TSO™
TEXAS STATE OPTICAL

Christy's Eye Associates, LLC
Texas State Optical Magnolia
6519 FM 1488, Suite 503
Magnolia, Texas 77354
Phone: (281) 946-2020 Fax: (281) 946-2025

Dr. Christy Y. Jew
Therapeutic Optometrist
Optometric Glaucoma Specialist

Patient Information

Today's Date: _____

Mr. / Mrs. / Ms.
Dr. / Rev. **Last Name**: _____ **First Name**: _____ **MI**: _____ **Suffix**: _____
(Jr., Sr., etc.)

Address: _____
City: _____ **State**: _____ **Zip Code**: _____-_____ **Patient's SS#**: _____-_____-_____
(if using insurance)

Cell Phone: (_____)_____ **Work Phone**: (_____)_____ **DL#**: _____ **State**: _____
(if paying by check)

Home Phone: (_____)_____ **Email**: _____
Other Phone: (_____)_____
Preferred Contact Method: cell phone home phone work phone email other: _____
(please circle one)

Date of Birth: _____/_____/_____ **Occupation** (or Grade in School): _____
Gender: male female **Employer** (or School Name): _____
(please circle one)

Marital Status: single married **Parent/Guardian Name** (if patient is a minor): _____
(please circle one) separated widowed

How did you find out about our office? _____
Is there anyone we can thank for referring you? _____

What is the purpose of today's visit? Eye Examination Contact Lens Evaluation Annual Diabetic Eye Exam
(please circle one) Glasses Purchase Contact Lens Purchase Other: _____

Insurance Information

✱ **Please note that routine Eye Examination insurance coverage does NOT automatically cover the contact lens fitting and evaluation fees.** ✱

VISION Insurance: _____
ID Number: _____
Policy/Group #: _____

If the patient is NOT the primary insured, please fill out information below.

PRIMARY INSURED Name: _____

Relationship to Patient: spouse parent other
(please circle one)

Gender (*of primary insured*): male female
(please circle one)

PRIMARY INSURED's Address: ☐ Check here if SAME as patient

_____
City: _____ State: ___ Zip Code: _____
Phone #: (_____)_____ **SS#**: _____-_____-_____
(of primary insured)
Date of Birth (*of primary insured*): _____/_____/_____

MEDICAL Insurance: _____
ID Number: _____
Policy/Group #: _____

If the patient is NOT the primary insured, please fill out information below.

PRIMARY INSURED Name: _____

Relationship to Patient: spouse parent other
(please circle one)

Gender (*of primary insured*): male female
(please circle one)

PRIMARY INSURED's Address: ☐ Check here if SAME as patient

_____
City: _____ State: ___ Zip Code: _____
Phone #: (_____)_____ **SS#**: _____-_____-_____
(of primary insured)
Date of Birth (*of primary insured*): _____/_____/_____

Please turn over and complete the back page →

Last Name: _____ First Name: _____ DOB: _____/_____/_____

30-Day TSO Magnolia Satisfaction Guarantee

4-WEEK DOCTOR PRESCRIPTION GUARANTEE

Since refraction is a subjective response, if you experience visual discomfort after an initial adaptation period with your eyewear, your eyes will be re-examined within 4 weeks of the initial visit at no additional charge. After the 4 weeks period, there will be a **$25 CHARGE** for a prescription check by the doctor.

(initial here)

30-DAY SATISFACTION GUARANTEE

If within 30 days from date of purchase you are not satisfied with your glasses, we will adjust or replace your glasses. A **50% RESTOCKING FEE** will be applied to any glasses returns and on any unopened boxes of contacts during this 30-day period. Should your frames break or your lenses scratch within the 1st YEAR after purchase, we will replace them for FREE! This warranty DOES NOT include uncoated lenses, mirror tints, loss, theft, damage by pets, or abuse of the eyewear. Any modifications done to the glasses (i.e. – superglue, welding, epoxy, etc.) will VOID the warranty!

(initial here)

HIPPA - Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Your point of contact about your rights to access your Health Records or complaints and comments about your health record privacy is:

TSO HIPAA Director, 6519 FM 1488, Suite 503, Magnolia, Texas 77354

A copy of the Notice of Privacy Practices is available for review at the office (*please see the laminated page attached to the clipboard*). If you would like a copy of the Notice of Privacy Practices to take home, you may request a copy from our front desk.

We will use your Protected Health Information to provide appointment reminders, describe or recommend treatment alternatives and provide information about health related benefits and services that may be of interest to you. We will maintain the privacy of your health records, provide this notice to you, abide by the terms of this notice and reserve the right to revise the privacy practices of this office.

You have the right to review or to copy your health records, request changes or offer amendments to your records, obtain a accounting of to whom we have disclosed information from your records and request restrictions on certain uses and disclosures from your health records. You also have the right to revoke our ability to disclose your health information by providing the practice with a signed written request. Until such a request is received, this notice will be in effect for six (6) years from the date of the most recently signed notice.

I acknowledge that I have received and reviewed the Notice of Privacy Practices with full understanding.

Patient's Name (please print)**: _____** **Patient's Signature** **Date**

(or parent/guardian if patient is a minor)

Authorization and Consent

I certify that I have read and understand the **Patient Information Forms** to the best of my knowledge. The questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the eye doctor to release any information including the diagnosis and the records of any treatment of examination rendered to my child or me during the period of such eye care to third party payers and/or health practitioners. I further authorize any holder of any medical information about me to release to any medical benefits provider information necessary to determine my eligibility and/or benefits.

Payment is expected at the time services are rendered. There is a $25 returned-check-fee for any checks that are written and returned by the bank due to NSF (non-sufficient-funds). I hereby authorize TSO Magnolia to file my insurance benefits on my behalf, and therefore, I authorize my insurance/medical benefits to be paid directly to TSO Magnolia. I further authorize release of any medical records or information to my insurance company that is necessary in order to process my insurance claim. I understand that my insurance carrier may pay less than the actual bill for services; therefore, I agree to be responsible for payment of the balance of all services rendered on my behalf or that of my dependents.

Upon future visits to this practice, I will review the **Established Patient Form** and make all necessary changes and sign and date a new authorization. I have the right to revoke this authorization at any time by providing the practice with a signed written request. Until such as request is received, the authorization will be in effect for six (6) years from the date of the most recent signed authorization. I have the right to expect my personal health information to be protected as outlined in the Notice of Private Practices above. The terms of the notice may change. If I desire, a copy of the new notice will be provided to me by requesting one in writing from this practice. I can request to have my consent to use my protected health information revoked at any time with a signed written request to this practice.

Patient's Name (please print)**: _____** **Patient's Signature** **Date**

(or parent/guardian if patient is a minor)

Last Name: _____ **First Name:** _____ **DOB:** _____/_____/_____

Patient Vision & Medical History

Current **PRESCRIBED MEDICATIONS** *(prescription eye drops, blood pressure, diabetes, cholesterol, thyroid, birth control, etc.):*

_____

_____

Current **OVER-THE-COUNTER MEDICATIONS** *(vitamins, eye drops, allergy, pain, sleep aid, etc.):*

_____

_____

ALLERGIES to medications? ☐ Yes ☐ No If yes, please list: _____

Do you use cigarettes/tobacco, alcohol, or other substances? ☐ Yes ☐ No

If YES, which one(s) and how much/how often? _____

***** Females ONLY ***** : Are you pregnant or nursing at this time? ☐ Yes ☐ No

Date of Last Eye Exam: _____

Name of Previous Eye Doctor: _____

Are **YOU** currently experiencing or have been previously diagnosed or treated for any of the following eye conditions? *(check all that apply)*

- ☐ **NONE**
- ☐ Blurry vision
  - ☐ ***NEAR*** ☐ ***FAR*** ☐ ***INTERMEDIATE (computer)***
- ☐ Squinting
- ☐ Eye soreness or fatigue
- ☐ Double vision
- ☐ Vision-related headaches
- ☐ Ocular Migraines
- ☐ Burning sensation
- ☐ Excess watering
- ☐ Dry/gritty feeling
- ☐ Redness
- ☐ Itching
- ☐ Glare/light sensitivity
- ☐ Floaters
- ☐ Flashes of light *(sudden onset)*
- ☐ Mucous discharge
- ☐ Chronic eye infections _____
- ☐ Eye Turn/Crossed Eye (Strabismus) _____
- ☐ Lazy Eye (Amblyopia) _____
- ☐ Eye injury _____
- ☐ Iritis/Uveitis
- ☐ Cataracts
- ☐ Glaucoma ***When diagnosed?:*** _____
  - ***Are you using glaucoma eye drops?*** ☐ ***YES*** ☐ ***NO***
  - ***Have you had any type of glaucoma surgery?*** ☐ ***YES*** ☐ ***NO***
- ☐ Macular Degeneration ***When diagnosed?:*** _____
  - ***Which kind of macular degeneration?*** ☐ ***DRY*** ☐ ***WET*** ☐ ***unknown***
- ☐ Retinal Detachment _____
- ☐ Eye surgery (cataract, LASIK, RK, etc.) _____
- ☐ Other: _____

_____

- ☐ Special Needs: _____

_____

Date of Last Physical Check-up: _____

Name of Family Physician: _____

Have **YOU** ever been diagnosed or treated for any of the following health conditions? *(check all that apply)*

- ☐ **NONE**
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Rosacea
- ☐ Stroke
- ☐ Diabetes
- ☐ Unusual weight loss/gain
  - ☐ ***Type 1*** ☐ ***Type 2***
  - ***When diagnosed?:*** _____
- ☐ Fever
- ☐ High blood pressure
- ☐ Allergies/hay fever
  - ***When diagnosed?:*** _____
- ☐ Rheumatoid arthritis
- ☐ High cholesterol
- ☐ Sinus infections
  - ***When diagnosed?:*** _____
- ☐ Thyroid
- ☐ Hearing loss
  - ☐ ***hyperactive*** ☐ ***hypoactive***
- ☐ Gastrointestinal problems _____
- ☐ Genitourinary problems _____
- ☐ Neurological problems _____
- ☐ Psychological problems _____
- ☐ Cancer _____
- ☐ OTHER _____

_____

Is there any <u>FAMILY</u> medical history of any of the following?

☐ **NONE** ☐ **Adopted** *(family history unknown)*

(check all that apply and please <u>list who in the family has the condition</u>)

- ☐ Blindness _____
- ☐ Lazy eye _____
- ☐ Cataracts _____
- ☐ Glaucoma _____
- ☐ Macular Degeneration _____
- ☐ Corneal problems _____
- ☐ Retinal problems _____
- ☐ High blood pressure _____
- ☐ Diabetes _____

Last Name: _____ First Name: _____ DOB: _____/_____/_____

Medical vs. Vision Benefits

We often have patients that carry BOTH medical and vision insurances. These types of insurances are very different in terms of services covered. Your vision plan provides you with a "routine eye screening exam". This assumes perfectly healthy eyes that only suffer from problems like nearsightedness, farsightedness, astigmatism, and presbyopia.

Your vision insurance will NOT pay for medical issues. If the nature of your visit today is due to a MEDICAL eye condition (see Medical Eye Exam explanation below), your medical insurance WILL be billed. You will be responsible for the medical office visit SPECIALIST COPAY and we will bill your medical insurance accordingly.

ROUTINE VISION EXAM	MEDICAL EYE EXAM
Patient has no complaints. An eyeglasses prescription is written if necessary.	Pink eye, dry eyes, itchy eyes, blurry vision, floaters, red eyes, foreign body, eye injuries, CL complications, etc.
The eye is perfectly healthy.	Management of diabetes, cataracts, contact lens overwear, glaucoma, macular degeneration, high-risk medication, etc.
No prescriptions for medications are written.	Prescriptions for medications written if necessary.
VISION INSURANCE is BILLED *The patient is responsible for the routine vision exam copay and the contact lens evaluation fee (if applicable).*	**MEDICAL INSURANCE is BILLED** *The patient is responsible for the medical specialist office visit copay and any unmet insurance deductible for services rendered.*

By signing this agreement you are stating that you understand the vision vs. medical insurance policy and do hereby agree to be financially responsible for all charges for products and/or services rendered to you at Texas State Optical Magnolia.

Patient's Name (please print)**: _____** **Patient's Signature** _____ **Date** _____

(or parent/guardian if patient is a minor)

Dilation of the Pupils & Optomap Retinal Imaging

A yearly thorough internal examination of the eyes is integral to a comprehensive eye examination. Without a thorough internal examination, serious eye diseases can be missed, including but not limited to diabetes, hypertension, cataracts, retinal detachments, or malignant tumors.

✱ Your Doctor's preferred method for this portion of the exam is an Optomap Retinal Image in conjunction with Dilation. ✱

Our office is proud to provide our patients with the most highly advanced digital retinal imaging technology available today. The Optomap takes a digital image of your retina that the doctor will review with you in the exam room and this image will be saved in your medical records. **There are select insurances that DO cover the Optomap Retinal Imaging in full or with a copay. If the Optomap is NOT covered by your insurance, we offer a discounted out-of-pocket fee of $39.**

Dilation of the pupils is included as a part of your comprehensive annual eye exam. Dilation involves placing drops in your eyes to enlarge the pupil size. With dilation of the eyes you may experience the following effects, which can last for 1-4 hours: *increased sensitivity to light, inability to focus up close, and a slight blurring of your distance vision.*

Please select (X) ONE of the following options and sign below:

☐ I do **CONSENT to BOTH** the **Optomap** and **Dilated Retinal Exam** today.
I do **AGREE** to pay the **out-of-pocket cost of $39** for the Optomap, if it is not already covered by my insurance copay.

I understand the importance of both the Optomap Retinal Imaging and Dilated Retinal Exam.

☐ I would like to **CONSENT** to only the **Optomap** & **DECLINE** the **Dilated Retinal Exam** today.

☐ I would like to **DECLINE** the **Optomap** & **CONSENT** to only the **Dilated Retinal Exam** today.

☐ I would like to **DECLINE both** today.
I release the doctors of TSO Magnolia from any liabilities related to the failure to diagnose or treat any eye conditions due to the lack of diagnostic information, which could have been obtained by the tests.

Patient's Name (please print)**: _____** **Patient's Signature** _____ **Date** _____

(or parent/guardian if patient is a minor)