La Grange Vision Center

Deborah A. Thomas, O.D.
1630 W. SH 71 Hwy Business
La Grange, Texas 78945
Phone: (979) 968-9987
Fax: (979) 968-8757
www.lagrangevision.com

Today's Date: _____

Patient Information

Name _____
LAST FIRST MI NICKNAME

Title: Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr. ☐ Male ☐ Female ☐ Date of Birth _____

Address _____ City _____ State ____ Zip Code _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email Address _____

Parent's Name/Responsible Party/Spouse _____

Patient's or Parent's Employer _____ Occupation _____

If Student, Name of school _____ Grade ____

Patient's Social Security Number _____

Have we seen other members of your family? Yes ☐ No ☐

If yes, please list names _____

How did you find out about our office? ☐ Mailout ☐ Insurance ☐ Location
☐ Newspaper ☐ Phone book ☐ Internet
☐ Direct Referral, Name _____

Financial Arrangements

Preferred Method of Payment. Cash ☐ Check ☐ Credit Card ☐

Do you have health insurance carrier that provides vision benefits? Yes ☐ No ☐

If yes, please give name of provider _____

Are you the: Member ☐ Spouse ☐ Dependent ☐

If not the Member, Member's name _____ DOB _____ SSN _____

Member's Employer _____ Policy # / Group # _____

Eye History

When was your last eye examination? _____ Doctor's Name _____

Please check any of the following conditions that apply:

Condition	You	Your Family	Condition	You	Your Family
Eye surgery	☐		Eye turn/crossed eye	☐	☐
Eye injury	☐		Glaucoma	☐	☐
Vision therapy	☐		Cataract	☐	☐
Eye disease	☐	☐	Macular degeneration	☐	☐
Blindness	☐	☐	Retinal disorders	☐	☐
Lazy eye	☐	☐			

Please check any of the following conditions that apply to you:

Frequent headaches	☐	Double vision (ever)	☐
Floaters or spots	☐	Eye strain	☐
Poor distance vision:	☐	Eyes itch, burn	☐
with glasses ☐ without glasses ☐		Eyes water	☐
Poor near vision:		Recent eye infection	☐
with glasses ☐ without glasses ☐		Sensitive to light	☐

Glasses History

Have you ever worn glasses? Yes ☐ No ☐

Do you currently wear glasses? Yes ☐ No ☐

What age were you when you first got glasses? _____

When do you wear your glasses? ☐ All the time ☐ Reading/Near tasks only
☐ Distance only ☐ Work safety

Refractive Surgery

Have you ever had refractive surgery? Yes ☐ No ☐ If yes, what kind? _____

Are you interested in information on laser refractive surgery? Yes ☐ No ☐

Contact Lens History

Are you interested in contact lenses? Yes ☐ No ☐

Have you ever worn contact lenses? Yes ☐ No ☐

If yes, when were you first fit in contact lenses? (year) _____

Do you still currently wear contact lenses? Yes ☐ No ☐

If no, when did you stop wearing them? (year) _____

Type most recently worn (*circle* all that apply):

Soft / RGP / Hard	Toric (for astigmatism)
Conventional / Disposable	Bifocal / Monovision (one eye for reading)
Daily remove / Sleep in	Colors

Are you interested in trying any of the above? Please list _____

What lens care system you are using? _____

Do you have any allergies to lens care solutions? If yes, please list _____

Describe any problems you are having with our contact lenses: _____

Medical History

Please check any of the following conditions that apply:

Condition	You	Your Family	Condition	You
Diabetes	☐	☐	Sinus Problems	☐
High Blood Pressure	☐	☐	Migraine Headaches	☐
Thyroid Disease	☐	☐	AIDS/HIV	☐
Arthritis	☐	☐	Tuberculosis	☐
Heart Disease	☐	☐	STD	☐
Neurological Disorders	☐	☐	Stroke	☐
Lupus/Autoimmune Disease	☐	☐	Head Injuries/Trauma	☐
Cancer	☐	☐	Seizures	☐
Kidney Disease	☐	☐	Asthma	☐
Multiple Sclerosis	☐	☐	Pregnant	☐

Other conditions you are being treated or tested for _____

Do you use cigarettes/tobacco? _____ Alcohol _____? Other substance(s)? _____

List all Medications you are taking	Reason

List any Medication Allergies _____

Pupil Dilation

Dilating eye drops are used to temporarily enlarge your pupils. This allows the doctor a more thorough examination of your retina (back of the eye) to look for eye disease that cannot otherwise be detected. Generally the effects last about 4 hours. During this time your eyes will be extra sensitive to light and near vision may be blurred. Distance vision will be fine in most cases.

We strongly recommend that all of our patients receive this procedure. The fee for the dilated examination is $20.00. Your insurance may cover this expense.

If you choose to **decline** this procedure, please sign below.

I do NOT want the dilated examination.

X _____

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care Deborah A. Thomas, O.D. & Associates originates and maintains paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care or treatment.

Our Privacy Principles:

- The privacy of your health information is important to us.
- We maintain physical, electronic, and procedural safeguards that comply with federal regulations to protect your health information.
- We do NOT share your health information unless permitted or required by law for treatment, payment, or health care operations, or unless it is authorized by you.

I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that:

- Deborah A. Thomas, O.D. & Associates is not required to agree to the additional restrictions requested.
- I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.
- by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations

I wish to have the following restrictions to the use or disclosure of my health information:
(Check any that is desired)

☐ Home Telephone _____
- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Work Telephone _____
- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication
- ☐ OK to mail to home address
- ☐ OK to email _____
- ☐ OK to fax to _____

☐ Cell phone _____
- ☐ OK to text messaging (i.e. appointment information

☐ I DO Authorize the release of prescription information/materials to family members or the following persons:
Names: _____

☐ I do NOT authorize the release of prescription information/materials to family members or others.

I understand and have been provided with an opportunity to review the *Notice of Privacy Policies* which provides more complete description of information uses and disclosures.

_____ _____
Patient's signature **Date**

FOR OFFICE USE ONLY
[ ] Consent received by _____
[ ] Consent refused by patient and treatment refused as permitted
[ ] Consent added to the patient's medical record on _____

Dr. Deborah Thomas Financial Policy Sheet

OUR PRACTICE FINANCIAL POLICY

We are dedicated to providing you with the best possible care and service, and regard your understanding of our financial policies as an essential element of your care and treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with our staff.

Unless other arrangements have been made in advance by either you or your health coverage carrier, full payment is due at the time of service. For your convenience we accept all major credit cards, checks, and cash.

YOUR INSURANCE

We have made prior arrangements with many insurers and other health plans. We will bill those plans with which we have an agreement and will collect any required copayment at the time of service. The copayment will be collected the day of your appointment. In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge. In that event we will bill you, and payment is due upon receipt of that statement.

If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you, on an unassigned basis. In this case, your insurer will send the payment directly to you. Therefore charges for your care and treatment are due at the time of service.

We will also bill your health plan for all services that we provide in the office. Any balance due or non covered services is your responsibility and is due upon receipt of a statement from our office.

MINOR PATIENTS

For all services rendered to minor patients, the adult accompanying the patient is responsible for payment.

MISSED APPOINTMENTS

In order to provide the best possible service and availability to all our patients, it is our policy to charge our office visit fee for any appointments not canceled at least one day prior. Please call us as early as possible if you know you will need to reschedule your appointment.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

_____ _____

Signature of Patient or Responsible Party if a Minor Date

_____

Signature of Co-responsible Party

_____

Please print the name of the Patient