



Welcome to **Williamson Eyecare** your Vision Source

Please complete the following forms in its entirety.

Last Name _____ First Name _____ MI _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Age _____ Social Security # _____ Marital Status _____

Home Phone _____ Cell Phone _____

E-Mail _____

Please list BOTH vision and medical insurances and bring all insurance cards with you to your appointment.

MEDICAL INSURANCE	
Ins. Co. Name:	Secondary Ins. Co. Name:
Insured's Name:	Insured's Name:
Identification #:	Identification #:
Group#:	Group#:
Insured's DOB:	Insured's DOB:
Patient Relation to insured:	Patient Relation to insured:
VISION INSURANCE	
Ins. Co. Name:	Insured's DOB:
Insured's Name:	Insured's SS#:
Identification #:	Patient Relationship to Insured:

Primary Care Physician _____ Phone: _____

Please list any medications that you are currently taking below (drug name and dosage)

_____	_____	_____	_____
_____	_____	_____	_____

Drug Allergies _____

Consent of treatment: I hereby grant MY authorization and consent for treatment and procedures for myself and/or minor children and certify that no guarantee or assurance has been made as to the result which may be obtained.

Signature of Patient or Legal Representative

Date



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EYEGLASS HISTORY

Do you wear glasses? ___ Yes ___ No ___ Part-time ___ Distance ___ Near

Glasses Owned: ___ Single Vision ___ Bi-focal ___ Tri-focal ___ Progressive ___ Backup Glasses ___ Sports Glasses ___ Other

Computer Used: ___ Yes ___ No Hours per day ___ Approximate distance from computer _____

Do you have problems with glare? Yes ___ No ___

Do you have problems with night vision? Yes ___ No ___

Are you allergic to nickel (e.g.: jewelry or eyeglass frames discoloring your skin)? Yes ___ No ___

If you currently wear glasses, does your spare pair have the same prescription? Yes ___ No ___

Do you wear prescription or non-prescription sunglasses? Yes ___ No ___

Do your sunglasses have UV (ultra-violet) protection? Yes ___ No ___

Are your sunglasses your current prescription? Yes ___ No ___

Are you interested in wearing contact lenses? Yes ___ No ___

Date of last eye exam: _____ Where did you get your last exam? _____

CONTACT LENSE HISTORY

Do you currently wear contact lenses? Yes ___ No ___

Have you ever tried to wear contact lenses? Yes ___ No ___

Answer the questions below only if you currently wear contact lenses:

What type/brand of contacts do you wear? _____

How old are your contact lenses? _____

How often do you replace or dispose of your contact lenses? _____

What brand of solution do your lenses soak in overnight? _____

What is your typical wearing schedule? _____ Hours/day _____

Do you ever sleep in your lenses? _____

Are you having any problems with your current contact lenses? Yes ___ No ___



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MEDICAL HISTORY

Review of Systems: Many diseases of the body have grave eye health consequences. While they may seem unrelated to eye problems, it is crucial to your care that we ask them. Please answer ALL of the following questions.

Please check Yes or No if you are experiencing any of the following:

Distance vision blur	Yes___ No ___	Seeing flashes	Yes___ No ___	Dry eyes	Yes___ No ___
Near vision blur	Yes___ No ___	Distorted vision (halos)	Yes___ No ___	Itching	Yes___ No ___
Glare/light sensitivity	Yes___ No ___	Red eyes	Yes___ No ___	Headaches	Yes___ No ___
Double vision	Yes___ No ___	Eye pain/soreness	Yes___ No ___		

Do you currently have any of the following: If YES, please explain:

Heart disease (ex. chest pain, irregular heartbeat, hypertension)..... No___ Yes_____

Respiratory problems (ex. shortness of breath, wheezing, coughing)..... No___ Yes_____

Gastrointestinal problems (ex. heartburn, abdominal pain, diarrhea, vomiting)..... No___ Yes_____

Genitourinary problems (ex. painful urination, blood in urine)..... No___ Yes_____

Musculoskeletal problems (ex. muscle aches, joint pain or swelling)..... No___ Yes_____

Skin problems (ex. Rashes, excessive dryness, growths or lumps)..... No___ Yes_____

Neurological problems (ex. numbness, weakness, headaches, "blackouts")..... No___ Yes_____

Psychiatric problems (ex. depression, anxiety)..... No___ Yes_____

Endocrine problems (ex. frequent urination, thirst, feeling hot or cold all the time)..... No___ Yes_____

Blood problems (ex. bruising, weakness, unusual paleness, swollen glands)..... No___ Yes_____

Immune problems (ex. frequent infections, allergic reaction to foods, dust, pollen)..... No___ Yes_____

Have you ever been treated for any medical conditions? (ex. diabetes, high blood pressure, high cholesterol, etc.) No___ Yes_____

Have you ever had any eye disease? (ex. glaucoma, cataract, wandering or "lazy" eye, retinal detachment)..... No___ Yes_____

FAMILY HISTORY

Has anyone in your immediate family suffered from the following: If YES, please list, FATHER, MOTHER, BROTHER, SISTER or CHILDREN

Cancer	No___ Yes_____
Diabetes (Type I, Type II)	No___ Yes_____
Hypertension	No___ Yes_____
Hyperthyroidism	No___ Yes_____
Hypothyroidism	No___ Yes_____
Cataract	No___ Yes_____
Macular Degeneration	No___ Yes_____
Glaucoma	No___ Yes_____

SOCIAL HISTORY

Do you drink alcohol? No___ Yes___ Occasionally 1/day 2-3/day 4+/day

Do you smoke or use tobacco products? No___ Yes___ Occasionally _____pack(s)/day



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AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (HIPAA)

I, **Print Patient Name** , authorize Williamson Eyecare, doctors and staff: to disclose information regarding my medical treatment and diagnosis and information regarding my financial account with the following designated individuals or organizations. (This includes any insurance company's pertaining to my eyecare.)

Name of person(s) I authorize release of information to (another doctor's office or family member); **you may revoke at any time.**

Name _____ DOB _____ Relationship _____

Name _____ DOB _____ Relationship _____

Name _____ DOB _____ Relationship _____

.....
NOTICE OF PRIVACY acknowledgement and receipt of privacy notice.

The health Insurance Portability and Accountability Act (HIPAA) is a federal law designated to protect the privacy of your health information. We understand that the information about you and your health is personal, and at **Williamson Eyecare**, we are committed to practicing the privacy of that information. Because of this commitment, we must obtain your written authorization before we can use or disclose your protected health information to any party. **This office will only use and disclose personal health information to permit the office to perform its administrative duties, provide eye care services, process vision benefit claims, process insurance claims, email per patient authorization, or mail exam recalls.**

I, **Print Patient Name** , have been presented a copy of the offices HIPPA privacy policies and I have read it and understand the content. I know that I can request my own personal copy of the form at any time.

By signing below, I acknowledge that I have read/received the copy of the Notice of Privacy Practices for review.

Signature of Patient or Legal Representative

Date

NO SHOW CANCELLATION POLICY

Our office requires 24 hours' notice for appointment cancellations. We understand that acute health emergencies and family crisis can sometimes occur. However, patients that or cancel for personal convenience and no-shows will incur a \$35.00 charge on their account. Thank you for your cooperation and understanding.

Patient or legal Representative Signature



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Our office is pleased to accept your insurance assignment. We offer this as a courtesy to our patients. However, it must be clearly understood that the “contract” is between you, the patient and your insurance company. You are thereby responsible for your account and any amount not paid by your insurance company.

- Although our office will bill your insurance company, it is necessary for the patient to fill out the insurance information form completely. If the form is not completed, or you do not know who your insurance is with, we will not be able to appropriately bill the insurance company and the responsibility for payment then becomes that of the patient.
- The patient will pay the **estimated** co-payment (the amount not covered by the insurance company) as agreed upon during the financial consultation. Your co-payment may be adjusted after the time of service depending upon the financial reconciliation of insurance payments.
- Insurance plans are categorized as either Medical or as a vision plan. A vision plan often covers a routine exam for glasses or contacts. A medical plan covers an exam for eye or vision problems. The reason for your visit, as well as the nature of your exam, will determine which insurance plan is filed.
- Insurance payments ordinarily are received within 30 to 60 days from the time of billing. If a patient’s insurance company has not made payment to our office within 90 days, we will require the patient to pay the balance due and then seek reimbursement from the insurance company when and if it pays.
- Our office does NOT guarantee that the insurance company will pay. We will perform our routine insurance billing procedures upon verification of coverage. However if for some reason the patient’s insurance claim is denied, the patient is then considered to be responsible for the full amount of the bill.
- Our office will not enter into a “dispute” with an insurance company over any claim, although we will work with the insurance company to sort out any confusions or questions that might arise. We cooperate fully with the regulations and requests of the insurance companies. It will be however, the responsibility of the patient to handle with the insurance company any type of dispute over payment by the company.
- If you do not have insurance, or we do not participate with the insurance plan, payment for an office visit is due at the time of service. We accept cash, checks, and most major credit cards. Any returned checks will carry a returned check fee of \$40.
- Patient balances are billed immediately on receipt of your insurance plan’s explanation of benefits. Your remittance is due within 15 business days of your receipt of bill. If previous arrangements have not been made, any account 60 days will be forwarded to a collection agency.

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WILLIAMSON EYE CARE FINANCIAL POLICY

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Williamson Eyecare is committed to caring for our patient's complete ocular health. Our patients will receive a **COMPLETE EYE HEALTH EXAMINATION.**

Routine Vision exams will be filed with the patients Vision Plan if you have one. A routine exam means there is not a medical diagnosis. Routine diagnosis is myopia (near-sightedness), hyperopia (far-sightedness), astigmatism and presbyopia.

If a **Medical Diagnosis** (cataracts, glaucoma, diabetes, pink eye-conjunctivitis, foreign body, etc.) is determined by the doctor the patient's exam is no longer routine, but medical. This means we will bill your Health (Medical) Insurance. We request a copy of your medical card in your chart for this reason.

I have read and understand when my **Vision Plan** will be billed and/or when my **Medical Insurance** will be billed by **Williamson Eyecare.**

I, _____, have read & understand **all** the above information.
Print name

Signature of patient or Guarantor

Relationship if not patient

Date





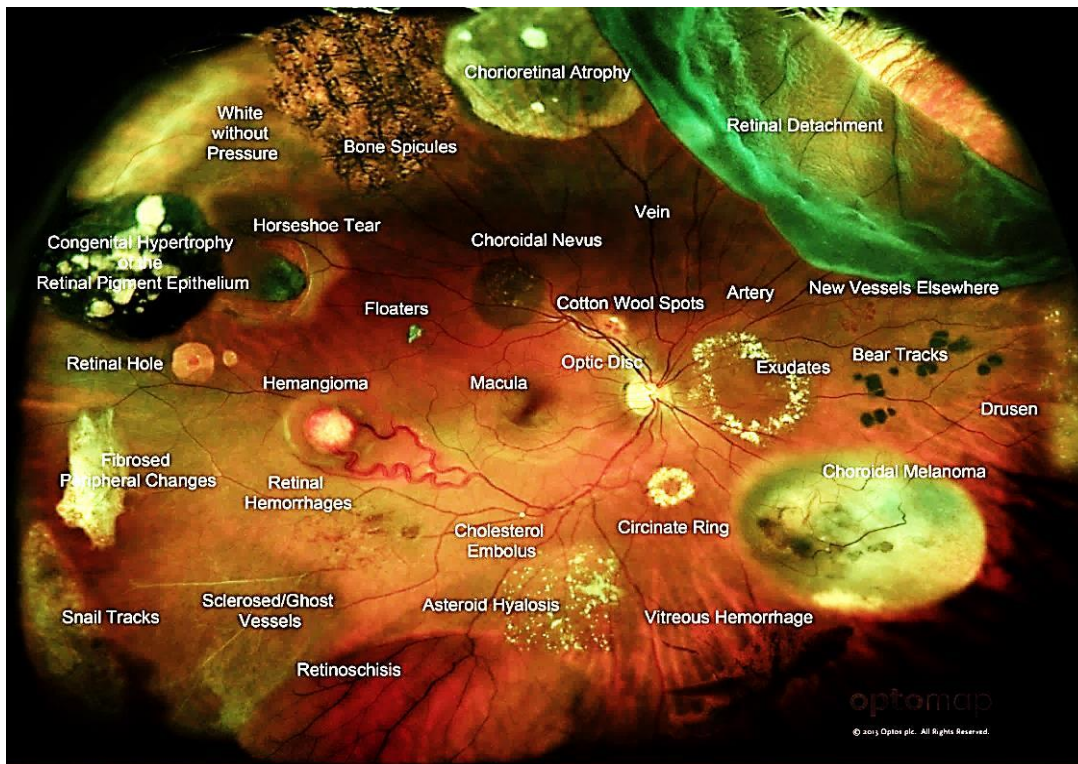
Welcome to **Williamson Eyecare** your Vision Source

At our practice, we pride ourselves on providing our patients with the best possible standard of care. Because of this, we now offer the **optomap**® retinal exam to all of our patients. Your doctor *strongly* believes that an annual eye wellness scan is an essential part of your comprehensive eye exam.

BENEFITS OF OPTOMAP®

- Provides a broader, more detailed view of the retina than is possible with conventional methods
- It takes just a few minutes start-to-finish, a much shorter office visit than if dilation is performed
- You leave the office with vision intact, rather than with light-sensitivity and blur
- The scan becomes a permanent record
- Allows for future side by side comparisons that can be viewed by other doctors if necessary

An **optomap**® retinal exam can aid in the diagnosis and monitoring of retinal diseases such as Macular Degeneration, Diabetic Retinopathy, Choroidal Folds, Retinal Vessel Obstruction, Choroidal Nevus, Hypertensive Retinopathy, Toxoplasmosis, Retinal Detachments, Tears, Tumors, Traction (Pulling), Bleeding, and Scarring



The optomap® retinal exam is generally not covered by insurance.

WOULD YOU LIKE TO ENHANCE THE EXAM WITH OPTOMAP® FOR \$30.00? **YES** **NO**

Signature: _____ **Date:** _____