

Welcome to Frisco EyeClinic! Please Fill Out Completely

Today's Date: _____ / _____ / _____

Patient's Name (Mr. Mrs., Ms, Dr): _____ Date of Birth: _____ / _____ / _____ Age: _____

Address: _____ APT#: _____ Phone: (_____) _____

City: _____ State _____ Zip: _____ Employer: _____

Email Address: _____

Parent (if under 18) or Responsible Billing Party _____

Address: _____ APT#: _____ Phone: (_____) _____

City: _____ State _____ Zip: _____

Medical Insurance: _____ ID#: _____ Vision Ins.: _____ ID#: _____

Primary Insured's Name & Social Security#: _____ & _____ - _____ - _____ Patient's Social Security#: _____ - _____ - _____

Primary Insured Date of Birth _____ / _____ / _____ Primary Insured's Employer _____

PLEASE READ AND INDICATE YOUR CHOICE ON EACH OF THESE RECOMMENDED ADDITIONAL TESTS

Visual Field - This computerized instrument checks for missing areas in your peripheral vision that can be present from a variety of ocular diseases. This test is a **SCREENING** only. Any possible defects can lead to further testing.

- Helps detect: Brain tumors, optic nerve disease, damage to the eye from high blood pressure, diabetes, glaucoma, multiples sclerosis and better enables us to diagnose cause of headaches.
- Recommended for: All new patients; patients with strong prescriptions, headaches, family history of glaucoma or any of the eye conditions listed above.
- Time Frame: Less than 2 minutes per eye.
- The fee for this test is **\$25.00**.

Dilation - This is done with eye drops to dilate, or open, the pupil so the doctor has a good view of the inside of the eye (retina). Dilation is **MANDATORY** for all patients with diabetes, patients with "lazy eye", patients on certain medications, or patients with symptoms of flashes and floaters. **While dilated, a photograph can be taken for your records and used as a baseline for any future changes that may be found.**

- Helps detect: Internal eye diseases (cataracts, macular degeneration, glaucoma, tumors, retinal tears, holes, detachments, diabetic changes, high blood pressure changes, and others).
- Recommended for: All new patients, patients with autoimmune disease, headaches and routinely every 1-2 years in healthy individuals.
- In some cases, especially children, this must be done to find the best prescription or to diagnose a problem.
- Time Frame: Adds 15-20 minutes to your visit. It is normal after dilation to experience blurry near vision and sensitivity to light for a few hours. Sunglasses are provided to enable you to drive, if needed.
- The fee for this test is **\$20.00**. Dilation may be covered through your vision or medical insurance as part of a comprehensive eye examination.

Please **check which additional test you would like performed today:**

_____ Visual Field (\$25.00)

_____ Dilation (\$20.00)

_____ Retinal Photography including Dilation (\$25.00)

_____ Visual Field Testing and Retinal Photography (\$40.00) Discounted Fee

_____ I understand the importance of both visual field testing and dilation and although both are recommended by my doctor, I do not wish to have either test performed and I release any liability from Frisco Eye Clinic with undetected visual issues related to the above tests.

Please read and acknowledge our OFFICE POLICY

1. All professional fees and hardware fees are due and payable at the time of service and are non-refundable.
2. A courtesy spectacle recheck must be done within 60 days from your initial exam or there will be a \$25 office visit. After 6 months, a new exam may be required.
3. One courtesy lens power change will be granted if needed within 60 days. If there is a non adaptation to 1st time progressive lens wearer, there is a courtesy refit to a different lens. Additional charges may apply.
4. Contact lens evaluations include 3 follow ups visits within 60 days. There will be a \$25.00 charge per office visit after 60 days or more than 3 visits. After 6 months from your initial exam another complete eye exam will be required
5. Contact Lens refits to a different lens incurs another evaluation fee.
6. Spectacles sales are final.
7. Unopened, unmarked, unexpired contact lens boxes may be exchangeable.

I acknowledge that I have received, read, and agreed to the Office Policy

Parent/Patient's Signature _____ Date _____

Acknowledgement of Review of Notice of Privacy Practices, Frisco Eye Clinic

I have been offered and/or reviewed the Notice of Privacy Practices which explains how my medical information will be used or disclosed. I understand I am entitled to receive a copy of the Privacy Practices. The Notice of Privacy Practices may also be found at www.friscoeyeclinic.com.

Initial Here _____

General Consent to Treat

I, knowing that I have a condition requiring diagnostic or medical treatment do hereby voluntarily consent to such procedures and care by Dr. Pearson, Dr. Buthod, or designee as necessary in his/her judgment.

Initial Here _____

Third Party Reimbursement Policy and Refraction Policy

Refraction is the process of determining the eyes refractive error or need of corrective spectacles and/or contact lenses. This is NOT covered by Medicare/Medicaid and may or may not be paid by other medical insurances. All vision insurance must be pre-approved prior to your examination. If we are unable to verify coverage all charges must be paid in full when services are rendered. If you are not eligible for insurance benefits, or are eligible for less than full coverage, your initial and signature below indicates that you agree to be financially responsible for any unpaid balances. Professional service fees are non-refundable.

Initial Here _____

Authorization Release of Medical Information

I certify that the above information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Frisco Eye Clinic on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare Services and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the CMS-1500 claim form or electrically submitted claim), my signature authorizes release of medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

Initial Here _____

Patient (Guardian) Signature

Date

Doctor Signature

Date

Whom can we thank for your referral?

Friend/Coworker _____ Insurance company _____ Drive By _____
Medical professional _____ Website _____ Other _____

Visual History: Please indicate all that apply

Blurry far Blurry near Tearing Itchy Dryness Pain Discomfort Headaches Glare Contact Lens Discomfort

Are you sensitive to (circle all that apply) Heaters Blowers Air Conditioning Cigarettes Smog Dust Pollen Contacts Contact Lens Solutions Animals

Do you currently wear glasses/contact lenses? Yes No Name of last eye doctor and exam date _____

Medical History:

Primary Care Physician: _____ Phone number: _____ Date of last physical _____

Do you have DIABETES? YES NO How many years? _____ Using Medication? YES NO

Do you have HYPERTENSION? YES NO How many years? _____ Using Medication? YES NO

Do you have Cholesterol Problems? YES NO How many years? _____ Using Medication? YES NO

Females: Are you Pregnant/Nursing? YES NO

Medications: (Please list any and all Medications including Over the Counter, Homeopathic, Birth Control or Remedies): _____

Are you **ALLERGIC to Medications?** YES NO I am allergic to: _____

List and date all Major Injuries, Surgeries, and Hospitalizations you have had:

Review Of Systems (ROS): Do you have Current or Past problems with:

Constitutional: Fever, Weight Loss, Appetite YES NO
Integumentary: Skin conditions/disorders YES NO
Neurological: Headaches, Migraine, Seizures YES NO
Endocrine: Thyroid, Diabetes YES NO
Ears, Nose Throat: Allergies, Sinus, Cough, Dry Throat/Mouth YES NO
Respiratory: Asthma, Emphysema, Bronchitis YES NO
Vascular: Hypertension, Stroke, Heart Pain YES NO
Gastrointestinal: Diarrhea, Constipation YES NO
Genitourinary: Genitals, Kidneys, Bladder YES NO
Bones/ Joints: Rheumatoid Arthritis, Muscle Pain YES NO
Lymphatic/Hematologic: Anemia, Bleeding YES NO
Allergic Immunologic: Allergies, Immune YES NO
Psychiatric: Depression, Anxiety YES NO

Ocular ROS:

Sudden Vision Loss YES NO R L
Blurred Vision YES NO R L
Loss of Side Vision YES NO R L
Double Vision YES NO R L
Floaters YES NO R L
Flashes of Light YES NO R L
Mucus Discharge YES NO R L
Redness YES NO R L
Gritty Feeling/Dryness YES NO R L
Itching/ Burning YES NO R L
Tearing/Watery YES NO R L
Glare/Light Sensitivity YES NO R L
Eye Pain/ Discomfort YES NO R L
Haloes at Night YES NO R L

Circle which eye(s)

Family History:

Blindness YES NO _____
Cataracts YES NO _____
Glaucoma YES NO _____
Macular Degeneration YES NO _____
Retinal Disease YES NO _____
Arthritis YES NO _____
Cancer YES NO _____
Diabetes YES NO _____
High Blood Pressure YES NO _____
Heart Disease YES NO _____
Kidney Disease YES NO _____
Thyroid Disease YES NO _____
Any Other? Explain: _____

Relationship to you (parents, grandparents, siblings):

Social: (this information is strictly confidential, you may discuss this part with the doctor) Check here to discuss with Doctor

Do you drive? YES NO Do you have visual difficulty driving? YES NO Explain _____

Use of tobacco products? YES NO

Use of alcohol products? YES NO

Use of illicit drugs? YES NO

Have you been exposed to any Infectious Disease? (HIV, STD's, Hepatitis, TB, ect.) YES NO