Rishav Kansal, M.D.
770 N. Coit Rd. #2486
Richardson, Tx 75080

Follow-Up History Form

Name (Print)		**Date**	

Please answer the following questions to the best of your ability.

1. **Please list your personal medical conditions.**

2. **List all medications, with dosages. Please include allergy medications, birth control pills, eye drops, supplements, etc.)**

3. **Please list allergies to medications and the outcome when you are exposed to them.**

4. **List any changes to your primary care doctor, specialists, or pharmacy. Please provide phone numbers and addresses.**

5. **Do you smoke? Y N If Yes, how many packs daily? _____ How many years? _____**
   Former smoker? Y N

Smoking increases your risk of heart attack and stroke by 2-4x and lung cancer by 25x. Information to stop smoking can be provided. It is a risk factor for many permanently blinding conditions.

- Dr. Kansal

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Patient Financial Agreement

Insurance Assignment and Patient Responsibility

The person signing below agrees, whether he/she signs as patient or representative of the patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of the doctor at the regular rates and terms of the practice. Should the account be referred to an attorney for collection, the person signing below shall pay reasonable attorney's fees and collection expenses.

"I assign payment for the unpaid charges for certain medical treatment and/or supplies furnished the by the physicians and staff of the practice for whom the practice is authorized to bill. I understand that I am responsible for any health insurance deductible, coinsurance and non-covered services at the time services are rendered."

We do our best to check your insurance coverage, requirements to be evaluated, and provide transparent estimated costs for your visit. However, it is still your responsibility to understand and know your coverage. You are the sole responsibility part for all charges incurred and guarantee payment thereof. If you need a referral, our office can help in obtaining it, but it is your responsibility to obtain it.

Any financial concerns should be discussed with our office first, and every effort will be made to work with any patient. **Payments on all accounts billed are expected within 30 days. Past due accounts may be sent to collections. A collections fee will be added. Returned checks are subject to a $25 fee. All fees incurred due to cancelled or disputed credit card charges for services rendered will be the patient's responsibility.**

All patients should notify our office if they cannot make an appointment. Missed appointments without notification at least 1 day in advance can result in a $25 missed appointment fee.

The Stark II (2004) legislation prohibits this office from extending courtesy discounts and/or professional write-offs.

MEDICARE AND/OR MEDICAID CERTIFICATION

"I certify that the information given by me in applying for payment under Title XVIII and/or Title XIX of the Social Security Administration is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries/carriers any information needed for this or related Medicare claim. I request that payment of authorized benefits be made on my behalf."

REFRACTION

A refraction (the measurement of your eyes for glasses prescription) is typically **NOT a covered benefit of your medical insurance plan.** It is performed routinely on new patients and yearly eye checks. It may be needed on other visits as well. You are held financially responsible for this charge.

This agreement remains in effect for any visits with Kansal Eye, PLLC, unless otherwise revoked by the patient or authorized representative. Revoking this agreement will terminate any future patient-doctor relationship between the patient and Kansal Eye, PLLC or its staff. A copy of this signed form can be provided at any time.

_____	_____	_____
Printed Name	**Signature**	**Date**