Welcome to Our Office!

Personal Information

Name: _____ Gender **M** **F** Date: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone: Home: _____ Work: _____ Cell: _____ Date of Birth: _____ Age: _____

Occupation: _____ Email: _____

Name of Parent/Spouse: _____

Insurance Information (VISION)

Insurance Co: _____ Member ID#: _____

Primary Insured's Name: _____ Employer: _____ Insured DOB: _____

Medical Insurance Information (Primary Health/Medical)

SSN(For Insurance Purposes Only): _____

Insurance Co: _____ Member ID#: _____

Primary Insured's Name: _____ Employer: _____ Insured DOB: _____

Health History

Primary Care Physician: _____ Last Medical Exam: _____

Where was your last eye exam? _____ Date of Last Eye Exam: _____

Do you currently wear glasses? Yes☐ No☐ Type: ☐ General Wear ☐ Reading ☐ Bifocal ☐ Progressive ☐ Sunglasses

Do you wear contact lenses? Y☐ No☐ If YES, how often do you replace your lenses? _____

Type of Contacts: ☐ Disposable ☐ Extended Wear ☐ Hard (RGP) Brand Worn: _____

Please List All Hobbies, Crafts, Sports, Recreational Activities, or Special Visual Tasks:

_____

Eye History	**NO**	**YES**	
		SELF	**FAMILY**
Blurred Vision	☐	☐	☐
Burning/Itching	☐	☐	☐
Cataracts	☐	☐	☐
Eye Turn	☐	☐	☐
Dry Eyes	☐	☐	☐
Eye Allergies	☐	☐	☐
Eye Pain/Soreness	☐	☐	☐
Eye Surgery	☐	☐	☐
Flashes/Floaters	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐
Glaucoma	☐	☐	☐

	NO	**YES**	
		SELF	**FAMILY**
Retinal Detachment	☐	☐	☐
Macular Degeneration	☐	☐	☐
Eye Injury	☐	☐	
Systemic:			
HIV	☐	☐	
Cancer	☐	☐	
Diabetes	☐	☐	
Headaches	☐	☐	
High Blood Pressure	☐	☐	
Stroke	☐	☐	
MS	☐	☐	

Have you ever been exposed to or infected with:

-Gonorrhea Y N

-Hepatitis Y N

-Syphilis Y N

-Chlamydia Y N

Are you currently pregnant or nursing?

Y N

Do you use tobacco products?

Y N

-If YES, type, amount, and how long?_____

Do you drink alcohol?

Y N

-If YES, type, amount, and how long?_____

Medical History	**NO**	**YES**	
		SELF	**FAMILY**
Arthritis/Joint Pain	☐	☐	☐
Seizures	☐	☐	☐
Kidneys/Bladder	☐	☐	☐
Fever	☐	☐	☐
Weight loss/gain	☐	☐	☐
Chronic Cough	☐	☐	☐
Hay Fever	☐	☐	☐

	NO	**YES**	
		SELF	**FAMILY**
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
Swelling	☐	☐	☐
Dry Mouth/Throat	☐	☐	☐
Medicinal Allergies	☐	☐	☐

	NO	**YES**	
		SELF	**FAMILY**
Heart Problems	☐	☐	☐
Vascular Disease	☐	☐	☐
Thyroid Problems	☐	☐	☐
Ulcers	☐	☐	☐
Sinus Problems	☐	☐	☐
Chronic Ear Infection	☐	☐	☐
Systemic Allergies	☐	☐	☐

List All Medications You Are Currently Taking: _____

_____

_____

HIPPA COMPLIANCE POLICY

Your medical records are confidential. Our Privacy Notice describes this policy in further detail. Please initial that you have viewed a copy of our office's privacy policy which can be found beneath this form on the clip board. COPIES ARE AVAILABLE UPON REQUEST. _____

Your insurance is meant to serve as a financial aid. We are happy to take assignment on your benefits. If you are not eligible for these benefits or are eligible for less than full coverage, your signature indicates that you agree to be financially responsible for the balance not paid by your plan for the services rendered. Our staff will make every effort to verify benefits on your behalf. **VERIFICATION OF BENEFITS IS NOT A GUARANTEE OF PAYMENT.** Contact Lens Wearers please be aware that insurance plans rarely provide full coverage for an eye exam, contact lenses, and the professional fees required for evaluation and fitting.

Signature: _____ Date: _____

OPTOMAP RETINAL IMAGING

- Provides the doctor with a detailed scan of the retina to assess the health of your eyes.
- Allows the doctor to detect the presence of disease early into its progression.
- The images serve as a baseline of your ocular health, allowing for future comparisons that help to discover or detect any changes to retinal health.

The fee for OPTOMAP retinal imaging is $ 39.00.

(Recommended for all new patients, diabetics, hypertensive, glaucoma, AMD and high myopes) Not covered by most vision insurances but maybe covered under health insurance.

_____Yes, I consent to have retinal imaging performed today.

_____No, I would like to discuss with the doctor about my need for retinal imaging.

VISUAL FIELD SCREENING

- The visual field screening tests the integrity of the optic nerve pathway.
- It is a non-invasive computerized test which helps detect early signs of glaucoma, optic nerve disorders, retinal diseases, and even certain brain tumors.

The fee for the VISUAL FIELD test is $20.00.

(Recommended if high risk of glaucoma, cataracts, head injuries or needing DMV form) Not covered by most vision insurances but maybe covered under health insurance.

_____Yes, I consent to having my visual field tested today.

_____No, I would like to discuss with the doctor about my need for visual field testing.

CORNEAL AND CONTACT LENS EVALUATION POLICY

Most insurance policies do not include corneal and contact lens evaluation coverage. However, any policy that does cover an evaluation will be billed and you will be charged appropriately based on the level of your evaluation. Your contact lens exam evaluation includes a follow-up appointment within 60 days of your initial visit. **It is your responsibility to keep your follow-up appointment. You must wear your trial contacts when you return for your follow up.**

If you come back for a follow-up more than 60 days after your initial visit the following fees will apply:

More than 60 days to 6 months after your initial visit= $60 Refraction Fee

More than 6 months after initial visit= Cost of a new examination and contact lens evaluation.

PRINTED RECORDS & PRESCRIPTION FEES

We will provide one copy of your prescription (glasses & contacts if applicable) at the time of your visit. After this, any further printed copies of your records or prescription will be a $15 charge. Due to protecting your private information we are unable to email a copy of your prescription to you due to non-encrypted email systems.

PATIENT CONSENT FORM (HIPAA)

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by requesting one from the front desk personnel. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I understand that my medical records may be transmitted electronically by fax and may be received in error by a third party. In the event that this should occur I absolve Dr. Pham & Associates, LLC of all liability. I give my consent to fax my records for the purpose of treatment, payment or healthcare operations and understand that I may withdraw this consent at any time in writing.

Please ask our staff if you have any questions regarding policies or procedures.

_____	_____	_____
Signature of Patient (or Parent/Guardian)	**Printed Name**	**Date**

VISION & MEDICAL INSURANCE AGREEMENT

This financial agreement applies to all patients.

Many have a vision care plan (EyeMed, VSP, Davis, etc.) or medical insurance (BlueCross BlueShield, Aetna, Medicare, etc.) or both. If you plan to use any insurance for your visit, we want you to understand the difference between them and how that applies to your visit. It is important to understand the difference because they differ in what they can cover as well as the copays. The amount of coverage can depend on the plan you selected as well as the insurance company you have chosen. It is impossible for us to know how every insurance plan works but we try our best to provide accurate information regarding your plan before, during and after your visit. We always make every effort to utilize your insurance(s) in a manner that is in your best interest.

Vision coverage is designed to determine a prescription for glasses or contacts, some plans will cover the contact fitting fee while others do not. Vision coverage is not designed to deal with complex medical conditions/diseases and does not include a detailed retinal exam. Therefore, the fee for this service is usually lower.

When a medical condition or diagnosis is present (such as hypertension, diabetes, glaucoma, cataract, dry eyes or any other disease), it is necessary to file with your **medical insurance**. Any copays and/or deductibles you have for that insurance are applicable. If you do not have medical insurance but require a medical exam, please understand you may be required to pay a higher fee or schedule a separate exam for the medical portion of your visit.

We make every effort to be in network with most major insurance carriers both medical and vision. In the event that we are out of network with your insurance we will try to bill for an out of network claim or help assist you in filing your own claim for reimbursement.

If you plan to use insurance for your visit, we HAVE to be able to verify coverage before you are seen.
The ONLY exception is in the event of an ocular emergency.

All fees, insurance copays, and contact fitting fees (that insurance may not cover) are due at the completion of your visit. If you have any questions, please let us know.

Eye examinations are considered a service and therefore all fees are NONREFUNDABLE after services have been rendered.

By signing below, you state that you have read and understand the above information. Whether or not you have insurance, you also understand that you are responsible for all fees/charges not covered by your insurance and agree to pay for any attorney and/or collections fees if you fail to pay your bill in a timely manner. I understand the information I've just read about the difference between vision and medical insurance. I authorize Dr. Peter T. Pham & Associates, LLC to file my claim with the appropriate insurance based on the reason for my visit and the results of my examination.

Patient Name _____

Signature of Patient (or Parent/Guardian) _____Date _____