Authorization Form

Patient: ____

Patient Phone Number: ____

Patient Address: ____

Purpose of Consent:
Signing this form, you are consenting to our use and disclosure of your protected health information to only carry out treatment, payment activities, and submitting insurance.
You are authorizing payment directly to Frisco Family Vision or its doctors. You are authorizing the signature on file to be used if you choose to pay for materials or services by credit card over the phone. Your credit card information will **NOT** be saved in our computer system. You will be authorizing that Frisco Family Vision has your signature on file.

Notice to Privacy Practices:
Before signing the consent form, you have the right to read the Notice of Privacy Practices. Upon request, we can issue you a copy of this policy for your records. We also have a copy posted in reception area.

You have the right to revoke this consent at any time by giving our office written notice submitted to our office address listed above. Please note that revocation of this consent will not affect any prior action taken on this consent before our office received the revocation; however, Frisco Family Vision can decline to treat you or continue any treatment if you revoke this consent.

I, ____, have had full opportunity to read and consider the contents of this consent form and the Notice of privacy practices. I understand that by signing this form, I am giving consent to this office and disclosure of my protected health information to carry out any insurance filing, treatment, and payment activity.

____ ____________________
Patient/Guardian Signature Date

Medical History **Welcome To Our Office**

We will be happy to help you fill out this form, ask for assistance.

Today's Date: ______________________ Cell Phone: ______________________

Home Phone:

____

Mr.

Work Phone:

____

Title: (circle) Mrs.

Ms.

Dr.

Name: ______________________ Preferred name: ______________________

First *Middle* *Last*

Date of Birth: ________ /________ /__________

Social Security Number: ______________________ Drivers License #: ______________ State: ______

Address: ______________________ City: ______________ ST: ______ Zip: __________

Email Address______________________ Male: ______ Female: ______

Preferred Methods of contact: (circle all approved) Phone Text Email Mail

How did you hear about us: ______________________

Occupation/Grade: ______________ Marital Status: ______________

Race: ______________ Ethnicity: (circle) Hispanic/Latino – Not Hispanic/Latino

Primary Insured: ______________________

Name *Social Security Number* *Date of Birth*

Vision Insurance: ______________________ Vision Insurance ID #: ______________________

Medical Insurance: ______________________ Medical Insurance ID #: ______________________

Medical Information Update:

Date of Last Vision Exam: ______ /______ /________ Previous Eye Doctor: ______________________

Date of Last Medical Exam: ______ /______ /________ Doctor: ______________________

Weight: ____________ Height: ____________ Are you Pregnant and / or nursing: YES / NO

Reason for Visit: ______________________

Do you wear Glasses: YES / NO

Do you wear Contact Lenses: YES / NO Are they Comfortable: YES / NO

Brand: ______________________ RX Right eye: ____________ Left eye: ____________

Do you have any Drug allergies: YES / NO If yes, please list: ______________________

List any medication you take: (including oral contraceptives, aspirin, over the counter and home remedies)

____

List all major injuries, surgeries and/or hospitalizations you have had: ______________________

Family History

Please note any family history (parents, grandparents, siblings, children: living or deceased) for the following conditions:

	YES	NO	Relative		YES	NO	Relative
Blindness	______	______	__________	Heart Disease	______	______	__________
Cataract	______	______	__________	High Blood Pressure	______	______	__________
Crossed/Lazy Eye	______	______	__________	Kidney Disease	______	______	__________
Glaucoma	______	______	__________	Lupus	______	______	__________
Macular Degeneration	______	______	__________	Thyroid Disease	______	______	__________
Retinal Detachment	______	______	__________	Diabetes	______	______	__________
Retinal Disease	______	______	__________	Arthritis	______	______	__________
Other __________	______	______	__________	Cancer		______	______

Social History

Do you drive: YES / NO If yes, do you have difficulty when driving: ____________________

Do you use tobacco products: YES / NO If yes, type / amount/ how long: ____________________

Do you drink alcohol: YES / NO If yes, type /amount / how long: ____________________

Do you use illegal drugs: YES / NO If yes, type /amount / how long: ____________________

Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis None

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

	YES	NO
Constitutional		
Fever, Weight loss / gain	______	______
Integumentary (skin)	______	______
Neurological		
Headaches	______	______
Seizures	______	______
Migraines	______	______
Eyes		
Asthma	______	______
Loss of vision	______	______
Blurred vision	______	______
Distorted vision / Halos	______	______
Double vision	______	______
Dryness	______	______
Mucous discharge	______	______
Redness	______	______
Sandy / Gritty feeling	______	______
Burning	______	______
Itching	______	______
Foreign body sensation	______	______
Excess tearing / Watering	______	______
Chronic infection of eye / lid	______	______
Glare / Light sensitivity	______	______
Stye / Chalazion	______	______
Flashes/Floaters	______	______
Eye Pain / Soreness	______	______
Tired Eyes	______	______
Glaucoma	______	______
Cataract	______	______
Crossed / Lazy Eye	______	______
Retinal detachment	______	______
Retinal disease	______	______
Macular degeneration	______	______
Blindness	______	______
Surgery / Injury	______	______

	YES	NO
Ears, Nose Mouth, Throat		
Allergies / Hay Fever	______	______
Sinus Congestion	______	______
Chronic Cough	______	______
Dry Throat / Mouth	______	______
Hard of Hearing	______	______
Respiratory		
Chronic Bronchitis	______	______
Emphysema	______	______
Vascular / Cardiovascular		
Heart Pain	______	______
High Blood Pressure	______	______
Gastrointestinal		
Diarrhea	______	______
Constipation	______	______
Genitourinary		
Genitals / Kidney / Bladder	______	______
Bones / Joints / Muscles		
Rheumatoid Arthritis	______	______
Muscle Pain	______	______
Joint Pain	______	______
Lymphatic / Hematologic		
Bleeding	______	______
Cholesterol	______	______
Anemia	______	______
Allergic / Immunologic	______	______
Psychiatric		
Anxiety	______	______
Depression	______	______
Insomnia	______	______
Endocrine		
Diabetes	______	______
Thyroid, hypo / hyper	______	______

If you answered YES to any of the above or have a condition not listed, please explain: ____________________

In order to process your insurance claim, you must present your insurance card or voucher at the time of service. Failure to do so may result in denial of your claim. Please understand that you are financially responsible for all charges, whether or not paid by said insurance. All returned checks are subject to a $30 service charge.

Please note that all sales are final, not subject to refunds or exchanges. Our goal is to provide excellent service, care, and quality. If you cannot adapt to your new eyewear from Frisco Family Vision, we must be notified and set up an appointment within 30 days from your dispensing or 6 weeks from your exam, whichever is shorter, at no charge. Lenses are custom made for you and the frame you chose and cannot be used for another frame. The patient may be responsible for any remake or difference in price for a remake. Frisco Family Vision is not responsible for eyewear obtained anywhere other than Frisco Family Vision.

____________________ ____________________

Patient/Guardian Signature/Responsible Party Date

Doctor's Signature: ____________________ Date: ____________________

Optomap

Our office is proud to provide our patients the most highly advanced digital retinal imaging technology available today! It is safe for adults and children of all ages.

Our doctors are concerned about retinal problems such as macular degeneration, glaucoma, retinal holes, retinal detachments, and diabetic retinopathy (all of which can lead to partial loss of vision or blindness).

Early detection is crucial!

Optomap:	*Dilation:*
A digital map of the retina	No permanent record
In depth view of the retina where disease can start	Blurred vision 4-6 hours
A permanent record for your medical file (at our office)	Light sensitivity 4-6 hours
No blurred vision or light sensitivity	Add up to 1 hour for exam
Ability to show you your images today during your exam	You can't see what I see

Your insurance is designed to cover only the basic eye exam; however, most insurance companies now cover the advanced screening tool, such as the Optomap, with a copay. **The doctor strongly recommends that ALL patients have an Optomap annually.** The extra charge for this service is ***$39***. For most patients, the Optomap can be used in lieu of a dilated eye examination, which will eliminate the need to use eye drops to dilate the eyes.

I choose the Optomap today

____________________________________ _______________

Patient/Guardian Signature Date

I choose the Dilation today

____________________________________ _______________

Patient/Guardian Signature Date

*****DIABETIC PATIENTS*****

The American Diabetes Association and American Optometric Association recommend that patients with diabetes receive an annual dilated eye exam. This exam is also a measure of clinical quality designated by the National Committee for Quality Assurance (NCQA).

Based on the NCQA, your insurance company require that patients with diabetes include dilation. The Optomap does not replace dilation for patients with diabetes or other conditions requiring dilation based on standard of care. However, our doctors still recommend the Optomap in conjunction with dilation for documentation of the retina to monitor for changes.

Agree: ____________________________________

Refuse: ____________________________________