TRES VISION Group

MEDICAL HISTORY

Name: _____ **Date:** _____

Age: _____ **DOB:** _____ □ **Male** □ **Female** **Referred By:** _____

PRIMARY CARE PHYSICIAN: _____
(First and Last Name)

NAME / PHONE # of PHARMACY: _____

_____

Please indicate if you have had problems in any of the following areas:

EYES

□ Loss of Vision	□ Double Vision	□ None
□ Glaucoma	□ Eye Injury or Trauma	
□ Cataracts	□ Retinal Detachment	
□ Macular Degeneration	□ Contact Lenses	
□ Surgery	□ Other	

CARDIOVASCULAR (heart/blood vessels)

□ Heart Attack	□ High/Low Blood Pressure	□ None
□ Heart Failure	□ Abnormal Heart Beat	
□ Chest Pain	□ Other	

RESPIRATORY (lungs/breathing)

□ Tuberculosis	□ Lung Cancer	□ None
□ Emphysema	□ Shortness of Breath	
□ Other	□ Asthma	

GENITOURINARY

□ Prostate Cancer	□ Hysterectomy	□ None
□ Prostate Surgery	□ Kidney Disease	
□ Kidney Stones		

GASTROINTESTINAL

□ Inflammatory Bowel Disease	□ Peptic Ulcer Disease	□ None
□ Other		

MUSCULOSKELTAL

□ Trauma	□ Arthritis	□ None
□ Other	□ Osteoporosis	

INTEGUMENTARY

□ Breast Cancer	□ Skin Rash	□ None
□ Skin Cancer	□ MRSA	
□ Other		

NEUROLOGICAL

□ Dizziness	□ Facial/Bell's Palsy	□ None
□ Stroke	□ Migraine	

PSYCHIATRIC

□ Anxiety	□ Depression	□ None
□ Other		

MEDICAL HISTORY-PAGE 2 Patient: _____

ENDOCRINE

□ Diabetes □ Thyroid Disease □ None
□ High or Low Cholesterol □ Other

HEMATOLOGIC

□ Hepatitis □ Blood Transfusion □ None
□ HIV/AIDS Virus □ Bleeding Disorder

PAST SURGICAL HISTORY – List any previous surgeries (including date if known)

_____
_____
_____

PAST HISTORY OF CANCER AND TREATMENT

_____
_____
_____

FAMILY MEDICAL HISTORY

□ Cancer □ Diabetes □ None
□ Heart Disease □ Hypertension
□ Cataracts □ Glaucoma
□ Macular Degeneration □ Other

Please list all medications you are now taking – include vitamins, food supplements and birth control

Medication	For What Condition	Medication	For What Condition
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES AND MANIFESTATIONS (Please List) □ No Known Allergies

_____

_____

_____

SOCIAL HISTORY

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed

Current Occupation: _____

Use of Alcohol: □ Never □ Rarely □ Moderate □ Daily
Use of Tobacco: □ Never □ Previously □ Current – Packs per day _____
Use of Drugs: □ Never □ Type/Frequency _____

Patient Signature: _____

Medical History Reviewed With Patient By: _____ Date: _____

TRES VISION Group
NEW PATIENT FORM

PATIENT'S NAME_____**DATE**_____

ADDRESS_____**CITY**_____ **ZIP**_____

Email Address: _____ Name by which you prefer to be called _____

Date of Birth_____ Race _____ ❑ Male ❑ Female ❑ Married ❑ Single ❑ Widowed ❑ Divorced

Home Phone (_____) _____ **Cellular Phone** (_____) _____ Work Phone (_____) _____ Ext. _____

Social Security # _____ / _____ / _____ Employer_____

Person Responsible for account _____

Person to notify in case of emergency: _____Phone (_____) _____

IF PATIENT IS A MINOR

We request a parent or guardian accompany any child 18 years or younger to appointments*
****If unable, parent or legal guardian must submit a***
Preauthorization to Treat Minors Consent Form
prior to appointment*

Whom may we thank for referring you? ❑ internet ❑ sign/building ❑ primary care physician

❑ family member /friend Name_____ ❑ Other _____

INSURANCE: ***(please show your insurance cards to the receptionist)***

Vision Insurance Co: _____ Address: _____

Subscriber: _____ Subscriber's SS No._____

Subscriber's Date of Birth: _____ Relationship to Patient: _____ Subscriber's Employer: _____

Subscriber's address if different from Patient: _____

Primary Health Insurance Co: _____ Address: _____

Subscriber: _____ Subscriber's SS No._____

Subscriber's Date of Birth: _____ Relationship to Patient: _____ Subscriber's Employer: _____

Subscriber's address if different from Patient: _____

Secondary Health Insurance Co: _____ Address: _____

Subscriber: _____ Subscriber's SS No._____

Subscriber's Date of Birth: _____ Relationship to Patient: _____ Subscriber's Employer: _____

Subscriber's address if different from Patient: _____

Please complete BOTH SIDES of this form

PAYMENT TERMS: As participating Medicare Providers, we agree to charge no more than the Medicare Allowable. Medicare pays only 80% of this amount after the annual deductible has been met. Office policy calls for payment of the deductible and the remaining 20% at the time of service. Payment in full is required on all eyewear and contact lenses orders. Cancellation of eyeglass orders after fabrication begins will result in a 25% restocking fee on the lenses. We accept cash, personal checks, Visa, Mastercard and American Express. A Refraction is the process of determining the eye's refractive error and the need for corrective lenses. It is an essential part of an eye exam, but Medicare and most health insurance companies **do NOT cover it**. The fee for this service will be collected today in addition to all insurance co-payments. I also understand that I could be responsible for additional collection fees should my account become delinquent.

*The adult accompanying a minor and the parents or guardians are responsible for all fees or co-payments on the date of service. For unaccompanied minors, non-emergency treatment and other non-routine eye examinations will be denied unless charges have been pre-authorized by a parent or guardian.

CANCELLATION POLICY: A 24 hour notice must be given to cancel appointment or a $25.00 fee will be assessed.

I have read and agree to all the provisions of the office financial policy. I understand that I am financially responsible for all charges incurred whether or not paid by insurance. I hereby authorize Medical City Eye Center/TRES VISION Group to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance forms.

Guarantor Signature: _____ Date _____

What is your main reason for coming here today? _____

_____

List any activities you would enjoy doing, but must restrict because of your vision:_____

_____

Are you interested in?

❑ Laser Vision Correction ❑ Contact Lenses ❑ Cosmetic Surgery

Do you wear glasses now? ❑Yes ❑No If yes: ❑For Distance ❑For Near ❑Wear Full Time ❑For Computer

Do you wear contact lenses? ❑Yes ❑No If yes: ❑Soft ❑Hard ❑Continuous Wear ❑Multifocal

Recreation and Leisure:

Please list hobbies and sports in which you participate: _____

_____

Do you wear any special or protective eyewear for your sport? ❑Yes ❑No

Does your vision, or do your lenses, interfere with any activity? ❑Yes ❑No

Does television viewing ever become visually uncomfortable? ❑Yes ❑No

Occupation _____

What activities do you do at work: ❑Driving ❑Data Entry ❑Computers – Hours per day _____ ❑Inspecting ❑Accounting

❑Sales ❑Loading ❑Deliveries ❑Monitor Instruments

Primary Care Physician _____

Date of last physical _____ How is your general health? ❑Excellent ❑Good ❑Fair ❑Poor

TRES VISION Group

HEALTH INFORMATION RELEASE FORM

In order to assist you in receiving your health information from TRES VISION Group, please complete this form.

I authorize the persons listed below to have access to any and all of my health information, including eyeglass prescriptions, contact lens prescriptions, diagnosis and treatment, HIV, drug and alcohol abuse, and psychiatric records. TRES VISION Group is permitted to share any medical information with them, including test results and information disclosed during office visits.

Persons or organization authorized to receive my medical information (full name and phone number):

_____
_____
_____

You may notify me or the parties listed above with normal test results, appointment reminders and other information regarding my health information as follows.

_____ Message on answering machine (Phone Number _____)
_____ Message on work voicemail (Phone Number _____)
_____ Message on cell phone (Phone Number _____)
_____ Other (Phone Number _____)

MY RIGHTS:
I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form to take part in a research study or to receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization *in writing*. If I did, it would not affect any actions already taken by TRES VISION Group. and all its related associates, Optometric Physicians based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance.

Should you wish to revoke this authorization you may write a letter to the Compliance Officer.

Once health care information is disclosed, the person or organization that received it may re-disclose it. Privacy laws may no longer protect it.

_____
Patient- Print Name

_____
Witness- Print Name

_____
Patient – Signature

_____
Witness- Signature

_____
Patient- Date of Birth

_____
Date

TRES VISION Group complies with all HIPAA and other federal privacy regulations, I acknowledge that I have been made aware of my rights to review or obtain a copy of the policies. _____ (initials)

NOTICE OF PRIVACY PRACTICES
SUMMARY

This Notice is Effective as of: November 23, 2016

This is only a summary of our Notice of Privacy Practices. A full Notice of Privacy Practices is available upon request to learn in detail how we use and disclose medical information about you and your rights concerning these uses and disclosures.

How We Use and Disclose Your Information

We will obtain your written authorization for any uses and disclosures of protected health information "PHI" not described in the Notice of Privacy Practices.

Treatment, Payment, and Health Care Operations. We may use your PHI in order to provide your medical care; to bill for our services and to collect payment from you or your insurance company; provide other healthcare providers in the event of needed emergency care; and for the general operation of our business.

Marketing, Fundraising, and Sale of PHI. We will obtain your prior written authorization before sending you certain marketing communications. We may use or disclose your demographic information in order to contact you for our fundraising activities, but you have the right to opt out of such communications. We will not sell your health information without your prior written authorization.

We may use your PHI as otherwise authorized or required by law for such purposes as:

- public health reporting and oversight activities
- judicial, administrative, or law enforcement proceedings
- complying with workers' compensation laws
- communicating with your family or caregivers
- sending appointment reminders

You Have the Right to:

- Receive confidential communication about your health status.
- Request certain restrictions on our use and disclosure of your PHI.
- Request communications from us by specific means or locations.
- Inspect and copy your medical record.
- Ask us to correct the information in your medical record.
- Receive an accounting of disclosures of your PHI by our practice.
- Be notified in the case of a breach of unsecured PHI.

CONTACT US

Contact our Privacy Officer with any questions, comments, or complaints or to exercise any of your rights at TRES VISION Group, 321-984-3200.

YOU WILL NOT BE RETALIATED AGAINST OR PENALIAZED BY US FOR FILING A COMPLAINT.

Patient Signature: _____ Date: _____

TRES VISION Group

PREAUTHORIZATION TO TREAT MINORS CONSENT FORM

We request a parent or guardian accompany any child (18 years or younger) for appointments. If you are unable to come to the clinic with your child, and your child is under the age of 18, you must complete this form prior to the appointment. This form can be faxed or mailed back to us prior to the appointment, or you may choose to have your child bring it with them. If you choose to send this with your child, please be aware that if your child arrives without this form, your child may not be seen. The adult accompanying the minor/the parents or guardians are responsible for all fees or co-payments on the date of service.

I request and preauthorize TRES VISION Group and its personnel to deliver routine eye care and intervention services to my child. Routine eye care and interventions may include, but are not limited to a comprehensive patient history, visual acuity, visual field screening and refractions. A dilated examination is an important part of this evaluation. This includes the use of topical eye drops that will leave the child with blurry vision and sensitivity to light for approximately 4-6 hours. Treatment options may include the prescribing of eyeglasses, contact lenses, vision therapy or medications.

Please make necessary arrangements for payment if you are unable to be there. For unaccompanied minors, non-emergency treatment and other non-routine eye examinations will be denied unless charges have been pre-authorized by a parent or guardian.

Child's Name: _____ DOB: _____ Age: _____

Parental contact information:

Parent's name:_____ Parent's Name: _____

Daytime Phone: _____ Daytime Phone: _____

Evening Phone: _____ Evening Phone: _____

Cell Phone: _____ Cell Phone: _____

Adult(s) (over 18 years of age) allowed to accompany my child to his/her appointment:

Name: _____ Name: _____
(please print) (please print)

Daytime Phone: _____ Daytime Phone: _____

I hereby indemnify and hold harmless TRES VISION Group and all their officers, agents, employees, attorneys, directors, insurers, affiliates, subsidiaries, related corporations, successors, heirs and assigns from any and all liability for acting in reliance on this authorization. I also agree to accept financial responsibility for all care and services delivered pursuant to this authorization. This authorization is valid for one (1) year following the date signed below unless withdrawn in writing to TRES VISION Group.

Only one parent or legal guardian signature is required.

_____ _____

(Signature of Parent or Legal Guardian) *(Date)*