Medical History
Review of Systems Form

Date:_____ Name:_____ Date of birth:_____

How did your hear about our office? _____Email Address_____

Tobacco Use: Yes / No How Much_____/Day How Long_____ Date Quit _____

Alcohol Use: _____ Drinks Per: Day / Week / Month

Have you had any of the following: (check all that apply)

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:
- ◯ Arthitis
- ◯ Fibromyalgia
- ◯ Ankylosing Spondylitis
- ◯ Osteoporosis

Skin:
- ◯ Eczema
- ◯ Psoriasis
- ◯ Rosacea
- ◯ Cold Sores
- ◯ Shingles

Endocrine:
- ◯ Diabetes Type 1
- ◯ Diabetes Type 2
- ◯ Thyroid Dysfunction

Hematology/Lymph:
- ◯ Anemia
- ◯ High Cholesterol
- ◯ Other_____

Allergic/Immunologic:
- ◯ Lupus
- ◯ Sjogren's Syndrome

Ocular:
- ◯ LASIK Surgery
- ◯ Cataract Surgery
- ◯ Other_____

Current Medications (including vitamins):

Allergies to Medications:

Family History:

Please specify WHO in your Immediate Family (Father, Mother, Sister, Brother, Son, Daughter) has been diagnosed with the following conditions:

◯ Diabetes Type 1	◯ Cataracts
◯ Diabetes Type 2	◯ Glaucoma
◯ High Blood Pressure	◯ Macular Degeneration
◯ Cancer	◯ Retinal Detachment
◯ Hyperthyroidism	◯ Diabetic Eye Disease
◯ Hypothyroidism	◯ Other

FRISCO IN FOCUS
OUR FOCUS IS YOUR EYES

Dilation and Photo

Annual eye examinations not only allow the doctor to improve the quality of your vision by updating the **prescription** of your glasses or contact lenses, but they also allow her to determine the **overall health** of your eyes from the front (the cornea) to the back of the eye (the retina). A good 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.

Dr. Clark is proud to offer a Retinal Photo Exam to all of her patients. This screening photo

- ***Is fast, easy, comfortable**
- ***Involves No Blur, No Dilation, No Light Sensitivity, No Stinging Drops**
- ***Provides a permanent record to compare and track potential eye disease**
- ***Provides a view of the central retina to help detect the effects of systemic conditions like hypertension and diabetes on the eye**

I have read and understand the benefits of the Retinal Photo Exam. I understand that it is highly recommended by Dr. Clark at Frisco In Focus and is an important part of my comprehensive exam. You may choose both a photo and dilation.

_____ **I elect to have the recommended Retinal Photo Exam of my retina for $39.**

_____ **I choose to be dilated**. Dilation drops will cause light sensitivity and near blur for a few hours. The cost of dilation is covered by insurance and included in the examination fee. (Patients with diabetes and certain medical eye complaints must be dilated by Dr. Clark at each medical visit.)

_____I **refuse** to let the doctor look inside my eye by photo or dilation and understand that I am limiting the doctor's ability to make a timely diagnosis of eye disease. I accept any and all risks of not detecting and delaying treatment of internal eye disease, including permanent loss of vision.

Patient's Printed Name: _____ Date:_____

Patient or Parent's Signature: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. **Contact lens wearers** – A contact lens evaluation is required annually to renew contact lens prescriptions. Do you want your contact lens prescription renewed this year? **Yes / No**

2. **Non-contact lens wearers**- Are you interested in learning about contact lens options? **Yes / No**

3. **All Patients**- After the doctor's examination, are you interested in speaking with an optician to order glasses or contacts today? **Yes / No**

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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 a free one-year scratch warranty on antireflective coatings and a one-year frame warranty. A $40 copay is charged should you need to utilize the warranty. Our opticians are here to assist you with adjustment needs.
  - I am aware that Frisco In Focus will not assume any responsibility for the accuracy of the prescription filled or quality of any materials made outside of the office. If I choose to have my eyeglasses made elsewhere, I understand it is important to ask for a copy of my eyeglass dispenser's prescription re-make policy so it is clearly defined prior to placing my order.
  - If I am supplying my own frame, I understand that many plastic and metal products may weaken over time and I will not hold Frisco In Focus or my vision carrier responsible for accidental laboratory breakage.
  - External Prescriptions: I understand that Frisco in Focus is more than happy to provide me with eyeglasses or contacts from a valid prescription from an outside provider. For outside prescriptions, I acknowledge there are no refunds or cancellations and the one-time remake policy within 90 days of a glasses order will apply.
- **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 if we are in-network with your plan. If we are an out-of-network provider with your medical insurance, we will collect the full private pay fee at the time of the visit and provide you with an itemized receipt so you can file with your insurance yourself.
  - I acknowledge that my examination today may be billed to my medical insurance or vision care program as deemed appropriate by my doctor. I understand that I am responsible for paying all co-payments as well as known deductibles and coinsurance at the time of service prior to leaving. Co-payments cannot be waived at any time by the provider of service or Frisco In Focus. If my insurance determines that medical services and/or materials are not covered, I acknowledge that I have been notified and will assume full financial responsibility for the service(s) and/or materials provided. If my insurance determines that I have not met my deductible or owe coinsurance, I understand that I will be fully responsible for payment in a timely manner, no more than 30 days after I have been notified by the insurance and/or provider. Yearly deductibles cannot be waived at any time by Frisco In Focus. I authorize Frisco In Focus to release information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.
  - I acknowledge that Frisco In Focus will transfer any outstanding balances to a collection agency sixty (60) days after my initial invoice was generated if I have not contacted the office and instituted a payment plan. I understand this action will incur a collection fee of $25 to my overall outstanding balance.
  - Our policy is to collect payment in full at the time of the order for any materials (glasses, contacts, etc.). Please make every effort to pick up materials within 60 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. Your prescription is customized for your eyes and cannot be returned for use by another patient.

    I have read and will adhere to Frisco In Focus' financial policy.

    Patient Name _____ Date_____

    Patient or Parent's Signature _____

- **Reason for Visit Determines Vision Insurance vs. Medical Insurance**

  One of the most challenging billing issues in an optometry office is determining if we should be billing a medical or vision plan. Optometrists are primary health care professionals who examine, diagnose, treat, and manage diseases, injuries, and disorders of the visual system, the eye, and associated structures as well as identify related systemic conditions affecting the eye. However, optometrists also provide routine well-vision exams for patients with no eye disorders. Our doctors and billers will determine the appropriate plan (medical or vision) to file your claim based on the primary diagnosis of your examination.

  For patients with BOTH medical and vision coverage: Your vision plan is intended to provide you with a baseline, well-vision exam. If you present with a medical concern and are being evaluated for medical reasons (corneal disorder, diabetes, flashes and floaters, painful or red eyes, cataracts, glaucoma suspect, double vision, dry eyes, etc.) you are being provided with medical care, not vision. Therefore, we will file a claim with your medical insurance for visits related to medical complaints and problems.

  For patients without vision coverage: If you are being seen for a routine well-vision exam and do not have vision coverage, your medical insurance will not pay for the exam.

  For patients with medical coverage: If you have a medical complaint (corneal disorder, diabetes, flashes and floaters, painful or red eyes, cataracts, glaucoma suspect, double vision, dry eyes, etc.), the medical portion of your exam can be billed to your medical insurance. However, refraction (measurement of your prescription) is not usually covered by major medical insurance and you will be charged $45 in addition to your medical deductible, copay, and coinsurance.

- **Behavior Standards**
  - Cancellations/No Shows: I acknowledge that 24 business hour advanced notice **by phone** is required to cancel an appointment. Text messages and emails will not suffice as they may not be seen in a timely manner. Failure to do so will result in a $40 broken appointment fee and a restriction in appointment time availability to non-peak hours.
  - Arrival Time: I understand that arriving late will result in a shortened appointment. A greater than 10-minute late arrival time will be considered a no-show and will be subject to the broken appointment fee.
  - Office Conduct: We strive to provide a safe environment for our children, families, and staff. When in the clinic, it is important to behave in a manner that is respectful to the eyes and ears of everyone present. This respect should also be maintained when communicating on the phone. Inappropriate behavior may result in being dismissed from our practice. Thank you for keeping our office friendly and pleasant for all to visit.

- **Acknowledgement of Notice of Privacy Practices** (attached to your clipboard and also available online)

The law requires that Clark Family Eye Care, d/b/a Frisco In Focus, make every effort to inform you of your rights related to your personal health information. By signing below, I acknowledge that: (please choose one)

____ I was given the opportunity to read, have read or had explained to me Clark Family Eye Care, PLLC's Notice of Privacy Practices prior to any services offered, OR

____ The Notice of Privacy Practices **could not be read** due to the emergent nature of the care and will be acquired as soon as possible.

I authorize Clark Family Eye Care, 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, or

____ 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 Printed Name Signature Date

If you are signing as a personal representative of the patient, please indicate your relationship. If you are signing for a minor, you attest you have the legal responsibility to make decisions for the minor.

_____ _____

Representative Name Relationship to Patient