



Leading the way to clear, healthy vision

Wesley K. Herman, MD Joseph M. Constable, OD Syed M. Ahmad, MD Abdulfatah Ali, MD

Advanced medical & surgical eyecare

- Cataract surgery & intraocular lens implants
- Medical & surgical treatment of glaucoma
- Treatment for diabetic retinopathy, macular degeneration, retinal detachment & trauma
- Laser vision correction (LASIK/PRK) & refractive lens procedures

Personalized care & conveniences

- Most insurance accepted & filed
- Visa, MasterCard, American Express & Discover welcome
- Financing plans
- Transportation available for seniors
- Convenient appointment times
- Free, handicapped accessible parking

Dear _____ :

Thank you for choosing Vision Quest - EyeCare & SurgeryCenter for your eye care needs. We appreciate your business and we look forward to seeing you on:

(Day) _____ (Date) _____ (Time) _____

for your appointment at our office located in

Dallas

5421 La Sierra Drive

Greenville

4501 Joe Ramsey Blvd #110

Enclosed you will find a profile of your doctor and a map to our office.

Please fill out the enclosed forms completely:

- Patient Profile (2 pages)
- Patient Communication Form
- Patient History Form

Please bring these 4 forms, along with your insurance card(s) and a list of all your current medications to your appointment. Since insurance benefits frequently change, if you are enrolled in a PPO or HMO insurance plan, please contact your insurance company or plan administrator to verify our doctors' participation in your Network. If you have a POS, HMO or EPO insurance plan, you may need a referral from your Primary Care Provider (PCP) prior to your visit. Please check your insurance plan before your visit.

Every attempt is made to complete all tests on the day of your visit to save you additional trips back to our office. If you are wearing contact lenses, we need for you to be out of them at least 10-days prior to your visit. In most cases, your eyes will be dilated so you may want to bring someone with you to drive after your appointment.

For these reasons, your visit may take up to 3 hours.

Thank you once again for choosing our office and we hope you enjoy your experience with our eye care team.

Sincerely,

The Doctors and Staff of Vision Quest - EyeCare & SurgeryCenter - SurgEyeCare



Vision Quest

5421 La Sierra Dr. - Dallas, TX. 75231 --- Phone: 214-361-1443 -- Fax 214-691-3299



PATIENT PROFILE

Please PRINT

Patient's Name: _____ Sex: M F
(First) (Initial) (Last)

Address: _____ City: _____ State: _____

Zip Code: _____ Home Phone: (____) _____ Date of Birth: ____/____/____

Cell Phone: (____) _____ Email Address: _____

Marital Status: (circle one) Single Married Widow

Patient's Social Security Number: _____ -- _____ -- _____

Person to notify in case of an emergency: (Name) _____

Relation to patient: _____ Phone: (____) _____

Place of Employment

I am Retired

Employer: _____

Address: _____

City: _____ State: _____

Zip: _____ Phone: (____) _____

Who may we thank for referring you?

Doctor -- their name: _____ OD / MD

Insurance _____

Friend, relative, other -- their name: _____

Yellow Pages Internet -- what site: _____

Other: _____

Please list all current and former doctors and their specialties, address and phone numbers. It may be necessary to obtain medical information from them.

DOCTOR	SPECIALTY	ADDRESS	PHONE

INSURANCE INFORMATION: (Please PRINT)

PATIENT PROFILE (Continued)

Patient's Full Name: _____

Responsible Party (if other than patient): Name: _____

Address: _____ Relation to Patient: _____

City: _____ State: _____ Zip: _____ DOB: ___/___/___

Home Phone: (____) _____ Work Phone: (____) _____

Please check those items below that apply to you (Patient):

Medicare -- Number: _____ -- _____ -- _____ Your Primary Insurance? Yes No
- Are you covered under Medicare HMO Policy? Yes No
If Yes, which HMO Plan _____

Medicaid -- Medicaid Number: _____

Commercial Insurance Company #1

HMO PPO

Name: _____

Policy Holder's Work History:

Address: _____

Employer: _____

City: _____ State: _____

Address: _____

Phone: (____) _____ Zip: _____

City: _____ State: _____

Group or Policy Number: _____

Phone: (____) _____ Zip: _____

Policy Holder's name: _____

Relation to Patient: _____

Policy holder's Social Security ##: _____ -- _____ -- _____ Date of Birth: ___/___/___

Telephone number to verify coverage: (____) _____

Primary Care Physician (PCP): _____ Phone: (____) _____

Commercial Insurance Company #2

HMO PPO

Name: _____

Policy Holder's Work History:

Address: _____

Employer: _____

City: _____ State: _____

Address: _____

Phone: (____) _____ Zip: _____

City: _____ State: _____

Group or Policy Number: _____

Phone: (____) _____ Zip: _____

Policy Holder's name: _____

Relation to Patient: _____

Policy holder's Social Security ##: _____ -- _____ -- _____ Date of Birth: ___/___/___

Telephone number to verify coverage: (____) _____

Primary Care Physician (PCP): _____ Phone: (____) _____

No Insurance -

(circle one) I will pay by: Cash, Check, MasterCard, Visa, Discover or American Express

Pharmacy Name: _____

Phone# _____ Fax# _____

I also certify and acknowledge that I have received a copy of the Notice of Privacy Practices Policy.

Signature: _____ Date: _____ © - VQ - 7/12/11



Vision Quest
5421 La Sierra Drive - Dallas, TX. 75231



HIPAA PATIENT COMMUNICATION FORM

Patient's Name: _____ Date: _____

1) FAMILY and FRIENDS: It is the office policy of Vision Quest (and related entities) not to release confidential medical information regarding your treatment to family members or friends, except for the following reasons:

- a) parent / legal guardian
- b) other persons authorized by the patient
- c) as we may reasonably infer from the circumstances (e.g.: *if you bring a family member into the exam room, we will assume, unless you object, that the person is entitled to receive information regarding your treatment*)
- d) in emergency situations
- e) or as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers / babysitters, please indicate that below so we that we may best serve your needs. By signing below, you authorize the listed persons to receive information regarding your treatment / care or you may indicate that no additional persons may access your information.

If you wish to add/delete names at a later date, please confirm this in writing or by calling our office.

No Additional persons may access my information. *Please initial:* _____

The following **MAY** receive the information: (*Print name of person*)

Spouse: _____

Parent: _____

Other: _____

Other: _____

2) ALTERNATIVE COMMUNICATIONS: You are also entitled to specify alternative, reasonable means of communication, if you do not wish to be contacted by us in a certain manner.

I do hereby request only the following means of contacting me:

- You may use any means available
- Use this ONLY: _____

Patient's Signature: _____

Date: _____

or Parent / Guardian Signature: _____

Date: _____

PATIENT HISTORY FORM

Patient Name _____ Date _____

Birth Date _____ Race: _____ Referred by _____

PAST OCULAR HISTORY: Have you been diagnosed with ANY ocular problems? (i.e. Cataracts, Glaucoma, Macular Degeneration, Retinal Problems, etc.)		
<input type="checkbox"/> Yes <input type="checkbox"/> No		
If YES, Please list all OCULAR PROBLEMS:		

PAST OCULAR PROCEDURES: Have you been diagnosed with ANY ocular Surgeries or Procedures? (i.e. Cataract Surgery, Glaucoma Surgery, Laser Surgeries, LASIK, Retinal Surgeries, etc.)		
<input type="checkbox"/> Yes <input type="checkbox"/> No		
If YES, Please list all previous OCULAR PROCEDURES:		

PAST SYSTEMIC ILLNESSES: Have you had any past systemic illnesses? (i.e. Thyroid Problems, Diabetes, Hypertension, Heart Disease, Cancer, etc.)		
<input type="checkbox"/> Yes <input type="checkbox"/> No		
If YES, Please list all PAST MEDICAL ILLNESSES:		

HEAD/OCULAR TRAUMA: Have you had any past Head or Ocular Trauma? (i.e. Falls, Head Concussions, Motor Vehicle Accidents, etc.)		
<input type="checkbox"/> Yes <input type="checkbox"/> No		
If YES, Please list all PAST HEAD/OCULAR TRAUMA:		

PAST BODILY SURGERIES: Have you had ANY general/bodily Surgeries or Procedures? Please List ALL Past Surgeries		
<input type="checkbox"/> Yes <input type="checkbox"/> No		
If YES, Please list all previous GENERAL SURGERIES:		

PLEASE TURN OVER –CONTINUED....

FAMILY AND SOCIAL HISTORY			
Does any of your family have any Medical or Eye Diseases?			
If YES, please note relationship to patient			
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Glaucoma			
Diabetes		Do you smoke? If YES, how much?	<input type="checkbox"/> Yes <input type="checkbox"/> No
High blood pressure		How much:	
Macular degeneration		Drink alcohol? If YES, how much?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other		How much:	
Comments: _____			

REVIEW OF SYSTEMS		
Do you currently have any of the following problems?		
If YES, please explain.		
1. Do you have any allergies to any medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Constitutional (fever, weight loss, other)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Eyes (glaucoma, cataract, lazy eye, retina problems, other - please specify)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Ear / nose / mouth / throat (hearing loss, sinus problems, sore throat)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Cardiovascular (heart problems, chest pain, irregular heart beat)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Respiratory (asthma, shortness of breath, wheezing, coughing)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Gastrointestinal (heartburn, abd. pain, diarrhea, vomiting)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Genitourinary (urinary problems, blood in urine)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
9. Integumentary (skin rashes, excessive dryness)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
10. Musculoskeletal (muscle aches, joint pain, swollen joints)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
11. Neurological (numbness, weakness, headaches, paralysis)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
12. Hematologic/Lymphatic (blood disorders, leukemia)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
13. Allergic/Immunologic (hay fever, allergies)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
14. Endocrine (thyroid problems)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
15. Psychiatric (depression, anxiety)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
CURRENT MEDICATIONS		
Do you take ANY current Medications or Vitamins/Supplements?		
If YES, Please list ALL with Included Milligrams if known:		
<input type="checkbox"/> Yes <input type="checkbox"/> No		

ATTENTION

All copays and balances are due at the time of service.

Thank you

Vision Quest Management

The Patient's Rights

Philosophy:

Each patient shall have a right to:

- Be treated with respect and dignity.
- Treatment which is:
 - Free of discrimination on the basis of race, religion, ethnicity, handicap or age.
 - Performed according to individual needs.
- Refuse specific medication or operative procedures.
- Initiate a complaint or grievance about his/her treatment.
- Consult, at his/her own expense, with outside consultants or legal counsel of his/her own choice.
- Safe and efficient treatment.
- Voice his/her personal feelings by oral or written means.
- Information concerning names, professions, and titles of the professionals providing and/or responsible for their care.

Informing patients of their rights:

- At the time of admission, each patient, as well as his/her family or legal guardian, shall have the right to request a copy of these Patient's Rights.
- All efforts shall be made to see that patients at the surgery center receive the best care to which they are entitled.
- Patients shall be advised concerning their diagnosis, treatment and prognosis where advisable. Where inadvisable, an appropriate family member or legal representative shall be advised of this information. The patient shall have the opportunity to take part in decisions involving his health care unless contraindicated.
- All records and treatment shall remain confidential.
- Patients shall be advised of all fees that may be incurred due to treatment and the provision for payment of those fees.

Patients:

- Patients shall be expected to conduct themselves in a quiet and orderly manner conducive to the quiet atmosphere of the facility.
- Each patient shall be advised of whom to contact in case of an emergency situation that may arise post-operatively after the center's regular operating hours.
- If a patient refuses treatment, a statement to that effect shall be placed in their clinical record.
- An unemancipated minor shall be accompanied by parent/guardian and shall have release for treatment signed by same.

Services Available:

Patients have the right to all services available at the facility including, but not limited to:

- Ophthalmology
- Professional nursing care

Financial Disclosure:

- This notice advises anyone of the financial interest between SurgEye Care & Wesley K. Herman, M.D.

Any unresolved grievances may be directed to the Texas Department of Health at 1-888-973-0022.

Vision Quest

EyeCare & Surgery Center

5421 La Sierra Drive
 Dallas, Texas 75231-4185
 (214) 361-1443

has an appointment on

Day	Month	Date	Time

Wesley K. Herman, M.D.
Ophthalmic Microsurgery & Consultation Ophthalmology

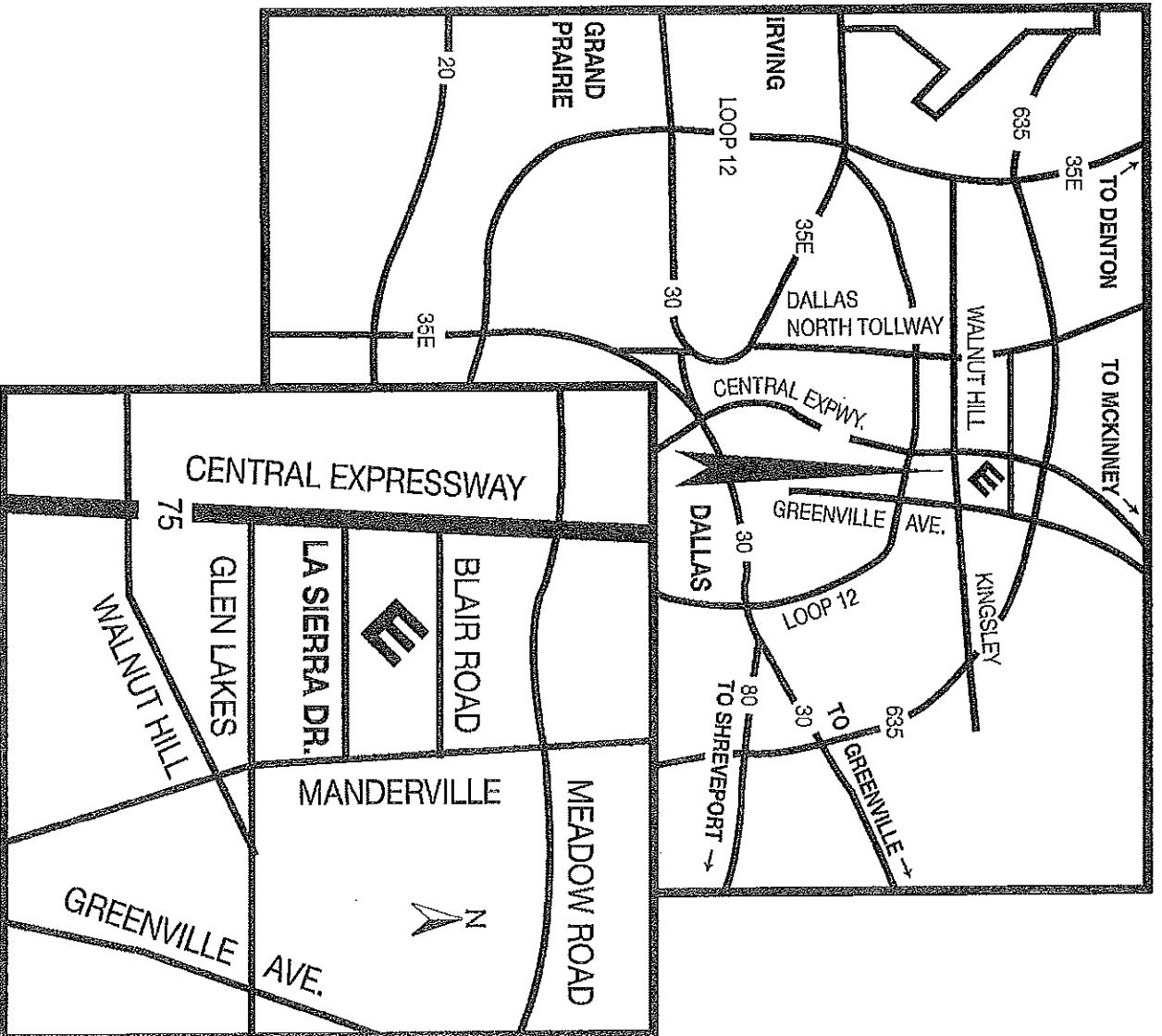
(See Important Patient Information on Reverse Side)



EyeCare & Surgery Center

Dallas • Greenville

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ATTENTION

No Show or Cancellation Fees

Effective immediately we will collect a fee for No Shows and Cancellations without a 48 hour notice.

Clinic: \$35.00

Surgery: \$100.00

Thank you for your cooperation

Vision Quest Management