**Welcome to Elite Family Vision**

Please fill out this patient history form so we may serve you better.

This information is kept private and confidential. This form will be shredded after its use is complete.

Patient Name:

Date of Birth:

Address:

City: State:

Zip code:

Phone Number:

Email (required):

**OFFICE USE ONLY NEW ESTABLISHED**

**Name of Insurance:**

**Exam copay:** CL fit copay:

**Exam type:** Glasses Contact Lens Medical

**Cl fit:** Spherical Toric/ Mono/Multi RGP

**Follow up**: \_\_\_\_\_\_\_\_ Call 1 week \***Order trials\*** None

**Retinal exam:** Optomap Dilation Reschedule None

**Health and Vision History**

Reason for today’s visit:

Date of last eye exam:

**Please circle any of the conditions that you are currently experiencing:**

Blurry Vision

Discharge

Dryness

Eye Strain

Flashes

Floaters

Halos

Itching

Light sensitivity

Poor night vision

Redness

Other\_\_\_\_\_\_\_\_\_\_\_

**Please circle any of the conditions that you have been diagnosed with, or taking medication for:**

Amblyopia/Lazy eye

Arthritis

Asthma

Cancer

Cataract

Diabetes

Eye infection

Eye Injury

Eye Surgery/LASIK

Glaucoma

Heart Condition

High Blood Pressure

High Cholesterol

Macular degeneration

Retinal problems

Seasonal Allergies

Thyroid problems

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list your medications:**

**Please list any food or medical allergies:**

**Please list any family history of health or eye conditions:**

**Smoking:** YES NO

**Recreational Drug Use:** YES NO

Alcohol use: **YES NO**

Occupation:

Please sign the next page

**Elite Vision Examination and Billing Protocols: PLEASE READ CAREFULLY**

* Your comprehensive eye exam will be conducted at the time of your appointment. You can delay the dilation part of your eye examination for 30 days at no extra charge. Declining the internal eye exam will require a signed consent and is NOT ADVISED.
* Contact Lens exams may require follow up exams on a separate date for no extra charge. Follow up exams should be maintained as scheduled, and prescriptions should be finalized within 90 days of the initial visit. If the process takes longer due to noncompliance with follow up exams, then there will be an additional contact lens examination fee payable by the patient.
* If you are not comfortable with your glasses, we will do one free prescription recheck within 90 days of the initial eye exam. If results are unchanged, then please take your concerns to the optical where you received your glasses.
* You must present your insurance information before or on the day of your visit. The decision to bill your vision insurance vs. your medical insurance depends on the reason for your visit and severity of eye condition when you present for your exam. The final decision is made by the doctor; and respective copays, coinsurance, and other responsibilities will apply to you. We will try our best to furnish you with your payables ahead of time. In some cases we have to receive an explanation of benefits from your insurance company.
* Payment in full is due at the time of service. Payments made toward services offered at Elite Family Vision PLLC are non-refundable.

**Notice of Privacy Practices: PLEASE READ CAREFULLY**

* We will use your health information for referrals to other physicians for your continued care, to provide appointment reminders, prescribe or recommend treatment alternatives, and provide information about health benefits and services that may be of interest to you.
* We will email your prescriptions and Optomap images to the email address you have provided on this form.
* Please request a copy of our Notice of Privacy Practice from the front desk personnel for more details. Signing this document acknowledges that you were offered the opportunity to review this document.
* Your point of contact about your rights to access your Health Records or complains and comments about your health records privacy is: Jordana Chettiparampil O.D., 17520 Southwest Freeway, Sugar Land, TX 77479.

**Authorization and Consent: PLEASE READ CAREFULLY**

* I certify that I have filled out the patient information form accurately and to the best of my knowledge.
* I understand that providing incorrect or incomplete information may be dangerous to my health.
* I authorize the eye doctor to release any information including the diagnosis and records of any care rendered to me, to third party payers/ health practitioners for the purposes of payment or continued care.
* I attest that the address, phone number, and email address provided is mine, and Elite Family Vision PLLC can contact me to remind me of appointments, mail patient information including prescriptions, Optomap images, and balance payable notices to any of the above.
* I authorize any holder of medical information about me to release any medical benefits provider information necessary to determine my eligibility/benefits.
* I authorize and request my insurance company to pay directly to the eye doctor, the benefits otherwise payable to me.
* I understand that my insurance carrier may pay less than what is billed, and I may be responsible for uncovered balances, copays, coinsurance payments or deductibles that are not covered under insurance contracted amounts.
* I understand that I will not receive prompt pay discounts or special pricing when I use my insurance for payment toward the eye exam.
* I am aware that Optomap testing is an out-of-pocket expense that will not be billed to insurance, or count towards insurance copays or deductibles.
* I understand that payment in full is expected at the time of service, unless billed to an insurance company. All payments for services are final and non-refundable.
* My balances may be forwarded to a collection agency if not paid after three attempts to contact me via phone, email or certified mail.
* I understand that this office is HIPAA compliant and acknowledge that the HIPAA policies are available to be read if requested.
* I understand that this authorization and consent to use my Protected Health Information is valid for 6 years until revoked by providing the practice with a signed and written request.
* I understand that Elite Family Vision PLLC may refuse treatment if I do not consent to the above protocols, notices, and authorizations.

SIGNATURE (Guardian if under 18 years of age).DATE.

Please sign the next page

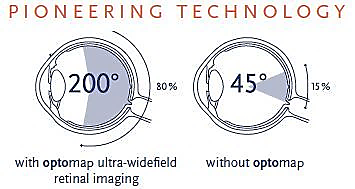
**Retinal Examination – Looking Inside Your Eyes**

* An important part of your eye exam, is the retinal evaluation. It enables the doctor to evaluate the health of your body by looking at the blood vessels, nerves, and other layers inside your eye.
* This evaluation is recommended once a year for all patients.
* The doctor requires this test for
  + Patients with vascular diseases (Diabetes, High Blood Pressure, High Cholesterol)
  + Patients with high myopic prescriptions (Over - 4.00)
  + Patients over 40 years of age.
  + Patients using medications that have ocular side effects (e.g. Plaquenil, Ethambutol, Topamax, Flomax, Blood Thinners, and herbal supplements)
* You may either get your eyes dilated using eye drops, or use the OPTOMAP retinal imaging system.

**The OPTOMAP Imaging System:**

**Fast, Comfortable, and Painless digital imaging of the retina without the use of eye drops**

* We now have state-of-the-art technology that allows us to take a 200 degree wide image of your retina **without the use of any eye drops.**
* The images become a part of your medical records and will be available for review and comparison at all your future appointments.
* There are **no side effects** to this test.

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**Please select one of these two options**

* I would like **Optomap retinal imaging**. I agree to the **$35.00 fee** for service. I understand that this new technology is not covered by my insurance. Reduced to **$25.00** for returning patients.
* I prefer **dilation with eye drops**. I understand that my near vision will be blurry, and my eyes may be light sensitive for up to 6 hours. I understand that I am not supposed to drive or operate any machinery until I feel like my vision has suitably recovered.

SIGNATURE (Guardian if under 18 years of age).DATE.

**OFFICE USE ONLY: Patient waivers**

**Section 1 – Refusal of procedure**

Date \_\_\_\_\_\_\_\_\_\_\_\_

**Procedure:** Dilated retinal examination

I do not wish to have this test at this time. The reason that this test has been recommended for me has been explained. I understand the risk I am taking by not having or delaying this test. I understand and release ELITE FAMILY VISION PLLC and their doctors from all liability to treat or diagnose any eye condition due to lack of diagnostic information that could have been obtained from this test.

Patient name (print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Guardian signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 2 – Refusal of treatment**

Date \_\_\_\_\_\_\_\_\_\_\_\_\_

**Treatment** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I do not wish to have this treatment. The reason that this treatment has been recommended to me has been explained. I understand what may happen if I do not undergo or delay this treatment.

Patient name (print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 3 – Acknowledgement of Referral**

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that my doctor at Elite Family Vision PLLC has recommended that I see \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Provider or facility name) regarding \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Disorder/condition). The reason for this referral has been explained to me. I understand what may happen if I do not follow or delay this recommendation.

Patient name (print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Guardian signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_