Dear patient:

We welcome you to our practice and ask that you kindly complete or update all information on this form.

PATIENT INFORMATION			
PATIENT NAME:		GENDER:	SOCIAL SECURITY NUMBER:
ADDRESS:		DATE OF BIRTH:	MARITAL STATUS:
CITY, STATE & ZIP:		LAST EYE EXAM DATE:	
MOBILE PHONE:	WORK PHONE:	EMAIL:	
EMPLOYER:		OCCUPATION	

Do you or your family have any history of the following conditions (check all that apply)

Self	Family	
❑	❑	Glaucoma
❑	❑	Cataracts
❑	❑	Diabetes
❑	❑	High Blood Pressure
❑	❑	Macular Degeneration
❑	❑	Heart Problems
❑	❑	Retinal Degeneration
❑	❑	Stroke
❑	❑	Thyroid Condition
❑	❑	Crossed/Lazy Eyes
❑	❑	Asthma/ Allergies
❑	❑	Color Blindness
❑	❑	Arthritis
❑	❑	Tuberculosis
❑	❑	HIV/Hepatitis
❑	❑	Cancer
❑	❑	Neuromuscular
❑	❑	Blindness
❑	❑	Mental Illness
❑	❑	Other: ____________ ____________

Do you currently have any of the following symptoms (check all that apply)

- ❑ Blurry distance vision
- ❑ Poor night vision
- ❑ Eye Strain
- ❑ Blurry Near Vision
- ❑ Trouble Reading
- ❑ Itchy Eyes
- ❑ Discharge
- ❑ Watering
- ❑ Pain in the eye
- ❑ Burning eyes
- ❑ Sandy/dry eyes
- ❑ Red Eyes
- ❑ Glare/reflections
- ❑ Discomfort in sunlight
- ❑ Double vision
- ❑ Floaters or spots in vision
- ❑ Flashes of light
- ❑ Eye injury
- ❑ History of wearing an eye
- ❑ patch
- ❑ History of eye surgery
- ❑ Headaches
- Dental Abscess

Are you interested in any of the following (check all that apply)?:

- ❑ New spectacles
- ❑ A new prescription
- ❑ Light weight glasses
- ❑ Anti-reflective lens
- ❑ Colored contact lens
- ❑ Sunglasses
- ❑ Clip-ons
- ❑ Safety glasses
- ❑ Lasik
- ❑ Contact lenses
- ❑ Dry eye therapy

How were you referred to us?

- ❑ Family doctor
- ❑ Yellow Pages
- ❑ Insurance company
- ❑ Another patient

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Medications:

Allergies:

- ❑ Unknown
- ❑ Seasonal
- ❑ Dust, Mold
- ❑ Pollen
- ❑

Other:____________

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Social History:

- ❑ Alcohol abuse
- ❑ Drug Use
- ❑ Tobacco use
- ❑ Other:

FINANCIAL RESPONSIBILTY /GUARANTOR: □ SELF □PARENT □OTHER (if Parent/Other please fill out)

NAME:	GENDER:	SOCIAL SECURITY NUMBER:
ADDRESS:	DATE OF BIRTH:	
CITY, STATE, ZIP:	PATIENT'S RELATIONSHIP TO GUARANTOR:	
HOME PHONE:	WORK PHONE:	

PRIMARY VISION INSURANCE

VISION INSURANCE NAME: PLEASE CIRCLE YOUR INSURANCE

EYEMED HUMANA VISION CARE PLAN SUPERIOR VISION COMMUNITY FIRST SUPERIOR HEALTH PLAN AVESIS BOON CHAPMAN VSP AETNA OTHER:______________

POLICY ID/SOCIAL SECURITY NO.:

PRIMARY INSURED NAME:	DOB

MEDICAL INSURANCE POLICY: As part of our services at this practice we are happy to assist you in determining the benefits of your individual policy and in collecting your reimbursement of insurance benefits for medical services. To avoid any misunderstandings please read the following statements carefully:

1. The legal obligations of your insurance provider are between yourself and your provider, not between this practice and your provider.
2. When your insurance provider (s) has settled your plan's covered items, you will be notified by a monthly statement if there were any unpaid balances. Unpaid balances can include non-covered items or services, co-pays, deductibles, lapses, ineligibility or termination of coverage's. Unpaid balances are the sole responsibility of the patient.
3. To keep the cost of records and collections down any patient portion amounts on your order will be due at the time of service.
4. I authorize the use of this form on all insurance submissions as well as authorizing the release of information to all my insurance companies as well as allowing the doctor to act as my agent to help me in obtaining payment from my insurance companies.
5. I authorize payment to be made directly to the provider and permit a copy of this authorization to be used in place of the original.

REFUND/RETURN POLICIES: No refund can be made on clinical procedures or services, including comprehensive eye examination, refraction, contact lens fitting, and medical office visits. Refunds for optical products, which unopened boxes of contact lenses can only be made within 30 days of receiving the product, provided that the product is returned to the store without damage at the time that the refund is issued. Opened boxes of contact lenses are non-refundable. After the 60 days period, only 50% of the original payment made by the patient (private-pay or with insurance) can be issued back to the patient as store credit with the return of the product. 90 days after a product is dispensed, no refund, no exchange, no return can be made on any goods purchased at this store.

CONSENT FOR TREATMENT: I hereby authorize Ingram Eye Care, to administer diagnostic and medical procedures as may be necessary for proper health care.

HIPPA CONSENT

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Permission to Use and Disclose My Health Information: By signing this form, I give **Ingram Eye Care**, permission to use and/or disclose my health information to provide treatment, obtain payment, and/or conduct health care operations.

Right to Refuse: I have the right not to sign this consent. If I refuse to sign this consent, **Ingram Eye Care** has the right to refuse to treat me. However, treatment required by law –such as emergency care– can be provided to me whether or not I sign this consent.

Right to Review Notice of Privacy Practices: I have been provided with a copy of the Notice of Privacy Practices for **Ingram Eye Care** which describes how **Ingram Eye Care** may use and disclose my health information. I have the right to review this Notice before signing this consent.

Changes to the Notice of Privacy Practices: Ingram Eye Care may change the Notice of Privacy Practices as needed. I may obtain a current copy of the Notice of Privacy Practices for **Ingram Eye Care** by contacting **Ingram Eye Care**.

Right to Request Restrictions on Use/Disclosure: I have the right to request that the usage of my protected health information by **Ingram Eye Care** be restricted in how it is used and/or disclosed for the purpose of providing treatment, obtaining payment, and/or conducting health care operations. However, **Ingram Eye Care** is not required to agree to any restriction that I request. If **Ingram Eye Care** does decide to agree to my request, the use and/or disclosure of my health information by **Ingram Eye Care** must be restricted as I requested. If I wish to request restrictions I can contact **Ingram Eye Care** will notify me on whether my restrictions have been accepted or declined.

Right to Withdraw Consent: I have the right to withdraw this consent at any time. I must do so in writing by contacting **Ingram Eye Care** at **Ingram Eye Care, 6301 NW Loop 410, San Antonio, TX 78238.** My withdrawal of this consent will not be effective for uses and/or disclosures that have already been made based on my prior consent. If I withdraw this consent, then **Ingram Eye Care** may refuse to provide to me further treatment or follow-up, other than required emergency services.

Effective Period: This consent is good unless and until I withdraw it in writing.

References to "I" or "me": References to "I" or "me" in this Consent include the individual for whom the signing party is authorized to sign. If I am signing this consent on behalf of another person, it is because I am that person's parent, legal guardian, or agent under an active Power of Attorney for Health Care; and I am legally authorized to sign this Consent on behalf of that person.

______________________________________ Signature of patient or authorized representative

__________________ Date