My Family Eyecare
820 Stateline Road
Colcord, OK 74338
918.422.5811

Welcome to our office!

Date _____
Last Name _____ First Name _____ MI _____
Mailing Address _____
City _____ State _____ Zip _____
Cell Phone _____Work Phone _____
Home Phone _____ Where do you work? _____
SSN _____ DOB _____ Sex _____
Email Address _____
How do you prefer us to contact you? ____Text ____ Cell ____ Home ____ Email
Emergency Contact _____ Phone _____
Marital Status _____ Spouse's Name _____
Race (optional) _____
Primary Language (optional) _____
Special Needs (optional) _____
Preferred Pharmacy _____
Responsible Party _____ DOB _____
Relationship to Patient _____ Phone _____
Responsible Party's Workplace _____ Phone _____

Insurance Information:
Vision Plan _____
Member or Subscriber _____ SSN _____
DOB _____
Primary Medical Insurance _____
Member or Subscriber _____ SSN _____
DOB _____
Secondary Medical Insurance _____ SSN _____
DOB _____

How will you be paying for your services today? ____ Cash ____ Check ____ Credit/Debit
Do you participate in a Health Savings Account or Flex Spending Account? ____ Yes ____ No

When was your last exam? _____
Where was your last exam? _____

Should you need refractive correction, are you wanting glasses, contacts or both? _____
If you are an experienced contact lens wearer, what brand do you wear? _____
What solution do you use? _____

What problems have you been having? Please check all that apply.

____ Blurry Vision ____ Eye Irritation ____ Sunlight Sensitivity
____ Eye Turn/Crossed Eye ____ Flashes of Light ____ Double Vision
____ Dryness ____ Floaters or Spots ____ Headaches
____ Trouble Seeing at Night
____ Other, Please Explain _____

We also offer our **I Wellness Screening** that reveals early indications of retinal or nerve disease. This screening is a non-invasive "picture" of the interior portion of your eye referred to as your retina. Dr. Vaughan recommends that every patient consider this screening as it helps to detect any vision threatening issues or any systemic disease. As a new patient, Dr. Vaughan will also use this screening as a baseline of retinal health. These images will help her determine what is normal for you as an individual. From these images, Dr. Vaughan will be able to detect any small changes that may happen over time. This information can be valuable in seeing changes over time.

If you want to have this important screening performed today, please check the box below and we will see to it that our technician discusses it with you. **We are offering this important test for only $39 as it is truly a helpful tool.** It is, however, not covered by most insurances. Should you decide to have this test performed, the charge will be your responsibility.

_____ Yes, I want to have the **I Wellness Screening**

Medical History:

Please tell us about the history of eye disease in your family _____
_____
_____

Please tell us about the family history of any other diseases in your family _____
_____
_____
_____

Name of your Physician _____
Where is your Physician Located _____
Date of Last Physical Exam _____

Current Medications (including vitamins, eye drops or birth control) _____
_____
_____
_____

Do you have any allergies to any medications? ____ Yes ____ No
If yes, what medications? _____

Please list any diseases, disorders, surgeries or physical problems that are an issue for you now or in the past _____
_____
_____
_____

Do you smoke? ____ Yes ____ No
Have you ever smoked? ____ Yes ____ No
Do you use other tobacco products? ____ Yes ____ No
Do you vape? ____ Yes ____ No
Do you use alcohol? ____ Yes ____ No

Have you ever been exposed to or infected with Gonorrhea, Hepatitis, HIV or Syphilis?
____ Yes ____ No If yes, which one(s) _____

Whom may we thank for referring you to our office today?
_____

If there was not a referral, how did you hear about us? _____

Signature on File

We are required by law to have your signature on file stating that you received a copy of the Privacy Notice. (We will provide a copy at your request.)

I, _____ acknowledge that I have been offered a copy of the Privacy Notice for the office of My Family Eyecare.

I also give my permission for the office to correspond with me via email.

Dilation is a significant part of the eye health examination. It should be performed at least every two years. I give my permission to have Dr. Vaughan dilate my eyes today.

_____ Yes _____ No

I certify that the information given by me in applying for payment by my insurance company is correct.

*I authorize use of this form on all my claim submissions
*I authorize release of information to all of my insurances companies as needed to process claims for payment.
*I authorize my doctor to act as my agent in helping obtain payment from my insurance companies.
*I authorize payment directly to my doctor.
*I permit a copy of this authorization to be used in place of the original.
*I authorize the release of personal health information to any other physicians or personnel who who may be utilized.

IMPORTANT: Payment is expected today for all copays, deductibles and non-covered services. As a courtesy to you we will bill your insurance for you for those services they may cover. We will make a good faith effort to collect all payments from your insurance companies for the services we provide to you. However, if payment is not received from your insurance companies within 60 days of filing, the balance will become your responsibility.

I have read all of the above and I give my consent and permission for each as it is written.

Signature _____ Date _____

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Patient Financial Responsibility Statement

Medical Insurance vs. Routine Vision Plans

Patients often have both medical and insurance and vision plans. Because they are very different in terms of the services and/or materials that they cover, it is very important to us that you understand the differences.

Vision care plans (Eyemed, Superior, VSP, etc.) ONLY cover routine services. This means that if you have a "refractive error" without a medical condition and you simply need glasses or contact to correct your vision, they may help you pay for your routine vision exam and the necessary materials. Most vision plans WILL NOT cover charges for medical issues we may encounter. If the examination today is to follow or treat a medical condition (macular degeneration, diabetes, glaucoma, dry eye, cataracts, etc.) your service today will be billed to your medical insurance coverage upon check in.

Please initial all that you have read and understood.

_____ Initials

To our patients without insurance:
Payment for all services rendered is due at the conclusion of the visit. If you are ordering materials, our policy requires half of the amount due at the time we order your materials. The remaining half is due upon the dispensing of your glasses/contacts.

_____ Initials

To our patients with insurance: (Medical or Vision):
It is our pleasure to help you file your insurance claim forms or take assignment with your insurance benefits as designated by the plan of which you have indicated you are a member. **A "refraction" fee of $39 is NOT COVERED by most medical insurance.** If your visit results in a medical diagnosis and we bill your medical insurance, the $39 refraction fee will be your responsibility at checkout. You will also be responsible for all medical co-pays, deductibles or any non-covered service. If you have no medical diagnosis and we file your vision insurance, you are responsible for all co-pays and/or non-covered materials or fees. If any materials are ordered, our policy requires half of the amount due at the time we order the materials. The remaining half is due upon the dispensing of your glasses/contacts. **All** insurances for which the patient is a member must be stated and presented at the time of the visit and WILL NOT be accepted after services are rendered. If you have vision insurance and medical insurance, we will work to minimize your out of pocket expense by coordinating benefits between the two plans if allowed.

_____ Initials

To our patients who wear contacts:
We charge a higher fee for our contact lens exams as they require more information gathering and interpretation. Contact lens wearers will also pay an additional contact lens evaluation and training fee to cover the training involved for the daily use and maintenance of the lenses. This fee also covers the doctor's time to determine the lenses

that will provide optimal vision and eye health. Experienced wearers may pay a lesser evaluation fee as training will not be necessary. In addition, fees will be determined by the type of lens required for both first time wearers and those experience with contact lenses. **Some vision plans and most medical plans will not pay for this additional evaluation.** Thus, it will be your responsibility at check out. Once lenses are determined the day of the appointment and you have received the necessary training, we will have you return for a follow up appointment to make sure the lenses are working well and are healthy. If changes are required, our policy dictates that we will allow 2 more appointments (at not charge) within 60 day period to fine tune or correct any issues.

_____
Initials

Financial Responsibility:
In the event that your medical or vision plan denies payment for services or materials, you hereby agree to be financially responsible for any and all charges incurred by you or your child/dependent. In the event that any payments are not made, all finance fees, collection fees and attorney fees will be your responsibility as well.

Responsibility Statement for (name of patient) _____

Patient/Guardian **PRINTED** name _____

_____ Date _____
Patient/Guardian **SIGNATURE**