Today's Date_____ FORD EYE CARE CENTER

PATIENT INFORMATION

Last Name_____ First _____ MI _____

Mailing Address _____City _____ State _____

Zip Code _____ Preferred Language _____ Race _____

Social Security # _____ (Required unless payment is cash)

Primary Phone _____Alternate Phone:_____

Date of Birth _____ Sex_____ Marital Status_____

Student: Full time or part time Occupation_____Employer_____

Driver's License # _____E-mail_____

Whom may we thank for referring you _____Communication preference: phone mail email

I am interested in: GLASSESCONTACTS LASIK OTHER_____

RESPONSIBLE PARTY (Must be filled out of patient is under 18 years old)

Last Name_____ First _____ MI _____

Mailing Address _____E-mail_____

City _____ State _____ Zip Code _____

Primary Phone _____ Alternate Phone_____

Date of Birth _____ Sex_____ Relation to Patient_____

Social Security # _____ (Required unless payment is cash)

INSURANCE MEMBER INFORMATION

Insurance Company _____ ID# _____ Group# _____

Policy Holders' Name _____ Birth Date_____ Sex _____

Address_____

Primary Phone _____ Alternate Phone:_____

Relationship of Patient to Policy Holder: Self Spouse Dependant

Policy Holder Social Security #_____ (Required to file insurance)

EVER EXPERIENCE ANY OF THE FOLLOWING EYE CONDITIONS? (Please circle all that apply)

Blurry Vision	Flashes of Light	Sunlight Sensitivity	Floaters/Spots
Burning	Crossed Eye/Eye Turns	Tearing	Grittiness
Double Vision	Headaches	Itchiness	Trouble seeing at night

EVER BEEN DIAGNOSED OR TREATED FOR THE FOLLOWING? (Please circle all that apply & list any additional conditions)

Cataracts	Iritis/Uveitis	Allergies	Heart Condition	High Blood Pressure
Corneal Abrasion	Lazy Eye	Asthma	High Cholesterol	Kidney Condition
Eye Infection	Macular Degeneration	Arthritis	Retinal Detachment	Thyroid Condition
Eye Injury	Cancer	Diabetes	Retinal Tear	Glaucoma

_____

_____

_____

Please list any problems regarding your eyes (past or present)

_____

_____

Please list any medications and drug allergies

_____

_____

IS THERE A FAMILY HISTORY OF ANY OF THE FOLLOWING?

	Relationship
Blindness	_____
Cataracts	_____
Corneal Problems	_____
Glaucoma	_____
Lazy Eye	_____
Macular Degeneration	_____
Retinal Problems	_____
Diabetes	_____
Heart Disease	_____

PAYMENT POLICY

Exam fees, co-payments, deductibles, and non-covered tests or materials are due at the time of service. Contacts lenses must be paid for at the time of ordering. Glasses must have a deposit of 50% (half of the total cost) upon order, with the balance due upon dispense.

Most insurance policies pay only a portion of your total charges. If you have any questions about your coverage, please contact your representative. Due to the uniqueness of carriers and individual policies, we may not always know the extent of coverage, and they may not provide coverage for some materials/services therefore, we do not guarantee the accuracy of benefit information given to us by the insurance companies. Please understand that financial responsibility for your account is yours, not the responsibility of your insurance company. I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical or vision benefits either to the physician or supplier of services rendered or to myself if the provider does not accept assignment. I understand that I am responsible for any balance that my insurance does not pay. Ford Eye Care Center is not liable for collecting your claim. After 30 days, we will expect payment in full if your insurance carrier has not paid.

ACKNOWLEDGEMENT

I hereby authorize my insurance carrier to make direct payment to Ford Eye Care Center for service rendered. I understand that I am fully responsible for any and 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.

Returned checks will incur a $30 service fee. I am aware that if my account is not paid within 30 days of service, it may be sent to collections. I assume all legal fees and service charges incurred if collection action must be taken. I have read & agree to the statement above:

SIGNATURE _____ **DATE:** _____

Dr. Bret Ford, OD
714 Hill Country Drive
(830)315-3673
www.fordeyecare.com

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: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

Ford Eye Care Center

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

714 Hill Country Drive

Kerrville, TX 78028

830/315-3673(FORD)

In an effort 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.

Our doctors highly recommend that all of our patients receive both evaluations. They believe these tests are the most important aspect of your exam. They are 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 fee for the **Optomap** is $74.00 and 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 and your fee will be **$49.00**.

The fee for the **Visual Field** is $99.00 and 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 and your fee will be **$29.00**

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 Dr. Ford or his staff responsible for any undetected eye health issues that may arise.

Print Patient Name _____

Signature _____

Date _____