____ Group # _____

TERTIARY INSURANCE

Name of Insurance: _____

Name of Subscriber:_____ Subscriber's DOB:_____

Subscriber's SSN # _____ Sex:_____ Employer: _____

Patient Relation to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy Effective Date:_____ Policy #_____ Group # _____

Clear Vision San Antonio

Diplomat of the American Board of Ophthalmology

Patient Name:_____ **DOB:**_____

GENERAL CONSENT FORMS

CONSENT TO TREATMENT

I consent to any medical treatment, laboratory procedures, diagnostic or therapeutic treatment, or any other services rendered by the staff of Clear Vision San Antonio, **(collectively referred to herein as CVSA)** under the general or special instructions of the physician. I also consent to the admission of observers and/or assistants to the room where procedures, tests, or examinations are performed and to the disposal of any specimens removed in accordance with CVSA policy.

PATIENT INITIALS: _____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign to CVSA reimbursement benefits on all insurance policies otherwise payable to me for services rendered. I authorize CVSA to submit insurance claims to insurance companies or plan administrators and to apply insurance proceeds to the CVSA bill and to make refunds to insurance companies, if refunds are due, under provisions of such insurance policies. I hereby assign all rights, as the insured, to bring any action against my insurance company for benefits due under the insurance policies.

PATIENT INITIALS: _____

ELECTRONIC PRESCRIPTION

I give my permission to obtain all my medications /prescription history when using an electronic system to process prescriptions on my behalf.

PATIENT INITIALS: _____

AUTHORIZATION DISCLOSURE AUTHORIZATION FORM (OPTIONAL)

In general, the HIPAA privacy rule gives individuals the right to request uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home or discussing PHI with family members. Individual's you authorize CVSA to disclose specific PHI:

BY LAW WE DO NOT DISCLOSE ANY INFORMATION CONTAINING DRUG, ALCOHOL, MENTAL HEALTH STATUS, OR SEXUALLY TRANSMITTED DISEASES, INCLUDING HIV/AIDS RELATED INFORMATION BY PHONE TO ANYONE

NAME	RELATIONSHIP	TELEPHONE

I HAVE READ A COPY OF THE NOTICE OF PRIVACY PRACTICES? ☐ YES ☐ NO INITIAL: _____
AND UNDERSTAND THAT I AM ENTITLED TO A COPY UPON REQUEST

I HAVE RECEIVED CVSA's FINANCIAL POLICY AND DISCLOSURE ☐ YES ☐ NO INITIAL: _____

I HAVE RECEIVED A COPY OF CVSA's PATIENT RIGHTS & RESPONSIBILITIES & DISCLOSURE OF OWNERSHIP ☐ YES ☐ NO INITIAL: _____

_____ _____

Patient Signature **Date**

Medical History Questionnaire

Clear Vision San Antonio

Diplomat of the American Board of Ophthalmology

Patient Name: _____ DOB: _____

YOUR EYE HEALTH

Date of last eye exam: _____ How old are your glasses? _____

Do you currently have trouble with bright lights or night vision? ❍ Yes ❍ No

Do you wear contact lenses? ❍ Yes ❍ No If so, what type of contacts? ❍ Soft ❍Toric ❍Hard ❍ Rigid Gas Permeable ❍ Disposable ❍ Daily Wear ❍ Extended Wear

Have you ever had a corneal abrasion or erosion? ❍ Yes ❍ No

Have you been treated for Dry Eye? ❍ Yes ❍ No

Have you ever had any surgery, injuries, or laser treatments to the eye? ❍ Yes ❍ No If so, please list: _____

_____

Please list any eye drops you are currently using: _____

_____

MEDICAL HISTORY

Do you have or have you ever been treated for the following?

❍ Stroke	❍ Ulcer	❍ Heart Diseases	❍ Seizure	❍ Stomach Disorder
❍ Heart Attack	❍ Brain Tumors	❍ Digestive Disease	❍ Bypass Surgery	❍ Other Brain or Nerve Disorders
❍ Asthma	❍ Liver Disease	❍ High Blood Pressure	❍ Hepatitis B or C	❍ Other Heart Disease
❍ Emphysema	❍ Autoimmune	❍ Pneumonia	❍ Tuberculosis	❍ Other Blood Vessel Disorders
❍ Arthritis	❍ Keloids	❍ Kidney Stones	❍ Kidney Infection	❍ Nephritis

❍ Currently Pregnant or Nursing ❍ Cancer/Tumor, Type: _____

❍ Diabetes, if so, how long? _____ Are you currently taking insulin? _____

❍ Keratoconus or have any other conditions that cause thinning of the cornea

❍ Cornea Transplant ❍ Herpes Eye Infections ❍ Take Accutane ❍ Take Cordarone or Imitrex

FAMILY HISTORY

Is there a family history of the following?

❍ Cataracts	❍ Glaucoma	❍ Retinal Disease	❍ Diabetes	❍ Blindness	❍ Strabismus
❍ Keratoconus	❍ Corneal Transplant	❍ Other Corneal Diseases _____			

MEDICATIONS/ALLERGIES

Medications you are allergic to: _____

Medications you are currently taking, including over the counter: _____

_____

List any previous surgeries: _____

_____ _____

Patient Signature **Date**

Clear Vision San Antonio
Patient's Rights and Responsibilities

Every patient has the right to be treated as an individual with his rights respected. We want to assure that the rights of all patients coming to Clear Vision San Antonio are respected without regard to sex, culture, economic status, education handicap, race, color, age, or religious background.

PATIENT RIGHTS

- To receive treatment without discrimination as to race, color, religion, sex, national origin, disability, or source of payment.
- To receive consideration and respectful care from competent personnel in a clean and safe environment. To be free from mental, physical, sexual and verbal abuse, neglect, and exploitation. And free from use of unnecessary restraints. Drugs and other medications shall not be used for discipline of patients or for convenience of facility personnel.
- To understand the indications for the procedure. To receive all the information they need to give informed consent for any procedure, including the possible risks and benefits of the procedure.
- To receive complete information regarding diagnosis, planned treatment and prognosis, as well as alternative treatments/procedures and the possible risks/side effects associated with treatment. If medically inadvisable to disclose to the patient such information, the information is given to a person designated by the patient or to a legally authorized individual.
- To participate in all decisions involving health care, except when such participation is contra- indicated for medical reasons.
- To refuse treatment in accordance with laws and regulations and to be told what affects this may have on their health.
- To assure safe use of equipment by trained personnel.
- To be provided privacy, confidentiality and integrity of all information and records regarding their care.
- To be provided privacy, safety and security of self and belongings during the delivery of patient care service.
- To have the right to access information contained in their medical record. To approve or refuse the release of their medical records except when it is required by law and to ask for an accounting of such.
- To be aware of fees for service and the billing process.
- To complain without fear of reprisals about the care and services that they are receiving.
- Has the right to be informed of any research or experimental projects and to refuse participation without compromise to the patient's usual care.
- The right to continuity of health care. The physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient sufficient opportunity to make alternative arrangements.
- To be informed if the facility has authorized other healthcare and educational institutions to participate in the patient's treatment. The patient also shall have a right to know the identity and functions of this institution and to refuse to allow their participation in the patient's treatment.
- To be assured that in the event of needed long-term care; this organization will provide the mechanisms to help advance the development of continuing quality care for those patients who require it.
- The right to appropriate assessment and management of pain.

PATIENT RESPONSIBILITIES

- To provide accurate past and present medical history present complaints, past illnesses, hospitalizations, surgeries, existence of advance directives, medication and other pertinent data.
- For asking questions when they do not understand something regarding their care or treatment.
- For assuring that the financial obligations for health care rendered are paid in a timely manner.
- For their actions if they should refuse a treatment or procedure, or if they do not follow or understand the instructions given them by the physician or CVSA employee.
- For keeping their procedure appointment. If they anticipate a delay or must cancel, they will notify the Center as soon as possible.
- For the disposition of their valuables, as CVSA does not assume this responsibility.
- For showing respect and consideration to other people and property.

COMPLAINTS/GRIEVANCES

Clear Vision San Antonio regard the doctor-patient relationship to be sacred, requiring trust, mutual respect, and confidentiality. To that end, if you have any comment, grievance or complaint regarding the care you received by this facility or a physician or employee of this facility, please voice your concern by letter, email or telephone call our Practice Administrator.

Clear Vision San Antonio
Attention: Practice Administrator
8002 West Ave
San Antonio, TX 78213
Telephone: (210) 904-2020 Email: info@2102020.com

Notice of Privacy Practices

Clear Vision San Antonio

Eff: 09/2025

Please Read and Sign

This notice describes how medical information about you may be used, disclosed, and how you can get access to this information. Please review this document carefully.

Patient Health Information (PHI)

Under federal law, your patient health information (PHI) is protected and confidential. Patient health information (PHI) includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your patient health information (PHI) also includes payment, billing and insurance information. We are committed to protect the privacy of your PHI.

How we use your patient health information (PHI)

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations, for administrative purposes, for evaluation of the quality of care, and so forth. We may also share your PHI for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI. Under some circumstances we may be required to use or disclose your PHI without your consent.

Treatment: We will disclose your PHI to provide you with medical treatment or services. We may also disclose your PHI to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, to laboratories performing tests, and to family members who are helping with your care, and so forth.

Payment: We will use and disclose your PHI for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan. PHI may be shared with the following: billing companies, insurance companies (health plans), government agencies in order to assist with qualifications of benefits, or collection agencies.

Operation: We may ask you to complete a sign-in sheet or staff members may ask you the reason for your visit so we can better care for you. Despite safeguards, it is always possible in a doctor's office that you may learn information regarding other patients or they may inadvertently learn something about you. In all cases, we expect and request that our patients maintain strict confidentiality of PHI.

We may use and disclose your PHI to perform various routine functions (e.g. quality evaluations or records analysis, training students, other health care providers or ancillary staff such as billing personnel, to assist in resolving problems or complaints within the practice). We may use your PHI to contact you to provide information about referrals, for follow-up with lab results, to inquire about your health or for other reasons. We may share your PHI with Business Associates who assist us in performing routine operational functions, but we will always obtain assurances from them to protect your PHI the same as we do.

Special Situations that DO NOT require your permission: We may be required by law to report gunshot wounds, suspected abuse or neglect, and so on; we may be required to disclose vital statistics, diseases, and similar information to public health authorities; we may be required to disclose information for audits and similar activities, in response to a subpoena or court order, or as required by law enforcement officials. We may release information about you for worker's compensation or similar programs to protect your health or the health of others or for legitimate government needs, for approved medical research, or to certain entities in the case of death. Your PHI may also be shared if you are an inmate or under custody of the law which is necessary for your health or the health and safety of other individuals.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities, for the purpose of a determination by the Department of Veteran Affairs of your eligibility for benefits, or to foreign military authority if you are a member of that foreign military services.

In some situations, we may ask for your written authorization before using or disclosing any identifiable health information about you. If you sign an authorization, you can later revoke the authorization.

Individual Rights

You have certain rights with regard to your PHI, for example:

Unless you object, we may share your PHI with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. We may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts.

You may request restrictions on certain uses and disclosures of your PHI. We are not required to accept all restrictions. If you pay in full for a treatment or service immediately, you can request that we not share this information with your medical insurance provider or our Business Associates. We will make every attempt to accommodate this request and, if we cannot, we will tell you prior to the treatment.

You may ask us to communicate with you confidentially by, for example, sending notices to a special address.

In most cases, you have the right to get a copy of your PHI. There will be a charge for the copies.

If you believe information in your record is incorrect, or if important information is missing, you have the right to request that we amend the existing information by submitting a written request. You may request a list of instances where we have disclosed PHI about you for reasons other than treatment, payment, or operations. The first request in a 12 month period is free. There will be charges for additional reports.

You have the right to obtain a paper copy of this Notice from us, upon request. We will provide you a copy of this Notice on the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible. You have the right to receive notification of any breach of your protected health information.

Our Legal Duty

We are required by law to protect and maintain the privacy of your PHI, to provide this Notice about our legal duties and privacy practices regarding PHI, and to abide by the terms of the Notice currently in effect. We may update or change our privacy practices and policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the admissions area and on our website at www.DoctorsCare.com. You can also request a copy of our Notice at any time.

If you are concerned about your privacy rights, or if you disagree with a decision we made about your records, you may contact the Privacy Officer listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. You will not be penalized in any way for filing a complaint

Contact Person

If you have any questions, requests, or complaints, please contact:

Clear Vision San Antonio

Attention: Privacy Officer
8002 West Ave
San Antonio, Texas, 78213

Patient Acknowledgement

My signature verifies that I have been provided a copy of Clear Vision San Antonio's "Notice of Privacy Practices" to review. I understand that if I would like a copy of this Notice, CVSA will provide me with a copy of this documentation.

_____	_____	_____	_____
Patient's Name	Date of Birth	Signature	Date

Clear Vision San Antonio
Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to providing you with exceptional medical care. Part of this commitment is providing you with a clear outline of our operational and financial policies. In response to the complex healthcare industry, we have taken the steps to optimize our operations in order to spend more time on patient care and less time on administration. Please carefully read items below as they are strictly enforced.

Financial Responsibility
Please understand that you are ultimately responsible for payment of medical services you receive. *Insured patients, know your insurance plan and what your benefits are.*

We will collect your deductible, co-pay, uncovered services or the percent you are responsible for at the time of your visit. Please be prepared to pay at the time of check-in, before you are seen by the provider.

SELF-PAY PATIENTS: This category includes patients with no insurance and the patients who have an insurance plan with which we do not participate. Payment for medical services is required prior to services being rendered. We accept Visa, MasterCard, Discover and American Express, checks, cash and money orders. We will provide you with a receipt.

Proof of Identity/Insurance
All patients must complete our patient information form(s), provide photo ID and current valid insurance cards. We will submit claims to your insurance carrier and assist you in any way we possibly can. It is important that you keep us informed regarding any changes in your insurance information.

Refractions for Eyeglasses
If you are requesting a prescription for eyeglasses., you will need to have a refraction done by your provider. Unfortunately, this service is not covered by Medicare nor private insurance plans. The fee for this service is **$80.00** and will need to be paid prior to services being rendered.

Referrals and Pre-Authorization
We make every effort to obtain appropriate insurance referral and authorizations prior to an office visit or procedure. However it is ultimately your responsibility to verify that these referral/authorizations are in place prior to services/test/procedures being performed. If services are performed without valid referral/authorization, you may be financially responsible for the entire bill.

Co-pays/Deductibles
All co-payments, deductibles, co-insurance and past due balances are due at time of service. These amounts are part of your contract with your insurance company. Failure to pay can be considered a breach of contract.

Returned Checks
There will be a **$35.00** charge on all returned checks.

Credit Card on File
We continue to look for ways to make your healthcare experience as hassle-free as possible. One of these things we can do is minimize paperwork, mail and additional fees associated with issuing patient's statements for balances un-collected at time of service. We have implemented a new process that allows us to charge your credit card on file once payment is received from your insurance company. Your authorization is **ONLY** to charge for any outstanding balance identified as patient responsibility.

Missed Appointments/Late Cancellation Fee
Clear Vision San Antonio is dedicated to providing the highest quality care to patients and want to thank you for the privilege of providing your care. Every scheduled appointment that is missed jeopardizes the patient/physician relationship and prevents us from providing care to other patients in need. Additionally, procedure appointments require medications and supplies being ordered and prepared in advance specifically for those patients.

We require notification of cancellation at least 48 hours prior to the appointment or earlier if possible. This can be done by calling our office @ (210)904-2020, if calling after hours you may leave a message or send a text with your name, DOB and appointment information.

A "**No Show**" is missing a scheduled appointment. A **"Late Cancellation"** is canceling an appointment without calling us to cancel 48 hours in advance of an office visit or a procedure. We understand that situations such as medical emergencies occasionally arise when an appointment cannot be kept and adequate notice is not possible. These situations will be considered on a case by case basis.

FEES **PHYSICIAN APPOINTMENTS $30.00** **PROCEDURES $50.00** **SURGERY APPOINTMENTS $300.00**

Additional Fees
- Please be aware that there may be charges involved for administrative requests that our office performs such as completion of disability forms, medical records, and yearly financial statements.

PATIENT ACKNOWLEDGMENT
I have read and understand Clear Vision San Antonio's Financial Policy.

_____
Patient Name (Please Print)

_____ _____
Patient Signature Date

Clear Vision San Antonio
Refraction Policy

1. What is a refraction?
   Refraction is the process of determining the eye's refractive error, or need for corrective glasses and/or contact lenses.

2. Why is it necessary?
   Refraction is sometimes necessary depending on the patient's diagnosis and/or complaints presented that day. For example, if a patient is experiencing blurred vision or a decrease in visual acuity on the eye chart a refraction would be needed to see if this is due to a need for glasses or due to a medical problem. The refraction is an essential part of an eye exam, however, Medicare and most insurances **DO NOT** cover it. These plans consider refraction a "vision" service, not a "medical" service. These plans allow that we charge separately for that portion of the examination since it is not a covered service.

3. What if I do not want the refraction?
   You may decline this part of the exam. Please notify the technician PRIOR to the beginning of the exam that you want this step skipped. IMPORTANT: If you decline we may not be able to determine the cause of your decrease in vision.

4. How much is it?
   The charge is $80.00 for this service. This is in addition to the office visit copay and /or deductible which is set by your insurance carrier. The refraction is due at the time services are rendered. We will bill your insurance according to the individual contracted fee schedules. However, if your insurance pays the fee we will gladly refund you this prepaid $80.00 amount upon receiving notice from your insurance.

ACKNOWLEDGEMENT I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service. The copay and deductible are separate from, and not included in the refraction fee. I understand that I am responsible for this fee if I fail to decline this service before it is performed.

_____

Patient Name (Please Print)

_____ _____

Patient Signature Date