1602 Lancaster Dr. Ste.102
Grapevine, TX 76051
Office (817) 885-7878
Fax (817) 885-7444

Glaucoma Consultants of Texas

Varun Reddy, M.D.
Sonal Patel, O.D.

1650 W. Rosedale St. Ste.201
Fort Worth, TX 76104
Office (817) 885-7878
Fax (817) 885-7444

New Patient Forms and Instructions

On your first visit, we make every effort to do a comprehensive exam and complete all testing, so please be prepared to spend two or three hours with us. Your eyes may be dilated unless dilation is found to be contraindicated upon examination of your eyes. There will be special diagnostic testing performed in order to evaluate for glaucoma. Since the effect of dilation can take one to four hours to wear off, we recommend that you arrange for someone to drive you home following your visit to our office.

Please bring the following items with you for your first appointment:

1. Current insurance cards.
2. Photo ID.
3. Names, addresses, and phone numbers of your current physicians.
4. Previous medical records relating to your visit and all information related to your eye condition.
5. Completed new patient forms.
6. A form of payment for your co-payment, deductible, or any out-of-pocket amount required by your insurance.
7. You will need to bring your glasses to your visit. If you wear contact lenses and are unable to bring your glasses, please bring a copy of your most recent glasses prescription from your eye doctor.

We look forward to seeing you. If you have any questions or require additional assistance, please contact our office using the information above or through email at info@gcot.net. You may also visit our website at www.gcot.net.

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Patient Information

Date _____/_____ /_____ Social Security #_____

First Name _____ Middle _____ Last_____

DOB _____ /_____ /_____ Sex_____ Marital Status: Single / Married / Widowed

Home Address:

_____

Street City State Zip

Home Phone (_____)_____ Cell Phone: (_____)_____

Work Phone (_____)_____ Email: _____

Best phone # to contact you and to leave appointment reminders (_____)_____

Race _____ Ethnicity _____ Language _____ Occupation_____

Emergency Contact: _____ Relationship: _____

Home Phone (_____)_____Work Phone (_____)_____ Cell Phone(____)_____

Doctor who **REFERRED** you to our practice:

_____

Doctor's Name Address City State Zip Code Phone #

Reason for referral?

_____

PRIMARY CARE PHYSICIAN:

_____

Doctor's Name Address City State Zip Code Phone #

Are you currently in a Skilled Nursing Facility? (check box) YES ☐ NO ☐

Which office location do you prefer (CIRCLE ONE): GRAPEVINE FORT WORTH EITHER

Insurance Information

Primary Insurance Company_____

Insured's Name _____ SS# _____

DOB ____/____/____ Patient's relationship to Insured (circle one): Spouse Child Self

Member ID _____ _____Group# _____

Secondary Insurance Company _____

Insured's Name _____ SS# _____

Member ID_____ Group#_____

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PATIENT HISTORY

Name: _____ Age:_____ Today's Date:_____

ALLERGIES
Are you allergic to any medications? If yes, please list below:

_____ _____ _____

Are you currently taking **EYE MEDICATIONS**? If yes, please list below:

Medication Name/Dose Medication Name/Dose Medication Name/Dose

_____ _____ _____

Are you currently taking **OTHER MEDICATIONS**? If yes, please list below:

Medication Name/Dose Medication Name/Dose Medication Name/Dose

_____ _____ _____

_____ _____ _____

Preferred Pharmacy Name:_____ **Phone Number**:_____
Location/Address:_____

EYE CONDITIONS/surgeries you have/had: (check all that apply)

- ☐ Glaucoma ☐ Cataracts ☐ Amblyopia/Strabismus
- ☐ Corneal Disease ☐ Retinal Disease Other: _____
- ☐ Iritis/Uveitis ☐ Macular Degeneration

Glaucoma Related Laser/Surgery: _____

MEDICAL CONDITIONS/surgeries you have/had: (check all that apply)

- ☐ High Blood Pressure ☐ Heart Disease ☐ Asthma ☐ Arthritis
- ☐ Diabetes: Type _____ ☐ Migraines ☐ Sleep Apnea ☐ Cancer:
- ☐ Stroke ☐ Thyroid Disease ☐ Allergies Type_____
- ☐ History of Seizure/Epilepsy Other: _____

Please check if you have a ***Family History*** of:

Glaucoma ☐ Yes ☐ No *If yes*, relationship? _____
Other: _____

Social History: (check all that apply)

Do you smoke cigarettes? ☐ Yes ☐ No Formerly: _____
Do you drink alcohol? ☐ Yes ☐ No Formerly: _____
Do you use recreational drugs? ☐ Yes ☐ No Formerly: _____

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REVIEW OF SYSTEMS

(Please circle all that apply)

Constitutional:
Fatigue, Fever, Night Sweats

Ear/Nose/Throat:
Hearing Loss

Respiratory:
Cough, Wheezing

Cardiovascular*:*
Chest Pressure or Discomfort, Irregular Heartbeat/Palpitations

Gastrointestinal:
Constipation, Diarrhea, Vomiting

Genitourinary:
Dysuria (pain with urination), Hematuria (blood in urine), Polyuria (increased urination)

Endocrine:
Cold Intolerance, Heat Intolerance, Polydipsia (excessive thirst), Polyphagia (excessive hunger),

Neurological:
Dizziness, Gait Disturbance, Headaches

Psychological:
Emotional Changes

Integumentary:
Rash

Musculoskeletal:
Arthralgias (joint pain), Joint Swelling, Muscle Weakness

Hematological/Lymphatic:
Bruising, Easy Bleeding

Allergy/Immunological:
Environmental Allergies, Food Allergies

***Please list any medical conditions or symptoms that you have which have not been noted above:**

Patient's Signature:_____ Date:_____

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Patient Signature Sheet

Patient Name: _____
(Please Print)

Please initial beside each policy to acknowledge that you have read and understood the information provided.

____ Office Policy

____ Financial Policy

____ Assignment of Benefits/Authorization to Treat

____ Joint Notice of Privacy Practices

I certify that I have read, understood, and agree to the terms set forth in these policies. I further certify that I have received a copy of these policies. Glaucoma Consultants of Texas reserves the right to change its policies at any time.

_____ _____/_____/_____

Patient/Guardian Signature

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Authorization to Speak to a Third Party

Patient Name:_____ Date of Birth: _____

☐ I **DO NOT** authorize a family member/caretaker to speak with our staff regarding my health information.

If you would like to authorize a family member/caretaker to speak with our staff regarding your health information, please list their information below:

Contact Person: _____ Relationship: _____

Contact Number: _____

Contact Person: _____ Relationship: _____

Contact Number: _____

Contact Person: _____ Relationship: _____

Contact Number: _____

HOW CAN WE CONTACT YOU REGARDING YOUR HEALTH CARE?

Check all that apply:

Home Phone # : ☐ May we leave a detailed message including your health care? ☐ Yes ☐ No
Cell Phone # : ☐ May we leave a detailed message including your health care? ☐ Yes ☐ No
Work Phone # : ☐ May we leave a detailed message including your health care? ☐ Yes ☐ No

This consent will continue until revoked unless you cancel it in writing by writing us at:

Glaucoma Consultant of Texas
1602 Lancaster Dr. Ste. 102
Grapevine, TX 76051

If the consent is cancelled, it will not change releases prior to the cancellation.

_____ _____
Patient Signature Date

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____
Address: _____ _____ _____
City State Zip Code
Telephone: _____

I authorize the release of records TO / FROM: **To be released TO / FROM:**

Glaucoma Consultants of Texas
1602 Lancaster Dr. Ste. 102
Grapevine, TX 76051
Office: 817-885-7878
Fax: 817-885-7444

Name _____
Address _____
City/State/Zip _____
Phone#_____ Fax# _____

Please check the type of information to be released:

☐ Most Recent Chart Note (Complimentary) ☐ Most Recent Visual Field (Complimentary)

☐ Medical Records: From (date)_____ To (date)_____ $25 minimum processing fee

☐ Demographic Sheet ☐ Billing Records

☐ Other (Specify)_____

I am authorizing the release of my Protected Health Information for the following purpose:

☐ Coordination of Care ☐ Transfer of Care (Specify Reason)_____

☐ Legal (Specify)_____ ☐ Other (Specify)_____

The Texas Medical Board (TMB) rules set the allowable charge for copies under Texas law. For paper copies, the charge is $25 for the first 20 pages, and 50 cents for each page thereafter. I understand there will be a $25 minimum processing fee. I understand I may opt for a copy of my most recent chart note/visual field at no charge. I understand that Glaucoma Consultants of Texas will process my request within 15 business days.

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

_____ _____
Patient/Legal Representative Signature **Date**

_____
Description of Relationship if not Patient

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OFFICE POLICY

Office Hours:
Physician office hours are by appointment only, Monday through Thursday, from 8:00am to 5:00 pm, and Friday, from 8:00 am to 1:00 pm.

Scheduling Appointment/Referrals:
Contact us to schedule an appointment. Please have your insurance card available when making your appointment. Many managed care insurance plans require a primary care physician referral prior to making a specialist appointment to ensure payment of full benefits. If a referral authorization is needed from your Primary Care Provider (PCP), **you are responsible for obtaining this referral prior to your visit.** If your care is non-emergent and there is no referral obtained, your appointment will be rescheduled. **If you are seen for your appointment without a referral, you will be held responsible for the visit charges in full.** If you were referred by a physician, we will be sending a report of our consultation to your doctor.

No–Show Policy:
A "no show" fee will be assessed to your account if you reschedule/cancel your appointment without advance notice. There will be a $20 fee for Follow Up appointments and a $50 fee for Laser appointments without 48 hours notice. There will be a $50 fee for New Patient appointments and a $250 fee for Surgery appointments without 72 hours notice.

Prescriptions:
For prescription refills, please have your pharmacist call our office during regular office hours. If you are out of refills, have your name, date of birth, pharmacy name, and pharmacy phone number ready. Many prescriptions cannot be refilled over the phone or by physicians not familiar with your case. Therefore, please make sure you always have enough medication for nights, weekends, and holidays. We will not call in prescription refills during non-office hours or on weekends.

Emergencies:
If you have an urgent concern related to your glaucoma when our office is closed, please call us at (817) 885-7878 to reach our doctor notification system and follow the prompts. If your eye emergency is not related to glaucoma, then please contact your general eye doctor. In case of a glaucoma emergency, the doctor on call will determine the time and location of where you will be examined. If the doctor needs to examine you, the doctor will meet you at the Grapevine office location in most cases. If for some reason you are unable to get a response or you are unable to meet the doctor, you should proceed to the nearest emergency room to avoid potential vision loss or damage to your eyes. Do not wait for instructions from Glaucoma Consultants of Texas before proceeding to the emergency room. Please note that prescription refill requests may not be considered an emergency. Please be sure to request prescription refills in advance and during normal business hours.

Medical Records:
There is a handling fee for obtaining a copy of your medical records which starts at $25. A medical records release must also be filled out if you require a copy to be sent to another physician. Please allow up to 2 weeks for preparation of your records.

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FINANCIAL POLICY

The following is a statement of our Financial Policy that we require you read, understand, and sign prior to any treatment.

• All patients must complete our Patient Information form before seeing the doctor. We verify your insurance information at each visit, so please bring your insurance card(s) and ID with you to every appointment. In order for us to bill your insurance company we need complete, current, and accurate information, including a copy of your cards.

• If you currently have no insurance, all services provided are to be paid in full at time of service.

• All co-payments, deductibles, and co-insurance are due at the time of service. All Medicare patients will be required to pay their yearly deductible and the 20% coinsurance, based upon the current Medicare Fee Schedule, at the time of services unless proof of secondary policy is evident.

The amount collected is only an estimate and does not guarantee payment from your insurance company.

• Payments may be made with cash, personal check, Visa, MasterCard, Discover or American Express.

• It is your responsibility to determine if you belong to an insurance plan with which Glaucoma Consultants of Texas contracts. It is your obligation to pay the full charges of all services rendered by Glaucoma Consultants of Texas if you belong to an insurance plan that is not a contracted insurance or is out of network.

• Glaucoma Consultants of Texas contracts with health care service plan (i.e., HMOs, PPOs) related only to items and services which are "covered" by the health care service plans. Accordingly, it is your full financial responsibility for all items or services which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Glaucoma Consultants of Texas to obtain necessary health care service plan authorizations.

• In return for the services provided by Glaucoma Consultants of Texas, you are required to pay the account at the time of service. If an account is sent to an attorney for collection, it is your responsibility to pay collection expenses and reasonable attorney's fees as established by the court. If your account is delinquent, it will be charged interest at the legal rate. Any benefits of any type, under any policy of insurance insuring the patient, or any other party liable to the patient, are hereby assigned to Glaucoma Consultants of Texas. If co-payments and/or deductibles are designated by your insurance company or health plan, you agree to pay them to Glaucoma Consultants of Texas.

• If the Clinic is a participating provider with your PPO or other insurance plan, we file charges to your insurance carrier. After the insurance company responds and if there is a balance due from the patient, you will receive a statement showing the charges, any payments, and the balance due. Although we have filed the charges to your insurance company, please remember that you are responsible for the account balance. Interest at the (maximum allowed by law) will be charged on all balances after 30 days.

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FINANCIAL POLICY- CONTINUED

• All account balances are due in full within 14 days of the billing date. Failure to meet your financial obligations may result in a collection action for your account balance. This may include the account being turned over to a collection agency, reported to a credit bureau, a claim filed for a judgment in small claims court. Once the account is placed in the collection status, your future services at the Glaucoma Consultants of Texas will be suspended. The outstanding balance must be paid in full before you can be seen again in the clinic. Your account will then be on a cash, credit card, or money order basis only. All attorney fees, court costs, and other expenses that relate to collecting your account will be added to your outstanding balance.

• All outstanding patient account balances must be paid in full before your next visit or your appointment will be rescheduled.

• If an over payment is made by you on the account, a refund will be issued as long as there are no other outstanding debts on any accounts which are under your responsibility. It is your responsibility to inform us of any change in address, phone, employment or insurance.

• There will be a $25 charge for all returned checks. If the check is forwarded to the District Attorney's office for non-payment collection, additional charges will be the patient's responsibility. Your account status following a returned check will be on a cash, credit card or money order basis only.

• It is our obligation under many of the managed care contracts to report patients who repeatedly refuse to pay co-pays and deductibles at the time of service or who repeatedly "no-show" for appointments. Your healthcare benefits could be lost due to noncompliance.

• Glaucoma Consultants of Texas will not become involved with any divorce issues. The adult accompanying a minor and the parents (guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized for payment by Visa/MasterCard/Discover, American Express, cash or check at time of service. The guarantor will be responsible for any balance on the account. Unresolved accounts will result in the account being sent to collections, regardless of who is responsible for the balance due.

• Glaucoma Consultants of Texas does not bill third parties such as attorneys or automobile insurance for liability services. Glaucoma Consultants of Texas will provide any documentation to the patient to submit to a third party for reimbursement. Medical records requested by the third party are to be paid in advance of release.

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ASSIGNMENT OF BENEFITS/AUTHORIZATION TO TREAT

Assignment of Benefits and Rights**:** I hereby irrevocably assign, transfer, and convey to Glaucoma Consultants of Texas any and all benefits, interests and rights (including but not limited to, the right to enforce payment and the right to appeal an adverse benefit determination) to which I am entitled under all insurance policies, benefits, any third party reimbursement, or prepaid health care plan for services rendered or products that I receive from Glaucoma Consultants of Texas. If my treatment was caused by events that result in legal action, I assign to Glaucoma Consultants of Texas and any practitioner providing care and treatment to me an interest in any claims and payments that I may have to pay for the services provided by Glaucoma Consultants of Texas to me. Medicare/Medicaid Assignment of Benefits and Release of Information**:** I request that payment of authorized Medicare/Medicaid benefits be made on my behalf to Glaucoma Consultants of Texas for services furnished to me by Glaucoma Consultants of Texas. I authorize any holder of medical information about me to release to the Centers of Medicare and Medicaid Services (formerly Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable for related service. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurance or agency shown. Glaucoma Consultants of Texas accepts the charge determination of the Medicare/Medicaid carrier as the full charge and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare/Medicaid Carrier.
Authorization To Treat: I consent to Glaucoma Consultants of Texas to provide me with necessary medical services, treatments, and diagnostic tests. My consent to treat includes any examinations, tests, medical treatment, medications including but not limited to dilating drops, and/or other services rendered by the physicians, their associates, technical assistants, or other healthcare providers, which in the judgment of such practitioners are advisable during the course of evaluation, diagnosis and treatment. I understand that there is the small risk of a general medical problem occurring during the course of my visit in the office, such as an unexpected allergic reaction to the standard eye drops used for my care. I understand that if my eyes are dilated, it may not be safe to drive. I recognize that the practice of medicine and surgery is not an exact science. I understand that no guarantees have been made as to the results from the treatment and care rendered by Glaucoma Consultants of Texas.
Settlement of Claims: A claim or dispute involving the patient and of Glaucoma Consultants of Texas shall be resolved by binding arbitration in accordance with the Federal Arbitration Act and the Commercial Rules of the American Arbitration Association. The Arbitration and any court proceeding related to this agreement shall be in Tarrant County, TX. The prevailing party shall be awarded any attorney fees and expenses related to the arbitration.

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JOINT NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information as well as your rights to access and control your Protected Health Information. "Protected Health Information" ("PHI") is information about you, including demographic information that may identify you and relates to your past, present or future physical or mental health and related health care. We are required to safeguard your PHI, to provide you with notice of our legal duties and privacy practices and to abide by the terms of this Notice of Privacy Practices. This notice takes effect on April 13, 2003 and will remain in effect until we replace or modify it.

Notice of Privacy Practices can be obtained by calling our office to request that a copy be sent to you in the mail.

Uses and Disclosures of PHI for Treatment, Payment and Healthcare Operations
Your PHI may be used and disclosed by your healthcare provider, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services, to pay your health care bills and/or to support the operation of our practice. Below are some examples of the types of uses and disclosures we may make. These examples are not meant to be exhaustive or all-inclusive.

Treatment: Glaucoma Consultants of Texas may use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination of your health care with the healthcare personnel at the facilities at which we treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services, through billing, claims management and collection activities. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities, including preauthorization of services. For example, a claim submission to your insurer would require your condition and services rendered to be disclosed to the insurer for payment.

Healthcare Operations: Glaucoma Consultants of Texas may use or disclose, as needed, your PHI to support our business activities. These activities include, but are not limited to, quality assessment, employee review, and licensing. We may share your health information with third party "business associates" that perform various activities (e.g., billing) for the practice. Any arrangement with a business associate involving the use or disclosure of your PHI, will have a written contract that contains terms to safeguard your PHI.

Uses & Disclosures of PHI with Your Written Authorization: Other uses and disclosures of your PHI will be made only with written authorization, unless otherwise required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that our company has taken an action in reliance on the use or disclosure indicated in the authorization.

Permitted or Required Uses & Disclosures with Your Opportunity to Object

Others Involved in Your Healthcare: Unless you object, we may disclose your PHI to a member of your family, a close friend or any others who are involved in your healthcare or help pay for your care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. 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.

Emergencies: We may use or disclose your PHI in an emergency treatment situation, without your authorization.

Communication Barriers: We may use and disclose your PHI if we attempt to obtain consent from you but are unable to due to substantial communication barriers and the provider determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances. Confidential Uses & Disclosures Without Your Authorization: We may use or disclose your PHI in the following situations without your consent or authorization. These situations include:

- as required By Law;
- for public health activities;
- to report adult abuse, neglect, or domestic violence;
- To health oversight agencies;
- in response to court and administrative orders and other legal proceedings;
- To law enforcement officials pursuant to subpoenas and other lawful processes;
- to coroners, medical examiners, funeral directors, and organ procurement organizations;
- to avert a serious threat to health or safety;
- in connection with certain research activities;
- to the military and federal officials for lawful intelligence, counterintelligence and national security activities;
- as authorized by state worker's compensation laws.

Required Uses & Disclosures: Under the law, we must make disclosures to 1) you and 2) to the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

YOUR RIGHTS: You have the right to access and receive copies of your PHI.

You must request this in writing. Glaucoma Consultants of Texas may charge a fee to cover certain costs. Under federal law, however, you may not inspect or copy the following records: information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI. Please contact the Privacy Officer about accessing your medical record.

You have the right to request a restriction of the use and disclosure of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Glaucoma Consultants of Texas is not required to agree to any restriction requested. If we believe it is in your best interest to allow use and disclosure of your PHI, your PHI will not be restricted. If we agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with our Privacy Officer.

You have the right to receive confidential communications from us. We will accommodate reasonable requests to communicate by alternative means. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Practice Administrator.

You may have the right to have your PHI amended. You must request this in writing. In certain cases, we may deny your request for an amendment. If we deny
your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Practice Administrator about amending your medical record.

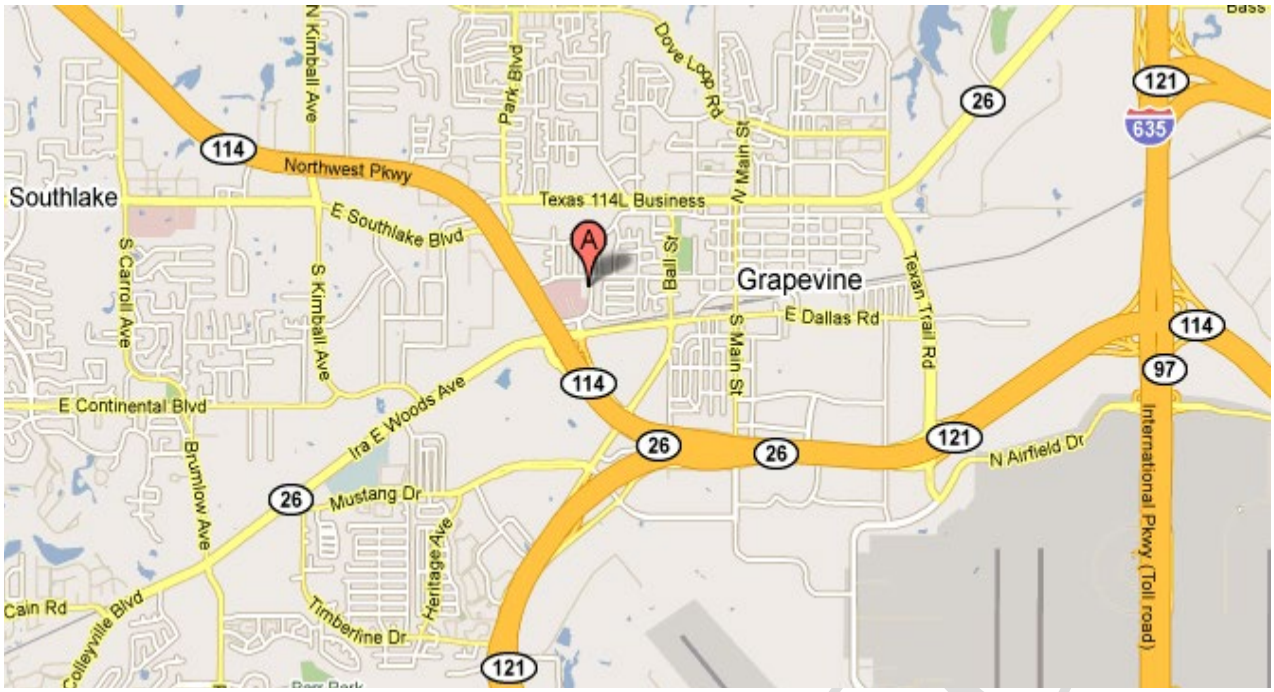
You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.
You have the right to obtain a paper copy of this notice from us, upon request.

Under the new federal law, Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule, it is required to provide all patients with a Joint Notice of Privacy Practices. This notice explains how we use information about our patients and under what conditions we are permitted to share that information with others.

1602 Lancaster Dr. Ste.102
Grapevine, TX 76051
Office (817) 885-7878
Fax (817) 885-7444

Glaucoma Consultants of Texas
Varun Reddy, M.D.
Sonal Patel, O.D.

1650 W. Rosedale St. Ste.201
Fort Worth, TX 76104
Office (817) 885-7878
Fax (817) 885-7444



Map to Grapevine Office
1602 Lancaster Drive, Suite 102
Grapevine, TX 76051

From The North:

- Take 121 South
- Merge onto 114 West towards Ft Worth
- Exit TX 26 and go straight towards 114 West
- 114W becomes Baylor Parkway
- Go straight through the stoplight at Baylor Parkway/26
- On the Baylor Hospital Campus
- Turn right at the stop sign (Lancaster Drive)
- Stop at 1602 Lancaster Drive, Suite 102 (on the left)

From The South:

- Take 121 North
- Exit William D Tate Ave towards 114 West
- Turn left onto 114 West but stay straight onto Baylor Parkway
- Go straight through the stoplight at Baylor Parkway/26
- On the Baylor Hospital Campus
- Turn right at the stop sign (Lancaster Drive)
- Stop at 1602 Lancaster Drive, Suite 102 (on the left)

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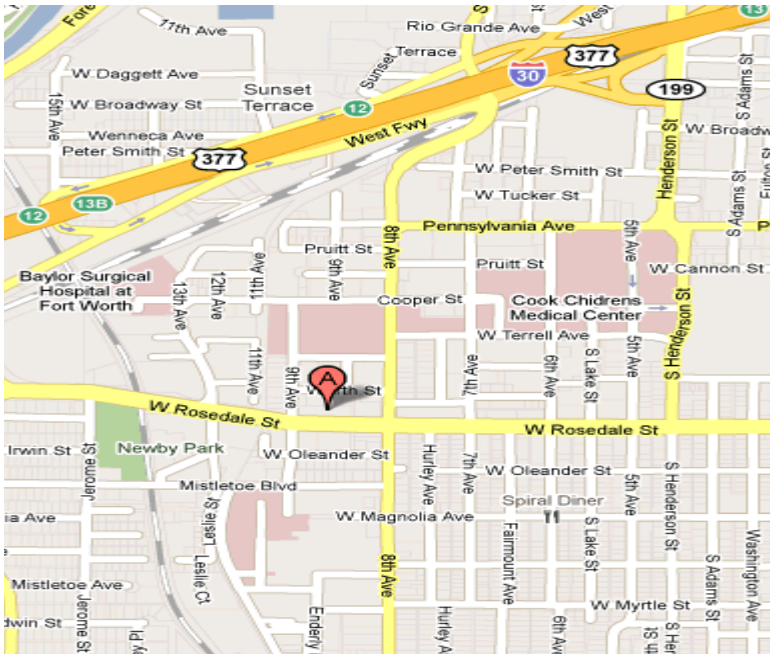

Map to Fort Worth Office:

1650 W. Rosedale Street

Suite # 201

Fort Worth, TX 76104

From The North

- Take 35W South
- Exit W Rosedale
- Turn right on W Rosedale
- Stop at 1650 W Rosedale (will be on right side, just past 8th Ave, next to Starbucks), 2nd floor, Suite 201

From The South

- Take 35W North
- Exit W Rosedale
- Turn left on W Rosedale
- Stop at 1650 W Rosedale (will be on right side, just past 8th Ave, next to Starbucks), 2nd floor, Suite 201

From The East

- Take I-30 West
- Exit Summit Ave, towards 8th Ave
- Turn left on Summit Ave, continue onto 8th Ave
- Turn right on W Rosedale
- Stop at 1650 W Rosedale (will be on right side, next to Starbucks), 2nd floor, Suite 201

From The West

- Take I-30 East
- Exit Summit Ave, towards 8th Ave
- Turn right on Summit Ave, continue onto 8th Ave
- Turn right on W Rosedale
- Stop at 1650 W Rosedale (will be on right side, next to Starbucks), 2nd floor, Suite 201

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What to Expect During Your Initial Glaucoma Evaluation Visits

Your initial glaucoma evaluation will be broken down into 2 different appointments:

FIRST VISIT

On your first visit, you will meet Dr. Varun Reddy who will review any notes from your referring doctor. This visit will be tailored to your specific medical needs and will consist of an exam with Dr. Reddy and any tests that they feel are necessary. The tests will be done that day and on site. In most cases, a diagnosis will be given at this visit, however, an additional visit with more baseline testing will be required following the initial visit to determine a proper treatment plan. This first appointment may take up to 3 hours and your eyes will most likely be dilated.

- **TESTING:**
  - Pachymetry
  - Visual Field
  - OCT Imaging (scan of the Optic Nerve)

SECOND VISIT

Your second visit will be within approximately 6 weeks from your initial visit. In most cases, we will need to know your eye pressure in the morning and in the afternoon. For this reason, your second visit may be at a different time of day from your initial visit. On this visit, you will likely meet Dr. Sonal Patel who will review all the information from your first visit and examine your eyes. She will discuss all the information with you, review treatment options (if needed), and answer any questions. You will also have the remaining baseline/diagnostic tests that are needed, which will be done in our office. This visit may take up to 1.5 hours.

- **TESTING:**
  - Fundus Photography
  - Electrophysiology Tests (VEP/ERG)

At your first visit, you will be given a packet with more detailed information for all the tests mentioned above, in addition to the frequency at which they will be needed for all subsequent visits. After your second visit, most patients are followed every 3-6 months once stable.

Note: We are providing you with an estimated cost for your first visit. Please let us know if you would like an estimate for your second visit.