TSO™

TEXAS STATE OPTICAL Dr. Jack Rountree, Therapeutic Optometrist, Glaucoma Specialist

Patient Information

Today's Date _____

Last _____

First_____MI__Title_____

Street_____

City_____State_____

Zip Code_____

Home Phone_____

Daytime Phone_____

Gender M F Marital Status_____

Date of Birth_____Age_____

Patient SSN_____

Employer (or School)_____

Occupation (or Grade)_____

Spouse (or Parent's name)_____

Spouse (or Parent's work)_____

E-mail Address_____

What is the Major Purpose of this visit?

_____

Any problems with your current glasses or contacts?

_____

_____

How did you find out about us?

_____

Insurance Information

Please note that *Eye Exam* coverage does not automatically cover the contact lens fitting fee.

Vision Insurance_____

Primary Name_____

Primary Member ID_____

Subscriber D.O.B._____

Primary Medical Insurance_____

Primary Name_____

Primary Member ID_____

Primary D.O.B._____

Do you Participate in a flex spending account?

( ) Yes ( ) No

How will you settle your account today?

( ) Cash ( ) Check ( ) Credit Card ( ) Care Credit (Inquire about application)

Patient Medical History

Please note

We do retinal photos on everyone. Because many diseases and disorders can be identified through this test, it is an essential part of your medical eye exam every year.

Date of Last Eye Exam_____

Name of Eye Doctor_____

Name of Family Physician_____

Date of Last Physical Check-up _____

Please list any surgeries you have had (Eye, Body).

_____

_____

The information in this confidential case history form is critical to the evaluation of your vision and health.

Vision History

Are you experiencing or have been diagnosed or treated for any of the following?

( ) Blurry Vision (near or far) **( ) Burning**

( ) Cataracts **( ) Corneal Abrasion**

( ) Crossed Eye/Eye turn **( ) Double Vision**

( ) Eye Infection **( ) Eye Injury**

( ) Flash of light (sudden onset) **( ) Floaters**

( ) Glaucoma **( ) Grittiness**

( ) Headaches **( ) Iritis/Uveitis**

( ) Itchiness **( ) Lazy Eye**

( ) Macular Degeneration **( ) Occasional Dryness**

( ) Retinal detachment **( ) Sunlight Sensitivity**

( ) Tearing **( ) Trouble seeing at night**

Allergies to Meds ( ) Y ( ) N Please list _____

Do you use cigarettes/tobacco, alcohol, or other substance?

If so how much/how often? ( ) Y ( ) N_____

Over the counter Meds (Eye drops, allergy, pain, sleep aid, etc)

_____

Current RX Medication (Blood pressure, cholesterol, birth control, etc.)_____

Are you Pregnant or Nursing? ( ) Yes ( ) No

Have you ever been diagnosed or treated for the following health problems?

	Yes	**No**
Allergies (medical or seasonal)	( )	( )
Arthritis (Rheumatoid)	( )	( )
Bronchitis	( )	( )
Cancer _____	( )	( )
Elevated Cholesterol	( )	( )
Diabetes Type I or II	( )	( )
Digestive	( )	( )
Ears/Nose/ Throat	( )	( )
Eczema/Rashes	( )	( )
Fatigue	( )	( )
Fevers	( )	( )

Patient Medical History

Have you ever been diagnosed or treated for the following health problems?

	Yes	**No**
Urinary Problems	( )	( )
High Blood Pressure	( )	( )
Skin Disorders _____	( )	( )
Kidney	( )	( )
Muscle/Bone	( )	( )
Neurological	( )	( )
Psychological	( )	( )
Sinus	( )	( )
Throat Infections	( )	( )
Thyroid Infections	( )	( )
Unusual weight losses/gains	( )	( )

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following:

( ) Yes (Please check boxes) ( ) No

Relationship:

(Who in the family and which side Mom or Dad's?)

Blindness	( )_____
Cataracts	( )_____
Corneal Problems	( )_____
Retinal Problems	( )_____
Glaucoma	( )_____
Macular Degeneration	( )_____
Lazy Eye	( )_____
Heart Disease	( )_____
Diabetes	( )_____

Dilation of the Pupils

Dilation of pupils is included as a part of your full annual eye exam. If you have a condition such as diabetes, high blood pressure, cataracts, headaches, high myopia (nearsightedness), symptoms of flashes of lights of floaters, glaucoma or a family history of glaucoma, dilation is even more an important part of your eye exam. By dilating your pupils, many diseases both in your eyes and body can be detected long before any signs or symptoms arise. Dilation involves placing drops in your eyes to enlarge the pupil size.

When an eye is dilated, we are able to get a much broader and fuller view of the inside of the eye. This aids the doctor in determining if diseases (such as macular degeneration, glaucoma and tumors) are present, if there is damage to the retina (such as holes and tears) and also in the evaluation of cataracts.

With dilation of the eyes you may experience the following effects:

- **Increased sensitivity to light**
- **A slight blurring of your distance vision**
- **Inability to focus up close**

These effects may last from 1 to 4 hours.

Please check one of the following options and sign below:

___ I do consent to having my eyes dilated.

___ I do understand the importance of the dilation, yet I do not wish to have it performed at this time. I release Dr. Jack Rountree from any liabilities related to the failure to diagnose or treat any eye condition due to the lack of diagnostic information which could have been obtained by the test.

Patient Signature_____ Date_____

Payment Policy: Payment is expected at the time services are rendered. Glasses and contacts require complete prepay before order is made. Uncollected fees, either from insurance, insufficient funds check, stop payment, credit card charge-backs, etc. remain the responsibility of the patient (parent or legal guardian, if a minor). When insurance benefits are verified, the information provided by the customer service representative is not a guarantee of payment. There may be additional fees for co-pays, deductibles and non-covered services after payment is received from the insurance company. By signing this statement, you agree to be financially responsible for any and all charges. If a credit card was used to pay for services initially, you agree to allow us to charge that credir card for any unpaid balances. In addition you agree to pay all fees incurred to collect on your account, if necessary. Unpaid balances accrue interest at the rate of 1.5% monthly (18% APR) and are sent to a Collection Agency after 45 days.

Assignment of Benefits: (Only applicable if we are filing with a Vision or Medical Insurance for you). "I hereby authorize my insurance/medical benefits to be paid directly to Dr. Jack Rountree. I further authorize release of any medical records or information necessary to process this claim". This assignment of benefits may be revoked by the patient at anytime, with prior written notice.

Patient Signature_____Date_____

Authorization and Consent

I certify that I have read and understand the **Patient Information Sheet** (dated _____) 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. I authorize and request my insurance company to pay directly to the eye doctor or ophthalmic group insurance benefits otherwise payable to me. I understand that my eye care 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 dependants. Upon future visits to this practice, I will review the **Patient Information Sheet,** 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 a request is received, the Authorization will be in effect for six 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 Privacy Practices below. 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.

X _____ _____

SIGNATURE OF PATIENT (Or parent or guardian of a minor) DATE

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
9091 Fair Oaks Parkway
Suite 307
Fair Oaks Ranch, TX 78015

You may file a complaint with the Director of HHS. 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 years from the date of the most recently signed Notice.

X _____ _____

SIGNATURE OF PATIENT (Or parent or guardian of a minor) DATE