# Welcome to Forney Eye Associates

**DEMOGRAPHICS**

Name (Last, First):_____ Name you go by: _____

DOB: ___/___/___ Age: ____ Male ___ Female ___ Social:_____

Address:_____City:_____State:_____Zip_____

Cell Phone (____) _____ Home Phone (____) _____ Work Phone (____)_____

The best time to contact me is: AM ___ PM ___ on my: Home # ___ Work #___ Cell # ___

Email Address_____ Do we have permission to send you emails? YES NO

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Responsible Party:_____ Relationship to Patient: Self__ Spouse__ Parent/Guardian__

Person to contact in case of emergency_____ Phone_____

Whom may we thank for referring you? _____

Pharmacy _____ Phone Number _____

**INSURANCE INFORMATION**

Primary Insurance Holder: _____ DOB_____ Last 4 of SS :_____

Phone #: ( ) _____ Relationship to Patient _____ Name of Employer:_____

Insurance Company (Vision) _____ ID#_____ Phone #: _____

Insurance Company (Medical): _____ ID#_____

**CONSENT FOR USE OF INSURANCE INFORMATION**

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above plan(s) and assign directly to Joey D. Tran O.D. and/or Hoa Nguyen, O.D., all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance. I understand that my vision and/or health insurance coverage is a contract between myself and my insurance company. Although Dr. Nguyen, Dr. Tran, and the staff have made every effort to verify my benefits before my appointment, no guarantee can be made that the information received is accurate since incorrect information may be provided by my insurance company from time to time. I understand that it is ultimately my responsibility as the patient to understand my vision and/or health insurance coverage as well as handle any charges my plan does not cover.

By signing below, I understand the above paragraph.

Patient/Guardian Signature: _____ Date: _____

**ACKNOWLEGEMENT OF PRIVACY PRACTICES**

I acknowledge that I have read and understand the Notice of Privacy Practices as implemented by Joey D. Tran O.D. and/or Hoa Nguyen, O.D. The notice of Privacy Practices provides a description of our treatment, payment activities, and healthcare operations. I am also aware that I may request a copy of the Privacy Practices for my personal records. I also consent to the use and disclosure of my information to only carry out treatments, payment activities and submission of insurances.

Patient/Guardian Signature: _____ Date: _____

**MEDICAL & EYE HISTORY:**

What is the reason for your visit today? _____

Last eye exam: _____ Results: _____

Do you wear glasses? _____ if yes, what are they for? _____How old are they? _____

Do you wear contact lenses? ____ if yes, what brand/kind? _____ if no, are you interested? ___

Date of last medical (physical) exam? _____ Doctor's Name_____ Office # _____

**PLEASE COMPLETE FRONT AND BACK**

Please check if you have had any of the following medical conditions:

__High Blood Pressure __Thyroid Disease __High Cholesterol __Tuberculosis __Headaches/Migraines

__Diabetes __Arthritis __Hepatitis __Asthma __Heart Disease

__Cancer __Multiple Sclerosis __Allergies/Sinusitus __Pregnant__ Months Other _____

Please list all medications you are currently using, **including** over the counter medications:

_____ _____ _____

_____ _____ _____

Please list any allergies: _____ _____ _____

Please list any previous medical and ocular injuries/surgeries: _____

**FAMILY HISTORY (please check all that applies to your immediate family members)**

__Glaucoma __Amblyopia, Lazy Eye __High Blood Pressure __High Cholesterol __Multiple Sclerosis

__Macular Degeneration __Blindness __Diabetes __Thyroid Disease __Lupus

__Cataracts __Retinal Disease __Heart Disease __Cancer __Other _____

**SOCIAL HISTORY**

Current occupation: _____ Hobbies: _____

Do you drink alcohol? Yes__ No ___ if yes, how often and quantity: _____

Do you use tobacco products? Yes___ No ___ if yes, what kind and how much each day: _____

**FUNDUS PHOTO**

The word "fundus" describes the inside or back of the eyeball. A fundus photo would contain an image of the center of the very back inner wall of the eye: the retina. The optic nerve, macula and main retinal blood vessels are common structures seen in a fundus photo. Fundus photography is very useful to document the natural state of the back of the eye in order to give the retinal specialist a future reference to compare with during follow-up visits. It is important to document the findings of most retinal diseases and conditions, especially diabetic eye disease findings, macular degeneration, epi-retinal membranes, macular holes and retinal tears and detachment.

******The fee for this procedure is **$25.00** Please check one and sign below, **This procedure is not covered by insurance.**

_____ **I DO** consent to having fundus photos performed.

_____ **I DO NOT** wish to have fundus photos performed. I release my doctor from any liability of failure to treat, or diagnose any eye condition due to lack of diagnostic information that could have been obtained by this test.

**DILATED EXAMINATION**

Dilation is the process of administering special pharmaceutical eye drops into the eyes in order to enlarge the pupils. **This procedure will require an additional 20-30 minutes on top of normal exam time to complete.** This allows a more thorough examination the structures of the eyes. Dilation is a key component of a comprehensive eye examination, as it sometimes leads to the detection and diagnosis of certain eye diseases and conditions such as: diabetes, eye tumors, high blood pressure, Infectious diseases, macular degeneration, retinal detachment and many more. Your near vision will be impaired with this procedure and you will also be light sensitive for approximately 4-6 hours. **This procedure is covered under insurance.**

- ○ Yes, I consent to have the dilated exam.
- ○ NO, I decline to have the dilated exam. I am aware of the risks associated with the failure to detect any eye conditions due to the lack of information that could have been obtained by this important procedure.

Patient/Guardian signature _____ Date: _____

**Office Policies**

**FINANCIAL POLICIES:**

• For patients with insurance, it is expected that your insurance will not pay for all services or materials that are received in this office. You will be financially responsible for any services or materials that are not covered by or paid for by your insurance company.
• For patients with insurance in which this office is not a network provider, the patient is expected to pay all expenses at the time services and/or materials are completed. It will be the responsibility of the patient to bill their insurance company directly for reimbursement.
• Co-payments are due on the same day services are rendered. A minimum 50% deposit is required prior to ordering prescription glasses and/or contact lenses. The remaining balance is due at pick-up. All balances must be paid in full prior to the release of materials.
• Accounts with an outstanding balance will be sent to a collection agency after 90 days. The patient must reimburse us the fees of the collection agency, which is based on 33% of the debt, and all costs we incur during such collection efforts.

Patient Signature _____ Patient Name _____ Date _____

**CONTACT LENS POLICIES:**

- Contact lens services are not included under your exam co-pay. Your insurance may not cover contact lens fitting/follow up services in full. Unpaid insurance balance is patients' responsibility.
- If contact lens services are not done at the initial examination you will have 30 days to receive a contact lens fitting, if it is after the 30 day period a new exam will be needed.
- Contact lens services start at $60 and include the initial fitting, training (for new wearers) and one follow up visit. Additional follow up visits will be charged accordingly. Pricing is based on lens type and complexity of exam.
- Contact lens service fees are to be paid in full on the date of service and are not refundable.
- Contact lens prescriptions will only be released after the initial fitting period is successfully completed (exam, fitting, and follow-up visits) and after all fees are paid. Contact lens prescriptions are valid for one year from the date the fit is finalized. Contact lens prescriptions must be finalized within **30 days** or you will be subject to an additional exam fee.

**Contact lens return/exchange policy:**
• All boxes must be unopened, unmarked, in good condition and are subject to a restocking fee. Contacts must be returned within 30 days from the exam date. Only units purchased through our lab may be brought back for return or exchange.

Patient Signature _____ Patient Name _____ Date _____

**PLEASE COMPLETE FRONT AND BACK**

**PRESCRIPTION POLICIES:**

**LAB POLICIES & REFUNDS**:
New frames have a 1-year warranty from the original order date for manufacturer defects only. This warranty does NOT cover normal wear and tear, breakage, loss, etc. In the event a frame is discontinued, we will offer a 50% discount on a new frame. Once an order is placed the frame selected can not be changed. If you request to cancel an order, a 50% non-refundable cancellation fee will apply unless canceled within 1 business day. If you request a special order (out of stock) frame to view, no charge will be incurred on the first frame. Additional frames will incur a $20 restocking fee should you choose not to purchase it. The fee to upgrade to progressive lenses is **non-refundable**. First-time progressive lens wearers who are unable to adapt will be given the option to replace lenses with lined bifocals or single vision lenses at no additional cost.

**PRESCRIPTION CHANGES**: If the patient is unable to adapt to his/her new prescription, the lab will re-do lenses with a new prescription (in the original frame) within a **30-day period**. All prescriptions made through an outside source will be charged $20.00 for prescription verification.

**REPAIRS AND MAINTENANCE**: We will service repairs to glasses at no charge provided the eyewear was purchased at our office. Any repairs sent to the lab will be charged accordingly. Glasses purchased outside our office will be serviced and charged accordingly. We recommend frames purchased at another location be serviced through that provider as we are NOT responsible for replacement should breakage occur.

**PATIENT OWN FRAME**: We are happy to make new lenses for your own frame. We pledge to take the utmost care in handling it. However, there is a small possibility that your frame may be damaged or lost during the manufacturing process. The lab and our office cannot be responsible for replacement or reimbursement. If your frame breaks during the new lens insertion process, the lenses made for your frame cannot be placed into a different style frame. We will make new lenses at no charge for a new frame, but the cost of the replacement frame is your responsibility. Your original lenses will be handled as carefully as possible, but we are not responsible for damage or loss during the manufacturing process.

Patient Signature _____ Patient Name _____ Date _____