Dr. Bret Ford

Dr. Layne Ford

PATIENT INFORMATION

Legal Name: _____ Male / Female

Preferred Name: _____ Date of Birth: _____

Mailing Address: _____

City_____State_____Zip_____

Full or Last 4 of SS# _____ Marital Status: Single / Married / Widowed

Primary Phone: _____ Mobile Phone: _____

Employer: _____ Occupation: _____

E Mail_____ Comm. Preference: Mail / Text / Phone / Email

Preferred Language: _____ Ethnicity: Caucasian / Hispanic or Latino / Other

Parent/Guardian Information (if a minor)

Name: _____Date of Birth: _____

Mailing Address: _____

City_____State_____Zip_____

Primary Phone: _____ Mobile Phone: _____

Relationship to Patient: _____

Primary Insurance Holder

Insured Legal Name: _____Date of Birth: _____

SS# (Insurance Requires): _____ Relationship to Patient: _____

Mailing Address: _____

City_____State_____Zip_____

Primary Phone: _____

Name:_____

Are you interested in: Eyeglasses Computer glasses Sunglasses Contacts

Are you interested in Lasik? Yes / No

Have you had any eye surgeries? Cataract Lasik Eye Injections Other:_____

Eye History

Please circle ALL that apply

Blurry Vision	Double Vision	Floaters/Spots	Trouble seeing at night
Burning	Crossed Eye/Turn Eye	Itchiness	Iritis/Uveitis
Cataracts	Dry Eyes	Lazy Eye	Glaucoma
Corneal Abrasion	Eye Injury	Sunlight Sensitivity	Macular Degeneration
Corneal Ulcer	Flashes of Light	Headaches	Retinal Tear/Detach.

Medical History

Please circle ALL that apply

Allergies	Cancer	High Blood Pressure
Asthma	Diabetes	High cholesterol
Arthritis	Heart Condition	Thyroid Condition

Please list *all* known allergies:

_____

Please list medications, vitamins & eye drops you are *currently* taking:

_____

_____

Primary Care Physician: _____ **Pharmacy:** _____

Family History

Please list your relationship

Glaucoma _____ Hypertension _____

Diabetes _____ Corneal Problems _____

Macular Degeneration _____ Retinal Problems _____

Welcome to FORD EYE CARE CENTER and thank you for choosing our office for your eye care needs! We appreciate your trust and are here to care for you and your family. To better serve you, we kindly request that you read and sign our office policies. Please let us know if you have any questions/concerns regarding the following:

APPOINTMENT TIME:

We ask that you arrive 10 minutes prior to your scheduled appointment time. Late arrival may result in appointment rescheduling to a different date and/or time. If possible, late arrivals will be accommodated on the date originally scheduled as time permits. Please understand that we do our very best to stay on schedule, however complications do arise and occasionally the doctor requires a longer amount of time to give the high standard of care you expect. Please be patient and understand that the same quality of care will be given to you.

CANCELLATIONS:

If you must cancel or reschedule your appointment, we ask that you contact our office within 48 hours of your appointment. Of course, we understand that emergencies do arise but ask that you call the office as soon as possible if you cannot make your appointment. Patients that repeatedly cancel or no show on the same day of their appointment will be charged a $75 schedule holding fee at the time of rescheduling. The $75 will be applied to purchases at that appointment but will not be refunded in the event of a cancellation or no show.

PAYMENT:

All applicable fees such as: deductible, co-insurance, co-pays or fees for materials must be paid at the time of service. Our office accepts cash, checks, credit cards, including Care Credit. Any account that reaches 120 days with no effort to pay will be assigned to a collection agency. Check payments returned to our office for insufficient funds will result in an additional fee of $30.

PRESCRIPTIONS:

Filling prescriptions written by our Doctors: An office visit to recheck the prescription will be provided at no charge within 3 months of the eye exam. New lenses of equal or lesser value will be made at no charge if remade within 45 days of pick up.

Filling prescriptions written by other offices: Eyeglass lenses of equal or lesser value will be re-made one time at no charge if the prescribing doctor provides a new prescription in writing within 45 days of pick up. Prescription changes after one free remake or after 45 days will be charged the usual lens price.

PRODUCT RETURN:

Eyewear: Refunds apply to frames and non-prescription sunglasses only. They must be requested within 45 days of the invoice date and will be inspected for signs of wear and damage prior to issuing a refund, exchange, or credit. Returned items must also have all their original parts, accessories, and packaging.

****No refunds on prescription lenses because they are custom made.

Eyeglass Lens Warranty: Lens anti-reflective and anti-scratch coatings are covered within one year of the original invoice date from manufacturing defects only. Warranty does not apply to damage. (i.e. chips, cracks, pitting, deep scratches, etc. due to improper care.) No charge lens replacements will be determined on a case per case basis.

Refunds for Contact Lenses: Refunds can only be applied to unopened boxes within 45 days of purchase and are subject to a 20% restocking fee. Opened boxes cannot be re-stocked or resold, therefore, no refund will be given for each box opened. Boxes that are damaged, marked, dented or in obvious unsellable condition cannot be returned.

INSURANCE VERIFICATION:

Your insurance policy is a contract between you and your insurance company. We must have your vision and medical insurance information prior to your appointment. As verifying benefits and filing your insurance claims is a courtesy, we cannot accept the responsibility of negotiating claims with your insurance company or any person. **Please understand that verifying insurance is not a guarantee of payment**. Our office will make every attempt to obtain current benefit information prior to your visit; **however, as the insured member you are ultimately responsible for understanding your benefit structure.** Please notify our office when making an appointment of any insurance changes and provide your new insurance card at your earliest convenience.

ACKNOWLEDGEMENT: I hereby authorize my insurance carrier to make direct payment to Ford Eye Care Center for services rendered. I understand that I am fully responsible for all charges, whether or not covered by insurance. I give my consent for any information regarding my treatment or condition to be released in order to obtain payment for professional services. I am aware that Dr. Ford's NOTICE OF PRIVACY PRACTICES is posted at the front desk, and I may obtain a copy upon request.

Patient:_____ Date: _____

Represenative:_____ Relationship:_____

Ford Eye Care Center

Bret Ford, O.D. **Layne Ford, O.D.**

714 Hill Country Drive

Kerrville, TX 78028

830/315-3673(FORD)

To provide our patients with the best care possible we have incorporated state of the art technology, using the Visual Field Analyzer and Optomap Retinal Imaging. Unfortunately, routine eye exams may not detect many diseases in their early stages.

The **Optomap** can detect retinal problems such as holes, tears, detachments, tumors, macular degeneration, etc. This can often take the place of dilation. Therefore, there are no side effects, and it is less expensive.

The **Visual Field Analyzer** detects loss of vision that can be signs of diseases such as: pituitary tumor, glaucoma, retinal and macular degeneration, optic nerve disease, or retinal disturbances due to vascular problems or medications.

Dr. Bret Ford and Dr. Layne Ford highly recommend that all our patients receive both evaluations. They believe this is the most important aspect of your exam. It is especially important for those who have a history of high blood pressure, diabetes, headaches, migraines, floaters, a high spectacle prescription, retinal problems, or have a family member who suffers from glaucoma or retinal problems.

The **Optomap** is covered by most major medical insurance plans if there is a medical diagnosis. If you do not have insurance, you will receive a professional courtesy fee.

The **Visual Field** is covered by most major medical insurance plans if there is a medical diagnosis. If you do not have insurance, you will receive a professional courtesy fee.

Please check the appropriate choice and sign below:

_____ I would **like** to include the **Optomap Retinal Scan** in my exam.

_____ I would **like** to include the **Visual Field** in my exam.

_____ I am ***declining***. I understand the importance of additional testing and will not hold Drs. Ford or their staff responsible for any undetected eye health issues that may arise.

Signature: _____Date: _____

Printed Name:_____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by:

Printed Name:_____Date: _____

Signature:_____Date: _____

Witness: _____Date: _____