

LAKE TRAVIS EYE CARE

Name: _____

D.O.B.: _____

Street Address: _____

Home Phone: _____

City, State & Zip: _____

Cell Phone: _____

Email Address: _____

Hobbies: _____

Employer/School: _____

Occupation/Grade: _____

When was your last eye exam? _____

Do you wear glasses?	Yes	No
Are you interested in contacts?	Yes	No
Have you worn contacts before?	Yes	No
Have you ever had eye surgery?	Yes	No
Have you ever had an eye injury?	Yes	No
Do you use any eye drops?	Yes	No

Have you or a family member been diagnosed with any of the following eye conditions?

Amblyopia ("Lazy Eye")	Self	Family	No
Cataracts	Self	Family	No
Glaucoma	Self	Family	No
Macular Degeneration	Self	Family	No
Retinal Detachment/Hole	Self	Family	No
Strabismus (Eye Turn)	Self	Family	No
Other Eye Condition(s):			

Are you experiencing any of the following symptoms?

Blurry Vision	Yes	No
Double Vision	Yes	No
Dry Eyes	Yes	No
Eye Pain	Yes	No
Eye Strain	Yes	No
Flashes of Light	Yes	No
Floaters	Yes	No
Glare	Yes	No
Headaches	Yes	No
Itchy Eyes	Yes	No
Light Sensitivity	Yes	No
Poor Night Vision	Yes	No
Redness	Yes	No
Watery Eyes	Yes	No
Other Symptom(s):		

Have you or a family member been diagnosed with any of the following medical conditions?

Allergies	Self	Family	No
Autoimmune	Self	Family	No
Blood/Lymphatic	Self	Family	No
Cancer	Self	Family	No
Cardiovascular (Heart)	Self	Family	No
Dermatological	Self	Family	No
Diabetes	Self	Family	No
Endocrine/Thyroid	Self	Family	No
Gastrointestinal	Self	Family	No
Genitourinary/Kidney	Self	Family	No
High Blood Pressure	Self	Family	No
High Cholesterol	Self	Family	No
Infectious Disease/STD	Self	Family	No
Muscle/Bones/Joints	Self	Family	No
Neurological	Self	Family	No
Psychological	Self	Family	No
Respiratory	Self	Family	No
Other Medical Condition(s):			

When was your last physical exam? _____

Are you pregnant or nursing? Yes No

Environmental and medical allergies: None

Medications and supplements: None



OFFICE POLICIES

- Payment is expected in full at time of service.
- No refunds are offered on services provided.
- The patient has 30 days to return for an office visit without a charge if any issues or concerns arise with spectacle or contact lens prescriptions. Any prescription checks or changes after 30 days will be subject to a recheck or refit fee.
- Opened boxes of contact lenses cannot be returned or exchanged.
- Because they are custom-made, no refunds, returns, or cancellations are offered on prescription spectacle lenses.
- Frames are warranted for one year against manufacturer's defects only. This warranty does not cover damage to the frame.
- No warranty is offered on a patient's own frame when ordering new lenses only. Any replacement needed or damage incurred during the lens-filling process is the patient's responsibility.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I have been provided with a copy of the Notices of Privacy Practices for Sarah E. Gibson, O.D. & Associates, effective date August 19, 2015. I understand my medical records are confidential and that by signing this consent form I am allowing my medical information to be released upon my insurance provider's request for the purpose of health care operations. I also understand that I may request to restrict disclosure of specific information in my medical records. Phone messages, email, and texts may be used to contact me. I can request disclosure restrictions or opt out of these contact methods at any time with written request to the Privacy Officer.

CONSENT TO SHARE INFORMATION WITH OTHER PERSONS

Health record information, including exam results, diagnoses, prescriptions, and billing information, is protected from sharing with other persons, including family members and spouses, unless consent is given. Please list any other persons with whom Lake Travis Eye Care is allowed to discuss the patient's health record information:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

or check below:

Do not share my health record information with any other persons.

I have read and understand all of the office policies and privacy policies of Lake Travis Eye Care and agree to abide by them.

Print Name of Patient/Guardian

Signature

Date



FINANCIAL RESPONSIBILITY

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible for all copays and any charges not covered by my health care benefits.

Lake Travis Eye Care will try to obtain advanced authorization and verification of my insurance benefits, but it is my responsibility to know the coverage and benefits of my insurance plan(s). All verified copays and out-of-pocket charges are due in full at the time of service. A quote of benefits is not a guarantee of payment by my insurance carrier. Exact insurance benefits cannot be determined until the insurance company receives the claim and returns payment.

Lake Travis Eye Care will bill my insurance plan(s) for services if the doctor is a participating provider. Lake Travis Eye Care will file the claim in a timely manner, but this process may take months to complete. If after submitting my claim, some fees are found to not have been paid by my plan, I am responsible for any unpaid deductibles, copays, or non-covered services.

If Lake Travis Eye Care is not a provider for my insurance plan, full out-of-pocket payment will be required at the time of service if I choose to be seen for an exam and/or purchase materials. I will then be provided with an itemized receipt for me to file with my insurance carrier for any reimbursement allowed.

MEDICAL AND VISION INSURANCE COVERAGE

There are two different types of health insurance that will help pay towards eye care services and products: medical insurance and vision care plans. Lake Travis Eye Care needs the patient's information for both types of insurance to bill the patient and the insurance carrier(s) appropriately.

Medical insurance must be used if the patient has any eye health problems (dry eye, ocular allergies, glaucoma, cataracts, etc.) or systemic health problems that can cause ocular complications (diabetes, high blood pressure, thyroid disorder, etc.). The doctor will determine if these conditions apply to the patient, but she may not be able to determine so until the exam is completed. The medical specialist copay will apply and will be collected at the time of service. This copay will need to be paid at the initial exam as well as at each subsequent office visit in order to continue care.

Vision care plans only pay towards vision wellness exams, determining glasses and contact lens prescriptions, and materials (glasses and contact lenses). They do not cover diagnosis, management, or treatment of eye diseases or ocular complications from systemic diseases.

If the patient has both types of insurance plans, it may be necessary to bill some services to the medical plan and other services to the vision plan. Lake Travis Eye Care will use coordination of benefits to bill properly and to minimize the patient's out-of-pocket expense.

I have read and understand all of the financial responsibility policies and insurance coverage policies of Lake Travis Eye Care and agree to abide by them.

Print Name of Patient/Guardian

Signature

Date
