Information Form

Patient's Name: _______________________________ Date:________________________________

How did you hear about our office? ____

Dilation and Photo

As part of your medical eye exam, the doctor is required to look inside your eye. A dilated view is important for the detection and diagnosis of glaucoma, age-related macular degeneration, diabetic retinopathy, retinal tears or retinal detachments, and ocular tumors. Noticeable vision changes are not present early on in many of these disorders, so good vision does not guarantee a healthy eye.

To look inside your eye**, the standard of care is to use dilation drops**, which lets the doctor see the widest view of inside of your eye. Dilation can cause light sensitivity and/or near blur for a few hours. The cost of dilation is covered by insurance and included in the examination fee.

You can also receive **a retinal screening photo which is $39** and may not be covered by your insurance. The photo allows you and the doctor to see a **wider view of the retina** (45 degrees), and serves as a baseline to detect subtle diseases earlier than they would normally be caught.

You can also refuse to let the doctor look inside your eye, in which case she will try to see about 10% of the inside of your eye. Timely diagnosis and treatment of all internal eye disease may not be possible. If you refuse, you accept any and all risks of not detecting internal eye disease, including permanent loss of vision.

Please select and sign for one of the following options:

_______Dilation

_______Retinal photo ($39)

_______Dilation and Retinal photo ($39)

_______Refuse Dilation and Photo

Office Policies

- **Prescription Policy**
  - When you choose to have your glasses made at Frisco In Focus, we will give you the utmost in service, including guaranteeing all of our lenses for 3 months for a prescription change and 12 months for scratches and defects. We are not responsible for online vendors or non-affiliated opticals who dispense wrong prescriptions or poor-quality materials. If you choose to have your glasses made elsewhere, ensure the dispenser agrees not to charge you if your prescription needs to be redone

- **Financial Policy**
  - Our relationship is with you, the patient. Fees for services rendered are ultimately your responsibility. As a courtesy, we will file and bill your insurance. Copays, coinsurance, and deductibles are due at the time of service. We will try to fight on your behalf to get your maximum benefit. Any claim that is still unsettled, denied, or rejected after 90 days will become your responsibility.
  - All balances must be paid prior to the release of materials (glasses, contacts, etc.). Our policy is to collect payment in full at the time of the order. Please make every effort to pick up materials by 90 days or they will be considered abandoned.
  - We are not allowed to accept returns, refunds, or exchanges of materials. Glasses and contacts are considered restorative medical devices by the FDA, just like prosthetic limbs or dentures. As such, medical facilities are not allowed to re-sell "used" devices that have already been manufactured or taken home for use by a patient.

- **Insurance Assignment and Release**
  - I, the undersigned, assign directly to Kari Clark, O.D. and Frisco In Focus all insurance benefits for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance company. I authorize Kari Clark, O.D. and Frisco In Focus to release information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

- **Reason for Visit Determines Vision Insurance vs. Medical Insurance**
  - Vision Insurance usually has a benefit for one preventative wellness exam (eye health) and refraction (glasses prescription) per 12 months. They usually do not cover any other medical office visits you may need during the year (See Medical Insurance below for medical visits).
  - Medical Insurance usually has no limit to the number of medical eye exams you receive during the year. Medical visits are for diabetic retinal exams, dry eye, sudden loss of vision, glaucoma, flashes and floaters, cataracts, painful or red eyes, macular degeneration, etc.) They do not usually cover refraction (measurement of glasses prescription). The fee for refraction is $45.

Signature: ____ Date: ____________________

Printed Name: ____

FRISCO IN FOCUS

OUR FOCUS IS YOUR EYES

Frisco In Focus Acknowledgement of Receipt of Notice of Privacy Practices

Print Patient Name: ______________________________

The Law requires that Frisco In Focus make every effort to inform you of your rights related to your personal health information. By signing below, I acknowledge that:

_________ I have read or had explained to me Frisco In Focus' Notice of Privacy Practices and agree to continue my care with Frisco In Focus said terms.

_________ I was given the opportunity to read Frisco In Focus' Notice of Privacy Practices and declined, but wish to continue my care with Frisco In Focus under the terms of Frisco In Focus' privacy policies.

_________ I have read or had explained to me Frisco In Focus' Notice of Privacy Practices and do not wish to continue my care with Frisco In Focus under said terms.

_________ The Notice of Privacy Practices could not be read due to emergent nature of the care or other reason described as ______________________________

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

Patient's Signature: ______________________________

Date: ______________________________

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

Representative's Name: ______________________________

Relationship to the Patient: ______________________________

Office Use Only:

Frisco In Focus will make a good faith effort to obtain a written acknowledgement of receipt of the Notice provided to the individual. If the patient is unwilling or unable to sign this acknowledgement, Frisco In Focus must document its good faith efforts to obtain such acknowledgement and record the reason why the acknowledgement was not obtained.

Reason: ______________________________

Staff Signature: ______________________________ Entered Initials: ______________________________

Medical History

Review of Systems Form

Date: __________ Name: ______________________________ Date of Birth: ______________

Tobacco Use : Yes / No How Much _______ / Day How Long? _____ Date Quit ______________

Alcohol Use: Drinks Per Day? __________

Please check each item as they relate to your health

Constitution:
- [ ] Developmental Disability
- [ ] Cancer
- [ ] Fatigue Syndrome

Ears, Nose, Throat:
- [ ] Hearing Loss
- [ ] Sinusitis
- [ ] Dry Mouth

Neurological:
- [ ] Multiple Sclerosis
- [ ] Epilepsy
- [ ] Tumor
- [ ] Migraine

Psychiatric:
- [ ] Anxiety/Depression
- [ ] Attention Deficit
- [ ] Bipolar Disorder

Cardiovascular:
- [ ] Hypertension
- [ ] Stroke
- [ ] Heart Disease

Respiratory:
- [ ] Asthma
- [ ] Bronchitis
- [ ] Sleep Apnea

Gastrointestinal:
- [ ] Crohn's/Ulcerative Colitis
- [ ] Ulcer
- [ ] Acid Reflux

Genitourinary:
- [ ] Kidney Disease
- [ ] Prostate Disease/Cancer
- [ ] Pregnant or Nursing
- [ ] STD

Musculoskeletal:
- [ ] Arthritis
- [ ] Fibromyalgia
- [ ] Ankylosing Spondylitis
- [ ] Osteoporosis

Skin:
- [ ] Eczema or Psoriasis
- [ ] Rosacea
- [ ] Cold Sores
- [ ] Shingles

Endocrine:
- [ ] Diabetes Type 1 or 2
- [ ] Thyroid dysfunction

Hematology/Lymph:
- [ ] Anemia
- [ ] High cholesterol
- [ ] Other

Allergic/Immunologic:
- [ ] Lupus
- [ ] Sjogren's Syndrome

Current Medications (including vitamins): ____

____

Allergies to medications: ____

Has anyone in your immediate family (Parents, Siblings, Children) been diagnosed with any of the following?

- [ ] Cataracts
- [ ] Glaucoma
- [ ] Retinal Detachment
- [ ] Macular Degeneration
- [ ] Diabetic Eye Disease
- [ ] Other