Harrel eyecare

WELCOME

Thank you for choosing our office for your eyecare needs. We're glad to help if you have questions.

All Patient Information is Confidential

Name: Date:

Address: City/State: Zip

Home Phone: Cell Phone: Text OK?:

Email: Birthdate:

Patient's SSN: Employer:

Primary Physician/Pediatrician:

Marital Status: Children:

Height: Weight:

Preferred Method of Communication: ❒Home Phone ❒Cell Phone ❒Email ❒Text

Preferred Language: ❒English ❒Spanish ❒Other: _____

Race:
- ❒ American Indian or Alaskan Native
- ❒ Asian
- ❒ Black or African American
- ❒ Hispanic
- ❒ Native Hawaiian or Pacific Islander
- ❒ White

Preferred Pharmacy: Phone:

Insurance Information

If you are using insurance, we need to copy your medical and vision cards. We treat both medical eye problems as well as vision care. Thank you.

Primary Member's Name: Primary Member's Employer:

Primary's social security #: Primary Member's Birthdate:

Please Fill Out Both Sides

Your Eye Health and Vision are important to us.

Health History

Please indicate if you or your family (blood relatives only) have any of the following:

Condition	Patient	Family	Condition	Patient	Family
Diabetes	❒	❒	Glaucoma	❒	❒
High Blood Pressure	❒	❒	Cataracts	❒	❒
Heart Disease	❒	❒	Turned Eye	❒	❒
Kidney Disease	❒	❒	Lazy Eye	❒	❒
Thyroid Disease	❒	❒	Eye Injury	❒	❒
Asthma	❒	❒	Eye Surgery	❒	❒
Cancer	❒	❒	Blindness	❒	❒
Macular Degeneration:	❒	❒	Other:		

Please indicate if any of the following conditions apply to you:

❒ Pregnant ❒ Drug allergies ❒ Frequent Headaches

❒ Allergies ❒ Sinus trouble ❒ Smoker

Please list all medications your are allergic to: ❒ None

Medications you are currently taking: ❒ None

Approximate Date of Last Eye Exam? 1 year 2 years 3 or more years

Do you currently wear glasses? ❒Yes ❒No If yes, when do you wear your glasses?

❒ All the time ❒ Reading/Near work ❒ Distance tasks only work

❒ Work Safety ❒ Computer wear ❒ Other, please explain

Are you planning on getting new glasses today? ❒Yes ❒No ❒Unsure

Have you ever worn contact lenses? ❒Yes ❒No

Are you renewing your contact lens prescription today? ❒Yes ❒No ❒Unsure

Do you work on a computer more than 4 hours per day? ❒Yes ❒No

Are you interested in Laser Vision Correction? ❒Yes ❒No

How did you become aware of our practice?

❒ friend recommendation ❒ co-worker recommendation ❒ referred by other professional

❒ insurance provider ❒ other: _____

Payment Information

I authorize you to bill my insurance for any applicable services or products, and I understand that payments for non-insured services are *due the same day services are rendered*.

Signature: _____

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Notice of Privacy Practice
Methods of Payments

No Insurance?

No problem. Harrel Eyecare offers a discount for all non-insurance patients for their Vision or Medical exam. We also, accept all major credit cards, Care Credit, cash or checks.

Vision Plans

Some vision insurance plans do not provide an insurance card. Vision plans usually include benefits towards glasses or contacts. (Examples: VSP, EyeMed, Avesis, Superior Vision, etc.). Medical insurances generally do not cover these benefits. Medicaid (Soonercare) only allows glasses for patients less than 20 years of age and they do not cover contact lenses.

Medical Insurance

Refractions (checking vision) & the contact lens portion of the exam are not generally covered by medical plans. We can file your insurance on your behalf, but this does not guarantee payment and any balance will be paid by you. If your deductible has not been met for the year, you will be responsible for services rendered. We keep medical insurance information on file because we perform medical eye care. We use medical insurance for infections, foreign body removals, eye disease, treatments, etc.

We are glad to answer any questions regarding your insurance benefits. Thanks!

Please Sign Here - Privacy Practices

I acknowledge that I have read or have had the opportunity to read the Notice of Privacy Practices (available at the front desk).

Patient Name (please print):_____ Date: _____

Signature of Patient or Guardian: _____

Monte Harrel O.D., F.C.O.V.D. Tiffany Harrel, O.D. Savanah Sayler, O.D.
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www.oklahomavision.com

Please check any that apply to help us know how to provide the best care for your child.

Developmental Checklist

- o Slow reader
- o Tracking issues: points with finger, omits small words while reading or copying
- o Obsessed with routines or difficultly with transitions?
- o Poor reading comprehension
- o Homework takes longer than it should
- o Hand flapping or toe walking
- o Short attention span, restless, unable to stay on task
- o Avoids close work
- o Difficultly toilet training or issues with bed wetting
- o Irregular sleep patterns
- o Unreasonable fears, high anxiety, or night terrors
- o Rubs eyes, squints or blinks excessively
- o Double vision
- o Are there any digestive/elimination problems
- o Check if your child does not eat any of these foods:
  Milk_____ Meats _____ Vegetables _____ Fruits _____
- o Smart in everything but school
- o Has individual educational plan (IEP)

Continued on Back

o Resource room for _____
o Tutor for_____

- Has repeated _____ grade
- Dietary modification in place
- Does your child take medicine for a health problem? (do not include vitamins, iron, or fluoride)
- Confuses left and right repeatedly
- Headaches after close work
- Frustration, fatigue, stress after/during close work
- Unusual posture/head tilt while reading or writing
- Difficultly with o fine motor skills (eating writing holding crayon)
  o large motor skills (riding bike, balancing, throwing/catching ball)
- Tactile defensiveness (clothing tags, food textures)
- Speech therapy On track now? Yes No
- History of seizures
- History of ear infections
- Difficultly showing affection or shows lack of empathy
- Frequent meltdowns/tantrums
- Angry or aggressive behavior issues
- Does your child have food allergies?
- Does your child use a feeding tube or other special feeding methods?
- Does your child have a problem with:
  a. Sucking b. Swallowing c. Chewing d. Gagging
- Does your child refuse to eat, throw food, or do other things that upset family dinner?

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"SoonerCare will provide for payment of lenses and frames for children only. This Coverage includes one set of lenses and frames per service year."

-Garth L Splinter, M.D., M.B.A
State Medicaid Director

We offer a one year warranty on all of our frames; one replacement frame may be obtained within one year of the exam date. Pieces of broken frame are required for any replacement; loss and theft are not covered by this warranty. Lenses are covered under a one year Scratch Warranty. Damaged lenses are required for replacement, and may only be obtained once within the year of exam date. This warranty is courtesy of Harrel Eye Care Center and is not affiliated in any way to your SoonerCare Coverage.

If frame or lenses have been replaced under warranty or a replacement is needed due to loss or theft, the prices are as follows:

$74.00 frame only
$68.00 lenses only
$99.00 frame and lens package price

"The replacement of or additional lenses and frames are allowed [to be billed to SoonerCare] only when medically necessary [as prescribed by doctor]… The replacement of lenses and frames due to abuse and neglect by the member is not covered."

-OAC 317:30-5-432.1

If you have any questions, please call your SoonerCare Case Worker.
If you would like to see a copy of the clarification letter in accordance with OAC 317:305-432.1 please ask an associate.

I acknowledge that I have read and understand the above Advisement and consent to the contents.

Patient Name: _____ Date: _____

Signature Patient or Guardian: _____