PATIENT FORM

GENERAL INFORMATION

First, Last, MI, Preferred Name

Street Address

City, State, Zip

Phone, Type

Phone 2, Type

Email

Preferred Contact Method *cell phone* | *email* | *text* | *other (please explain)*

Patient Social Security Number

Date of Birth

Male/Female

Occupation/Employer *full-time* | *part-time*

Marital Status *married* | *single* | *divorced* | *legally separated* | *widowed*

Language, Race, Ethnicity

Emergency Contact Person and Phone

INSURANCE INFORMATION

Vision Insurance

Vision Insurance Member Name

Vision Insurance Member ID#

Vision Insurance Member Date of Birth

Primary Medical Insurance

Primary Member Name

Insurance ID#

Insurance Policy#/Group ID#

Primary Member Date of Birth

Primary Member Social Security Number

Primary Member Employer

Your Relationship to Primary Member *spouse* | *child* | *other (please explain)*

Secondary Medical Insurance

Secondary Medical Insurance Member Name

Secondary Medical Insurance ID#

Secondary Medical Insurance Policy #/Group ID#

Secondary Medical Insurance Member Date of Birth

Secondary Medical Insurance Member Social Security Number

Your Relationship to Secondary Medical Insurance Member

PATIENT FORM

EYE HISTORY

Date of Last Eye Exam

Currently Wear Glasses?

Currently Wear Contacts?

Reason for Today's Visit

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

Cataracts	*yes*	*no*	*family*
Crossed Eye	*yes*	*no*	*family*
Glaucoma	*yes*	*no*	*family*
LASIK or RK	*yes*	*no*	*family*
Lazy Eye	*yes*	*no*	*family*
Macular Degeneration	*yes*	*no*	*family*
Retinal Detachment	*yes*	*no*	*family*

Are you currently experiencing, or have experienced, any of the following? Check all that apply.

- ☐ Blurry Vision *near or distance*
- ☐ Burning
- ☐ Discharge
- ☐ Double Vision
- ☐ Dryness
- ☐ Excess Tearing/Watering
- ☐ Eye Infection
- ☐ Eye Pain or Soreness
- ☐ Floaters or Spots
- ☐ Halos
- ☐ Headaches
- ☐ Itching
- ☐ Light Flashes
- ☐ Light Sensitivity
- ☐ Redness
- ☐ Sandy or Gritty Feeling

MEDICAL HISTORY

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

AIDS/HIV	*yes*	*no*	*family*
Allergies	*yes*	*no*	*family*
Arthritis	*yes*	*no*	*family*
Asthma	*yes*	*no*	*family*
Blood/Lymph Disorder	*yes*	*no*	*family*
Cancer	*yes*	*no*	*family*
Diabetes	*yes*	*no*	*family*
Ears, Nose, Throat Conditions	*yes*	*no*	*family*
Gastrointestinal Conditions	*yes*	*no*	*family*
Heart Disease	*yes*	*no*	*family*
High Blood Pressure	*yes*	*no*	*family*
High Cholesterol	*yes*	*no*	*family*
Kidney Disease	*yes*	*no*	*family*
Lupus	*yes*	*no*	*family*
Neurological Conditions	*yes*	*no*	*family*
Psychiatric Disorder	*yes*	*no*	*family*
Seizures	*yes*	*no*	*family*
Skin Conditions	*yes*	*no*	*family*
Stroke	*yes*	*no*	*family*
Thyroid Dysfunction	*yes*	*no*	*family*

Current Medications
(prescription and over-the-counter and dosage)

Medication Drug Allergies

Height **Weight**

Are you pregnant or nursing?

Do you smoke?

Have you ever smoked?

Schertz Vision Source
17323 IH 35 North, Ste #110
Schertz, TX 78154
(210) 651-5800

To our valued patients,

As we are all aware, the Coronavirus outbreak requires special precautions to reduce the risk of contagion both at home and in public places. We want to assure you that your health and well-being are our top priority. Our team at Schertz Vision Source is dedicated to keeping our patients and family safe.

As we do on a daily basis, we are taking even more proactive steps to prevent contamination. We are constantly wiping down all surfaces after each patient with an antibacterial spray and wipes. We are also wiping down all areas of the waiting room periodically throughout the day and at the end of the day.

To decrease risk for patients and staff, we now require that your medical history and all forms be completed **BEFORE** you arrive at our office.

We will also recommend that all patients receive the **Optomap®** retinal imaging for $29 as dilation using eye drops will not be offered during this time. The **Optomap®** will increase safety by decreasing the amount of time you spend in the office and with any one person allowing the doctor to evaluate the health of the eyes.

In an effort to limit crowding and practice social distancing, we ask all patients to come alone or with one caretaker/parent.

We strongly recommend frequent hand washing with antibacterial soap and using proper coughing and sneezing techniques.

Masks are required while visiting our office. Please bring your mask with you.

All patients scheduled for an office visit will have their temperature taken before your appointment. If your temperature is 99.5 or higher, we will ask you to reschedule your appointment.

We have instructed our employees to stay home if they are showing any cold/flu related symptoms. In addition, we strongly request that patients exhibiting any cold/flu like symptoms or patients in close contact with anyone exhibiting cold/flu like symptoms to **reschedule** your appointment. We reserve the right to reschedule anyone who comes to our office showing cold/flu related symptoms or has recently traveled outside of the state.

We want you to feel comfortable knowing that we are doing all we can to keep our patients healthy.

Wishing you good health,

Schertz Vision Source Staff

COVID-19 SCREENING

You must answer the following questionnaire:

1. Have you tested positive for COVID-19?
   - ☐ Yes. When? Fully recovered? _____
   - ☐ No
2. Have you been tested for COVID-19 and are awaiting results?
   - ☐ Yes
   - ☐ No
3. Do you have any of the following symptoms? Fever, sore throat, cough, shortness of breath?
   - ☐ Yes. Please Explain:_____
   - ☐ No
4. Have you recently lost your sense of smell or taste?
   - ☐ Yes
   - ☐ No
5. Do you have any GI symptoms? Diarrhea? Nausea?
   - ☐ Yes. Please Explain:_____
   - ☐ No
6. Even if you don't currently have any of the above symptoms, have you experienced any of these symptoms in the last 14 days?
   - ☐ Yes. Please explain _____
   - ☐ No
7. Have you been in contact with someone who has tested positive for COVID-19 in the last 14 days?
   - ☐ Yes
   - ☐ No
8. Have you traveled outside of the United States in the past 14 days?
   - ☐ Yes
   - ☐ No
9. Have you traveled within the United States by air, bus or train within the past 14 days?
   - ☐ Yes
   - ☐ No

_____	_____	_____
Print name	Date	Patient/Parent Signature

Schertz Vision Source

17323 IH 35 North, Ste #110 * Schertz, TX 78154 * (210) 651-5800 * (210) 651-9733 Fax
www.visionsource-schertz.com

Thank you for choosing *Schertz Vision Source* as your health care provider. We are committed to providing you with the best available vision and medical care. Our personnel will be pleased to discuss our fees and this policy with you at any time. We ask that all patients read and sign our Financial Policy prior to seeing the doctor.

This is a legally binding contract between *Schertz Vision Source* and you. The words, I , me, my, you and your all refer to the patient.

1. *Schertz Vision Source* has a contract with my insurance company and will receive payments from my insurance company for covered services provided by my insurance benefits. I agree to pay copayments and deductibles at the time of service. If co-payments are not made at the time of service, I understand that my appointment may be rescheduled.
2. I understand that my insurance may or may not agree to the usual, customary or reasonable charges for my local area. I understand that my benefits may not cover all services or might deny payment for services that have been approved of in advance. I agree to pay the balance remaining on my account after insurance has been processed. Cash, check, or credit cards as well as Care Credit are acceptable forms of payment for these services.
3. Current insurance cards must be presented at every office visit. *Schertz Vision Source* is not responsible for filing your insurance claim, but as a courtesy we will do so. I agree to pay the remaining balance after my insurance has paid on my claim immediately upon receipt of a statement.
4. I agree to give *Schertz Vision Source* my complete and accurate insurance information for primary and secondary insurance benefits including referral documents from other providers, if needed. I understand that if a referral authorization is not present or I fail to give complete and accurate information about my insurance benefits this may result in a denial of my claim or a delay in payment. I agree to pay *Schertz Vision Source* the balance on my account after my insurance claim has been processed.
5. I understand there will be a $25.00 fee for all returned checks. Returned checks and balances older than 45 days may be subject to collection payment and collection fees.
6. I understand that refraction is a covered service by most vision plans, but not all insurance companies. There is a $40.00 charge, which will be collected in addition to my co-payment at the time services are rendered, if applicable.
7. I understand that I will be responsible for any missed appointments or any cancelled appointments in which a 24 hour notice is not given. There will be a $25 fee for appointments missed on any weekday (Monday - Friday) and $50 for any appointment missed on Saturday.
8. Professional services are non-refundable including but not limited to contact lens fitting, in-office testing and the **Optomap®**.
9. Glasses orders are custom made and as such are non-refundable. Orders canceled while in production will be subject to a 40% restocking fee. Our full remake policy is available upon request.

I have read and understand *Schertz Vision Source's* financial policy listed above and I accept responsibility for the payment of any fees associated with my care.

I understand that my signature authorizes payment be made directly to *Schertz Vision Source* to pay my claim. My signature authorizes the release of medical information necessary to pay my claim and to be released to physicians or optometrists in connection with the continuity of care and for the release of benefits payable and medical information necessary to pay any secondary insurance payer.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

_____ _____

Signature Date Print Patient Name

optomap® ultra-widefield retinal imaging

Schertz Vision Source is proud to provide state-of-the-art digital scanning technology that allows us to study the inside of your eye. The **Optomap®** provides the quickest and most comfortable method to obtain this view. This image allows the doctor to evaluate your retina to ensure there are no signs of macular degeneration, retinal holes, retinal detachments, hypertension, cancers and/or diabetic retinopathy.

The great news is that with your vision benefits, this imaging is covered with a co-pay of $29 and this copay can also be paid with your FSA, HSA &/or FLEX.

EARLY DETECTION IS CRUCIAL! The doctors of Schertz Vision Source ***strongly recommend*** the **Optomap®** for all patients as a screening tool for pathology. The doctor can NOT fully assess the health of your eye without the **Optomap®** (or a dilated exam).

The **Optomap®** ultra-widefield retinal image is a unique technology that captures more than 80% of your retina in a single image while traditional imaging methods typically only show 15% of your retina at one time.

** At this time, we are **NOT** offering dilation using eye drops due to COVID-19. Discontinuing the use of drops increases safety by decreasing the amount of time you spend in the office and with any one person. The **Optomap®** will allow us to evaluate the health of the eye quickly and safely.

By signing below, you are consenting to the **Optomap®** and agree to pay $29 for the digital imaging.

_____ _____ _____

Signature Date Print Patient Name

If you would like to ***decline*** the **Optomap®**, please print your name below to waive evaluation of your retina.

I, _____ decline the **Optomap®** at this time.

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Medical Information Release Form (HIPAA Release Form)

Patient Name: _____ Patient Date of birth:_____

Release of Information

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

- ☐ Spouse: _____
- ☐ Child(ren): _____
- ☐ Other: _____

☐ Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Patient/Parent Signature: _____ Date: _____

Printed name of person completing form: _____