Welcome to our office

Please fill out this form as completely as possible and return to the front desk

Date: _____ Date of Birth: _____ Sex: M / F

Name: _____ SSN: _____

Address: _____ City: _____

State: _____ Zip: _____ Marital Status: married / single / divorced / widowed

Email Address: _____

Home Phone: _____ Cell Phone: _____

Preferred Contact Method: text message / email / phone call

Primary Care Physician _____

Phone of Primary Care: _____

Last Eye Exam: _____

VISION INSURANCE INFORMATION

Insurance: _____ Card Number or ID # _____

Primary Cardholder: _____ Primary D.O.B. _____

Primary SSN#: _____ Relationship to Insured: Self / Spouse / Child

MEDICAL INSURANCE INFORMATION

Insurance: _____ Card Number or ID # _____

Primary Cardholder: _____ Primary D.O.B. _____

Primary SSN#: _____ Relationship to Insured: Self / Spouse / Child

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone _____

MEDICAL HISTORY

Reason for today's visit: _____

_____

_____

Currently Wear Glasses? _____

Currently Wear Contacts? _____

Have you or a family member experienced, or been treated for any of the following?

Cataracts yes no family

Crossed Eye: yes no family

Glaucoma: yes no family

LASIK or RK yes no family

Lazy Eye yes no family

Macular Degeneration yes no family

Retinal Detachment yes no family

Are you currently experiencing, or have experienced any of the following?

Blurry Vision (Near or Distance) Burning

Discharge Double Vision Dryness

Excess Tearing/Watering Eye Infection

Eye Pain or Soreness Floaters or Spots

Halos Headaches Itching

Light Flashes Light Sensitivity

Redness Sandy or Gritty Feeling

Have you or a family member experienced or been treated for any of the following?

AIDS/HIV yes no family

Allergies yes no family

Arthritis yes no family

Asthma yes no family

Blood/Lymph Disorder yes no family

Cancer yes no family

Diabetes yes no family

Ears, nose, throat yes no family

Gastrointestinal condition yes no family

Heart Disease yes no family

High Blood Pressure yes no family

High Cholesterol yes no family

Kidney Disease yes no family

Lupus yes no family

Neurological Conditions yes no family

Psychiatric Disorder yes no family

Seizures yes no family

Skin Conditions yes no family

Stroke yes no family

Thyroid Dysfunction yes no family

Current Medications: _____

_____

_____

Medication Drug Allergies: _____

_____

Height: _____ **Weight:** _____

Are you pregnant? _____ **Do you smoke?** _____

Contact Lens Service Agreement

Important information, please read carefully

30 Day Trial Period – The fee you paid for the Contact lens evaluation covers all disposable trial lenses and contact lens follow-ups for a 30 day period from the day of the initial exam. If a medical visit is necessary within that period, the medical visit will not be included in the trial period and will be filed with your medical insurance if available or subject to self-pay charges. If for any reason the patient goes beyond the 30 day trial period, additional fees may be incurred.

Return Policy – If you are not satisfied with your contact lens purchase and they are undamaged, unopened and not expired, you may return them within 60 days of the original purchase date. We can either exchange or credit the amount towards eyeglasses or other materials. Fees for services are not refundable.

Vision Source is not responsible for contact lenses that are purchased and not picked up within 90 days.

We recommend **new wearers** gradually adjust their eyes to contact lenses by starting with 6 ours of wear and add 2 hours each day until the normal wear time is reached.

If you have insurance, your exam copay is for the comprehensive exam only. Wearing contact lenses is usually considered an elective form of vision correction. Therefore, the contact lens exam is not covered and you are responsible in full for this charge. Some insurance do allow a certain reimbursement for the contact lenses IN LIEU OF glasses.

Notice to patient: Contact lenses are federally regulated medical devices that can only be dispensed by prescription. They must be regarded with the same caution given to prescription drugs, which includes recognizing prescription expiration dates, number of refills and follow-up visits with your eye doctor. Your eyes go through gradual changes in size, shape and physiological requirement (such as oxygen) over time, which can change the contact lens fit and affect the health of your eyes. You should understand the importance of regular examination and as recommended by your doctor to preserve your sight.

If questions or problems arise related to contacts obtained outside this office, the doctor may charge service fees for temporary lenses as well as fees for doctor's time related to problem solving. This office cannot be responsible for negative outcomes if the RX is filled beyond expiration limits, filled incorrectly by outside sources or if the lenses are worn improperly by the patient such as sleeping in them. In the event of eye redness, discomfort or vision changes, discontinue contact lens wear and call the office at 281-466-1700.

In efforts to maintain your ocular health we suggest that any contact lens patients purchase a pair of ophthalmic sunglasses to wear. Please see option for details.

Print Patient Name: _____

Sign Name: _____ (Patient / Guardian)
Circle one

Date: _____

HIPAA PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to Privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessment and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this practice has the right to change this notice from time to time, and that I may contact the practice at any time to obtain a current copy.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

The type of PHI to be restricted or limited: _____

_____

_____

I give permission to discuss my medical care with the following individuals: _____

_____

_____

I understand that I may revoke this consent in writing at any time, except to the extent that you have take action relying on this consent

Patient's Name:_____

Signature of Patient: _____

Relationship to Patient:_____

Date: _____/_____/_____

Most people have vision insurance and medical insurance. They are very different in terms of the services they cover and it's important for our patients to understand those differences. Vision coverage (VSP, Spectera, EyeMed, Davis etc) is mainly designed to determine a prescription for glasses and is not equipped to deal with complex medical conditions and/or diagnoses. It does allow for screenings of conditions, but once they are determined, then medical insurance is filed on those services. When a medical condition is present (such as diabetes, cataracts, dry eye, floaters, etc.) it is necessary to file the visit with your major medical carrier (BCBS, Aetna, UHC, Cigna, etc) and the co-pays for that insurance will apply. Insurance carriers set these rules and our office is required to follow them. In most cases, there is no way to know prior to the examination which type of insurance our office will be able to file for you.

1. If you have ANY problems or complaints that MAY be attributable to a medical condition which requires a more in-depth investigation and additional medical decision-making to rule out any underlying eye disease, we will accordingly bill your MEDICAL insurance, NOT your vision plan. These include, but are not limited to:

- New or sudden blurry vision
- Eye pain or redness
- Flashes or floaters
- Headaches
- Dry or itchy eyes
- Loss of vision
- Eyestrain or double vision

2. There are a variety of systemic conditions that can profoundly and permanently affect a patient's vision that require a more in-depth investigation, which may include additional testing, follow up visits, and reports to your primary care physician. This type of examination is NOT covered under "vision" plans, and we will bill your MEDICAL insurance, NOT your vision plan. These include, but are not limited to:

- Diabetes
- Lupus or autoimmune disease
- Hypertension
- Diseases resulting in use of high risk medications like Placquenil
- Thyroid disease

3. If you have previously been diagnosed by another eye doctor for any eye issues that require medical decision-making, treatment or management, we will bill your MEDICAL insurance, NOT your vision plan. These include, but are not limited to:

- Cataracts
- Macular or retinal disease
- Amblyopic/lazy eye
- History of eye surgery
- Glaucoma/previous diagnosis of high eye pressure

We make every effort to be on every major carrier for your convenience and we will file those claims for you. In the event that we do not take your insurance we will provide you with an itemized receipt so that you may file with your carrier for reimbursement. If you have any questions, please let us know.

I understand the paragraph above & authorize Vision Source Woodlands to file my insurance by the above guidelines.

Signature: _____ Date: _____

Patient Financial Responsibility

This agreement will renew each year after the initial visit until the patient or patient's guardian states otherwise.

Eye Care Services: Our office provides a full scope of eye care services, including routine vision care (i.e. check-ups, glasses and contact lenses), as well as medical eye care services (i.e. eye infections, dry eye and lid disease, treatment and evaluation of ocular allergies, cataracts, glaucoma, and trauma related care). Payment for all services rendered by this office are the responsibility of the patient. Regardless of the amount or type of insurance you or your employer have purchased, each patient assumes full responsibility for all fees incurred. You are responsible for all charges not paid by your insurance carrier. Depending on the nature of your visit, we may be able to bill your vision plan insurance, your medical insurance, or both. Your medical insurance may be able to be billed for certain eye conditions and procedures that your insurance company deems medically necessary and has included in your policy. **Please present all of your insurance information to the receptionist upon arrival.** Even with this information, it is impossible for our office to determine with any certainty what, if any, charges will be covered by your insurance company. What your insurance company deems medically necessary has no bearing on the quality of care we provide. Our services are aimed at providing you with the best care possible, regardless of insurance. In the event of a dispute or rejection of a claim, you are responsible for payment. If we do not contract with any of your insurance providers, you should assume your insurance is not accepted by this office and that payment for services will be due on the day of your visit. If you are an **HMO** insured patient, you may elect to see us and pay for the services directly or see your **HMO** primary care physician for a referral letter prior to visiting our office.

Materials: The payment for any balance is due when products are ordered. If after 90 days the order has not been picked up, you will receive a message that the order will be cancelled and the payment forfeited.

Records Release: We will provide a report of your most recent exam results and current spectacle and contact lens prescriptions upon request at no charge. If you request copies of your full medical records, there will be a charge of $0.25 per page and we will impose a minimum handing fee (including copies) of $10 plus the cost of delivery method that you choose. All charges must be paid before the records will be released.

Methods of Payment: All major credit cards, bank debit cards, checks and cash will be accepted. There will be a $30 fee plus our bank fee for a returned check. Balances due, notwithstanding insurance balances, that are not paid in full within 30 days may be turned over to an outside collection agency for final payment. We will bill **one** insurance claim for you as a courtesy. Patients with more than one insurance company, additional claims can be billed on your behalf for a $10 processing fee.

I have read and understood the office financial policies and agree to the conditions above and further agree that I, as the patient receiving the services or the responsible party for the patient, am ultimately responsible for payment of any materials ordered and/or services rendered.

Acknowledgements, Assignment of Benefits Authorization, and Release of Medical Information:

I have read, understood, and agree to the policies outlined above. I consent to the performing of optometric procedures agreed to be necessary or advisable. I authorize the release of any information contained in my records for the purpose of my treatment, billing and processing of insurance claims. I authorize all payment form my insurance carrier to make directly to Vision Source Woodlands. I certify that the information I reported with regard to my insurance coverage is correct. I will permit a copy of this form to be used in place of the original; the duration of this document is indefinite and continues until revoked in writing. I acknowledge that a copy of Vision Source Woodlands Notice of Privacy Practices has been made available to me to view.

Name	Signature	Date

Refunds and Cancellations

Prescription lenses are specifically designed to adapt to you and your prescription only. This is the reason we cannot offer refunds on prescription lenses. In the event you wish to cancel your order it must be done by the close of business on the same day, in order to receive a full refund. All costs incurred once a prescription order has been started at the lab, whether or not completed, will be the patient's responsibility. Therefore, a cancellation fee might be applicable and prices might vary.

Prescription Rechecks

Only one recheck will be honored for a period of 30 days from the date of dispense. Costs associated with changes other than the prescription recheck will be the responsibility of the patient.

Refraction rechecks for glasses that were made elsewhere will incur a $30 fee.

Warranty

Frames are warranted against manufacturers' defects for a period of one year from purchase date and will be replaced with the same or like item of the same price range.

Non Adapt

If for any reason you are not able to adapt to using the progressive lenses, we will replace those lenses within 60 days of receipt with either a pair of single vision distance, single vision near or a lined bifocal. No refunds will be issued.

Name: _____ Date: _____

Signature: _____

Dilation

Dilating ones pupils on a yearly basis is a very important part of your preventative eye care. By performing a method of dilation, the doctor can get a much better view of your retina, optic nerve and vessels in the back of the eye to make sure there are no signs of damage or disease.

Dilation Drops: The dilation drops are included in the cost of your exam. In summary, the doctor must put eye drops into your eyes and wait roughly 10-15 minutes before seeing you again while the drops take effect (*side effects may occur). Once your pupils are fully dilated, you will go back into an exam room so the doctor may look into your eyes and check the overall eye health.

Circumstance where dilation may be recommended: flashes, floaters, diabetes, and cataract surgery.

OptoMap Retinal Imaging: The OptoMap Retinal Photo is a quick and efficient way of allowing your doctor to view the majority of your retina without using drops or having to wait an extended period of time. A thorough screening of the retina is recommended and can lead to early detection of common disease such as Glaucoma, Diabetes, High blood pressure, macular degeneration, bleeding in the retina and even Cancer. The OptoMap is a great asset in the Optometry field as it allows the doctors to keep a permanent digital photo of your eyes year to year as a comparison to any changes of variations that may occur. If also provides an in-depth digital image to discuss and answer questions about your eye health during your examination. The cost for this service is $26. If you and a family member both decide to get the OptoMap during your visit on the ***same day***, the additional OptoMap is only $20 for the other family member(s). Must be same day, *no exceptions.*

Dilation Drops	**vs.**	**OptoMap Retinal Imaging**
1. Blurred near vision for 2-4 hours		1. No drops required
2. Light sensitivity for 2-4 hours or more		2. No light sensitivity/No blurry vision
3. Longer overall time for exam while drops take effect		3. Photo takes less than 2 minutes to take
4. No permanent record of retina		4. Permanent digital image of retina year to year

*With the dilation drops, possible side effects may occur. These side effects may include nausea, drowsiness, sensitivity to light, headaches, and lightheadedness (possibly painting). While dilated, you will not be able to see clearly up close for reading and computer use for approximately 3-5 hours, and in some cases longer. Those that opt for dilation drops will need to exercise caution while driving and operating machinery as vision will be impaired.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION AND HOW YOU CAN GET ACCESS TO SUCH INFORMATION. PLEASE READ IT CAREFULLY. Your "health information," for purposes of this Notice, is generally any information that identifies you and is created, received, maintained or transmitted by us in the course of providing health care items or services to you (referred to as "health information" in this Notice).

We are required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable laws to maintain the privacy of your health information, to provide individuals with this Notice of our legal duties and privacy practices with respect to such information, and to abide by the terms of this Notice. We are also required by law to notify affected individuals following a breach of their unsecured health information.

USES AND DISCLOSURES OF INFORMATION WITHOUT YOUR AUTHORIZATION

The most common reasons why we use or disclose your health information are for treatment, payment or health care operations. Examples of how we use or disclose your health information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we must carry out in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

OTHER DISCLOSURES AND USES WE MAY MAKE WITHOUT YOUR AUTHORIZATION OR CONSENT

In some limited situations, the law allows or requires us to use or disclose your health information without your consent or authorization. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are: • when a state or federal law mandates that certain health information be reported for a specific purpose; • for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices; • disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence; • uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws; • disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies; • disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else; • disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations; • uses or disclosures for health related research; 2 v.2013.05.17 • uses and disclosures to prevent a serious threat to health or safety; • uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service; • disclosures of de-identified information; • disclosures relating to worker's compensation programs; • disclosures of a "limited data set" for research, public health, or health care operations; • incidental disclosures that are an unavoidable by-product of permitted uses or disclosures; • disclosures to "business associates" and their subcontractors who perform health care operations for us and who commit to respect the privacy of your health information in accordance with HIPAA; Unless you object, we will also share relevant information about your care with any of your personal representatives who are helping you with your eye care. Upon your death, we may disclose to your family members or to other persons who were involved in your care or payment for heath care prior to your death (such as your personal representative) health information relevant to their involvement in your care unless doing so is inconsistent with your preferences as expressed to us prior to your death.

SPECIFIC USES AND DISCLOSURES OF INFORMATION REQUIRING YOUR AUTHORIZATION

The following are some specific uses and disclosures we may not make of your health information without your authorization:

Marketing activities. We must obtain your authorization prior to using or disclosing any of your health information for marketing purposes unless such marketing communications take the form of face-to-face communications we may make with individuals or promotional gifts of nominal value that we may provide. If such marketing involves financial payment to us from a third party your authorization must also include consent to such payment.

Sale of health information. We do not currently sell or plan to sell your health information and we must seek your authorization prior to doing so.

Psychotherapy notes. Although we do not create or maintain psychotherapy notes on our patients, we are required to notify you that we generally must obtain your authorization prior to using or disclosing any such notes.

YOUR RIGHTS TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES

• Other uses and disclosures of your health information that are not described in this Notice will be made only with your written authorization.

• You may give us written authorization permitting us to use your health information or to disclose it to anyone for any purpose.

• We will obtain your written authorization for uses and disclosures of your health information that are not identified in this Notice or are not otherwise permitted by applicable law.

• We must agree to your request to restrict disclosure of your health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law and such information pertains solely to a health care item or service for which you have paid in full (or for which another person other than the health plan has paid in full on your behalf). Any authorization you provide to us regarding the use and disclosure of your health information may be revoked by you in writing at any time. After you revoke your authorization, we will no longer use or disclose your health information for the reasons described in the authorization. However, we are generally unable to 3 v.2013.05.17 retract any disclosures that we may have already made with your authorization. We may also be required to disclose health information as necessary for purposes of payment for services received by you prior to the date you revoked your authorization.

YOUR INDIVIDUAL RIGHTS

You have many rights concerning the confidentiality of your health information. You have the right:

• To request restrictions on the health information we may use and disclose for treatment, payment and health care operations. We are not required to agree to these requests. To request restrictions, please send a written request to us at the address below.

• To receive confidential communications of health information about you in any manner other than described in our authorization request form. You must make such requests in writing to the address below. However, we reserve the right to determine if we will be able to continue your treatment under such restrictive authorizations.

• To inspect or copy your health information. You must make such requests in writing to the address below. If you request a copy of your health information we may charge you a fee for the cost of copying, mailing or other supplies. In certain circumstances we may deny your request to inspect or copy your health information, subject to applicable law.

• To amend health information. If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, you must write to us at the address below. You must also give us a reason to support your request. We may deny your request to amend your health information if it is not in writing or does not provide a reason to support your request. We may also deny your request if the health information:

o was not created by us, unless the person that created the information is no longer available to make the amendment,

o is not part of the health information kept by or for us,

o is not part of the information you would be permitted to inspect or copy, or

o is accurate and complete.

• To receive an accounting of disclosures of your health information. You must make such requests in writing to the address below. Not all health information is subject to this request. Your request must state a time period for the information you would like to receive, no longer than 6 years prior to the date of your request and may not include dates before April 14, 2003. Your request must state how you would like to receive the report (paper, electronically).

• To designate another party to receive your health information. If your request for access of your health information directs us to transmit a copy of the health information directly to another person the request must be made by you in writing to the address below and must clearly identify the designated recipient and where to send the copy of the health information.

Contact Person: Our contact person for all questions, requests or for further information related to the privacy of your health information is: Karin Gerdts.

Complaints: If you think that we have not properly respected the privacy of your health information, you are free to complain to us or to the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown above. If you prefer, you can discuss your complaint in person or by phone.

Changes to This Notice: We reserve the right to change our privacy practices and to apply the revised practices to health information about you that we already have. Any revision to our privacy practices will be described in a revised Notice that will be posted prominently in our facility. Copies of this Notice are also available upon request at our reception area.