TODAY'S VISION
THE ONE TO SEE®

Last Name: _____

First Name: _____ Nickname: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Daytime Phone (if different): _____

Cell Phone: _____ May we text you: ❑ Y ❑ N

E-Mail Address: _____

Referred By: _____

Sex: ❑ M ❑ F Date of Birth: _____ Social Security Number: _____

Marital Status: _____ Employment Status: _____

Employer: _____ Occupation: _____

Race:

- Native American/Native Alaskan ❑
- Asian ❑
- Black/African American ❑
- Hispanic ❑
- Native Hawaiian/Other Pacific Island ❑
- White ❑

Do you currently wear contacts? ❑ Y ❑ N If yes:

What time of day do you start to feel them on your eyes? _____

Do you ever use lubricating drops? ❑ Y ❑ N

Do you desire an improvement in comfort and/or vision? ❑ Y ❑ N

If no:

Would you like to wear contacts? ❑ Y ❑ N

Have you worn them in the past? ❑ Y ❑ N

If so: Why did you stop? _____

Are you interested in LASIK? ❑ Y ❑ N

Last Eye Exam: _____ Doctor: _____

PATIENT HEALTH HISTORY

Primary Care Physician _____ Date Last Seen: _____

Medical/Family History (use additional sheet if more space is needed)

Please list all your current medications (include over the counter, vitamins and herbal therapy): _____

_____

_____

List all major surgeries in the last five years (Eye Surgery included): _____

_____

List any allergic reactions to medications, eye drops or food: _____

Please indicate if any of the conditions apply to you or a family member (blood relatives only).

Disease Condition	Yourself		Family Member		Relationship (blood relatives only)
	Yes	*No*	*Yes*	*No*	
Cataract	❑	❑	Blindness	❑	❑	_____
Eye Turn	❑	❑	Eye Turn	❑	❑	_____
Glaucoma	❑	❑	Glaucoma	❑	❑	_____
Macular Degeneration	❑	❑	Macular Degeneration	❑	❑	_____
Retinal Detachment	❑	❑	Retinal Detachment	❑	❑	_____
Other:						

Women: Are you pregnant? ❑ Yes ❑ No Are you breast feeding? ❑ Yes ❑ No

Office Policies and Patient Financial Responsibilities

Our goal is to provide the best, personalized professional eye care for you and your family. We provide:

- Routine eye examinations
- Medically related eye care
- Complete contact lens care

It is important for our patients to understand the difference between routine eye examinations and medically related eye care. We are providers for select vision plans and most medical insurances.

Routine Eye Examinations and Vision Care Plans

A routine eye examination is for the following: Nearsightedness Farsightedness Astigmatism Eyeglasses Contact Lenses Presbyopia (difficulty seeing up close with increasing age)

A routine eye examination does **NOT** cover diagnosis, management, or treatment of medically related eye diseases.

***Please Note: If you come in for a routine eye examination and a medical eye condition is diagnosed at that time, additional visits will be needed for further diagnosis, management and possible treatment.**

Medically Related Eye Care and Medical Insurance

Medical insurance coverage is used to pay for eye care when there are specific concerns that are medical in nature, previously diagnosed medical condition of the eye, as well as health conditions are present that damage the eye. Some examples are: Cataracts Glaucoma Diabetes High Blood Pressure Dry/Irritated Eyes Allergies Conjunctivitis (Pink Eye) Floaters/Flashes

***Please note: If you are using any insurance for which we are providers, routine eye examination coverage cannot be used the same day as medical eye care coverage and additional visits will be required.**

I have read and understand the differences between routine eye examinations and medically related eye care. I also understand that my eye doctor is a provider for both routine eye examinations and medical eye care insurances and will bill
the appropriate insurance according to insurance guidelines.

**** Initial_____

Fees. Our office is committed to providing the best treatment to our patients. Our fees are representative of the usual and customary charges for the level of service provided, materials prescribed, as well as the level of advanced technology used to provide our patients
with the most modern eye care in our area.

Non-Covered Services. Please be aware that some, and perhaps all, of the services you receive may be uncovered or not considered reasonable or necessary by Medicare or other medical and vision insurers. These services may be required to be paid in full at the
time of your visit or after we receive your explanation of benefits.

Refraction: Medicare and most other insurance plans no longer pay for refractions. The refraction is the test that is performed during your office visit to determine your best possible vision ("which is better, one or two?"). A refraction is also required to determine the health of your eyes. You will be asked to pay for the refraction at the end of your visit. If we do not collect this fee at the end of your visit, you may be sent a statement after we receive your explanation of benefits(EOB) that this service was not covered.

The fee for this test is $60.00.

Consent to Treat. I request and give consent to Today's Vision Creekside to provide and perform such medical and vision eye care, tests, procedures, medications and other services and supplies as are considered medically necessary or beneficial for my eye and vision
health, and well being.

**** Initial_____

Payment. You are responsible for any co pays, co-insurance, deductible and other non-covered services. Any surcharges for spectacle upgrades set by your vision insurance must be paid at the time of service before any orders will be processed. If you are a self pay patient and/or your insurance cannot be verified prior to your appointment you will be required to pay in full the day services are rendered. We accept cash, MasterCard, Visa, Discover Card and Care Credit. If you are being seen for any ongoing medical problem, co-pays are due at each and every visit. If you foresee any payment problems please speak to our office manager prior to your appointment.

Claims Filing. As a courtesy to our patients, we will file claims with insurance companies for which we are providers. We will do our best to accurately verify benefits for services and/or materials, however, benefits quoted by your insurance carrier are not a guarantee of payment. Should your insurance deny a claim for any reason you will be responsible for any remaining balances as directed by your insurance. When required by your insurance company, you are directly responsible for obtaining a referral from your Primary Care Physician.

Billing. Patients that receive a statement from our office are expected to remit full payment upon receipt unless previous payment arrangements were made with our billing office. If your account must be referred to an outside collection agency for non-payment, a fee will be added to your account to cover the expense incurred from the agency. Patients in collections must make payment arrangements prior to scheduling another appointment with our office. If you receive a billing statement that you do not understand, please contact our office.

Proof of Insurance. We are required by law to get an up-to-date copy of your insurance card(s) before seeing the eye doctor. If you do not present this at the time of your visit or fail to provide us with the correct insurance information, you will be responsible for the balance of the claim.

Secondary Insurances. If you have secondary medical or vision insurance, it is your responsibility to have them set up to crossover to each other. Any balance that does not automatically crossover to your secondary insurance will be your responsibility. We will provide you with an itemized receipt that you can send a copy of your EOB (Explanation of Benefits) that you received from your primary insurance for possible reimbursement.

Non-payment. If we do not receive payment from your insurance company within 60 days, the balance will automatically be billed to you. If your account is over 90 days past due, you will receive a letter stating that you have 21 days to pay your account in full. Partial payments will not be accepted unless previously discussed. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative eye care. During that 30 day period, our office will only be able to treat you on an emergency basis.

Missed Appointments. Once your appointment has been confirmed it will be reserved for you to meet your eye care needs. Please be courteous to our staff and fellow patients by keeping your confirmed appointment. If you are unable to keep your confirmed scheduled appointment, please inform us as soon as possible. We do require a 24 hour notice of cancellation of your confirmed appointment.

With my signature below I confirm that I have been informed of and agree with the above outlined policies and insurance authorization. Unless revoked by me in writing, this authorization is effective for my lifetime.

SIGNATURE: _____(Patient or Responsible Party)
DATE: _____

I have received a copy of Today's Vision Creekside's Office Policies and Patient Financial Responsibilities.
SIGNATURE: _____(Patient or Responsible Party)
DATE: _____

Acknowledgment of Notice of Privacy Practices

2020 Vision PLLC
25640 Kuykendahl Rd Ste G Tomball TX 77375
3468087342

The law requires that 2020 Vision PLLC make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

___ I was given the opportunity to read, have read or had explained to me 2020 Vision PLLC's Notice of Privacy Practice prior to any services offered

___ The Notice of Privacy Practice could not be read due to the emergent nature of the care and will be acquired when possible

I authorize 2020 Vision PLLC to release my personal health information to the following individuals:

_____ _____ _____

My vision plan requests that all diagnoses related to any medical condition I may have be released to them. As a non-traditional disclosure, release of this information requires my specific authorization:

___ I authorize the release of medical information to my vision plan

___ I do not authorize release of medical information to my vision plan

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____
Patient Signature

_____
Date

If you are signing as a personal representative of the patient, please indicate your relationship

_____
Representative Signature

_____
Relationship to Patient

ADVANCED RETINAL EVALUATION (Inside/Back Part of Your Eye)

Indicate your choice below

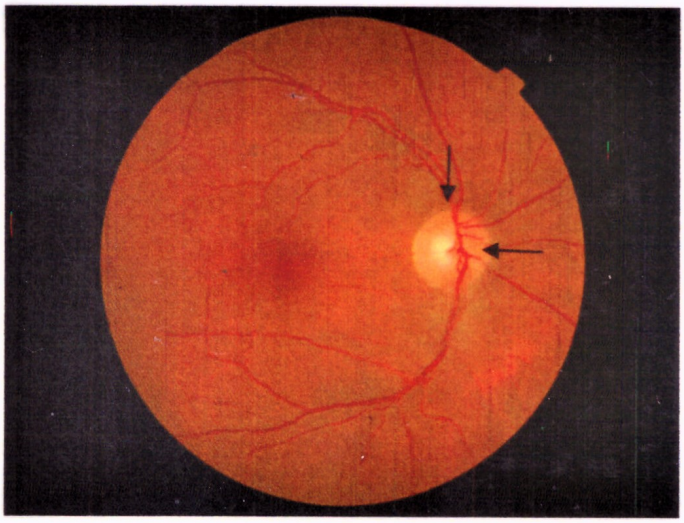
( ) **YES**, I want to have Retinal Screening to protect my Retinal Health. I undertsand that Retinal Screening utilizes state of the art laser technology to capture a digital image of the retinal **without dilation** of the pupil and there are no side effects. Our doctors recommend these tests.

- ❑ Level 1 - Retinal Photography for ages 4-29, $39
- ❑ Level 2 - Retinal Photography + Optic Nerve images for ages 30-49, $45
- ❑ Level 3 - Retinal Photography + Optic Nerve + Macula images for ages 30-49, $50

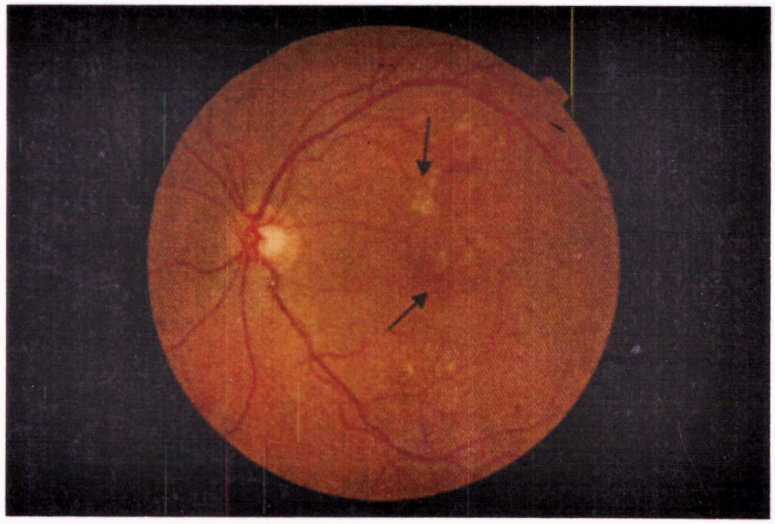
OR

( ) **YES**, I would like to protect my Retinal Health by having a Dilated Exam. I understand that dilation drops will enlarge the size of my pupil and the side effects include light sensitivity and difficulty in focusing for reading. Your dilation can last up to 6hours. If dilation is not covered by your insurance, the cost is $20.

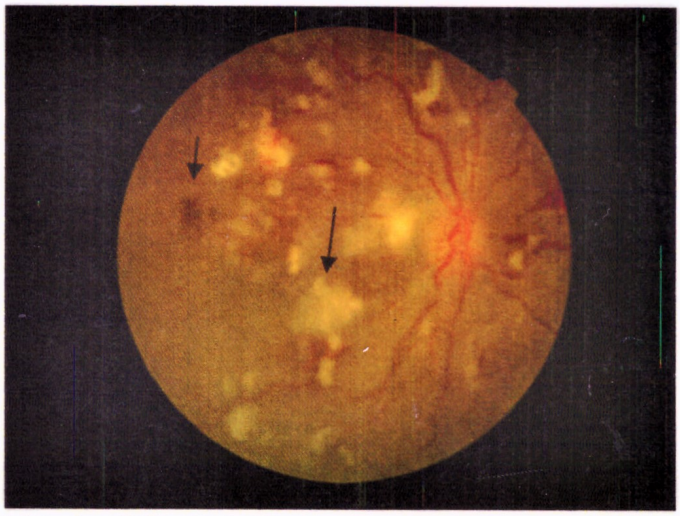
WHY RETINAL EVALUATION IS IMPORTANT



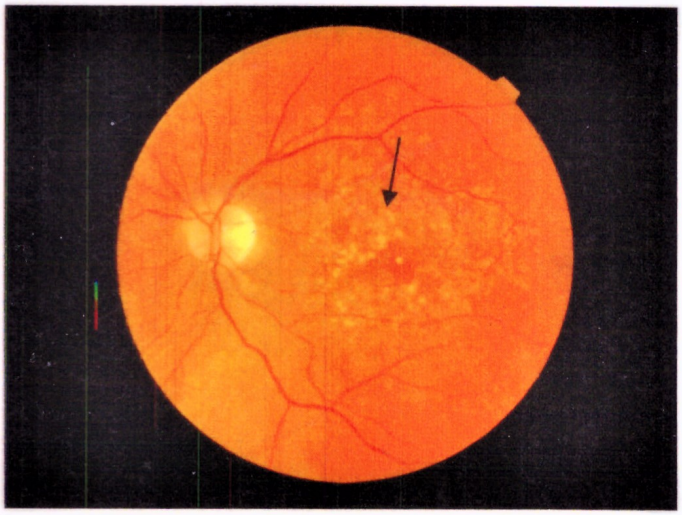
Normal Eye



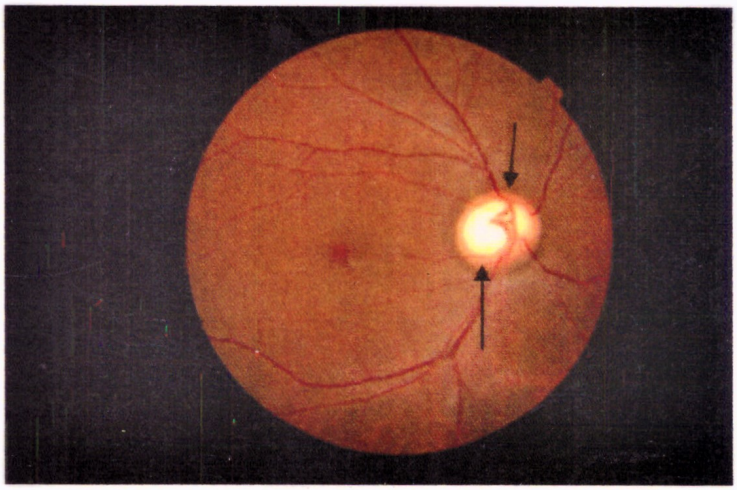
Diabetes in the Eye



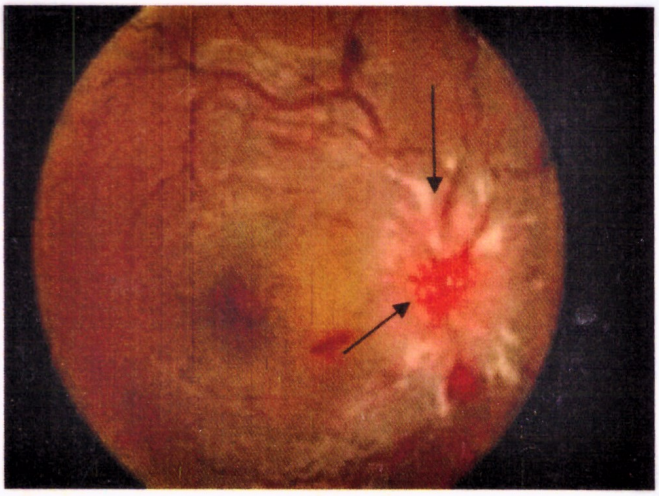
High Blood Pressure in the Eye



Macular Degeneration



Glaucoma



Optic Nerve of a Brain Tumor