PATIENT HISTORY QUESTIONNAIRE

Last Name_____**First Name**_____ **MI** _____

Date of Birth (mm/dd/yyyy)_____ **Marital Status** _____

Address _____ **City, State, Zip Code**_____

Social Security Number_____**Driver's License No** _____

Occupation_____ **Employment Status** _____

Medical Information

What is your general health? _____
Do you have problems with any of these systems? (Please circle Yes or No)

Gastrointestinal	Yes/No	Nervous system	Yes/No	Endocrine (glands)	Yes/No
Ears/Nose/Throat	Yes/No	Urinary	Yes/No	Blood/lymph	Yes/No
Cardiovascular	Yes/No	Muscles/bones	Yes/No	Allergic/immunologic	Yes/No
Respiratory	Yes/No	Skin	Yes/No	Headaches	Yes/No
High blood pressure	Yes/No	Eyes	Yes/No	Mental health	Yes/No

Please explain _____

Other health problems _____

Allergies to medication Yes/No Which?_____Reactions? _____

Current medications_____

Diabetes? Yes/No Type_____ Date of diagnosis _____

Any operations? Yes/No What kind?_____When? _____

Family doctor- full name _____Telephone_____

Family History

Cataracts – relation _____ Retinal detachment – relation _____
Glaucoma – relation_____ Diabetes – relation _____
Macular degeneration-relation_____ High blood pressure – relation_____

Personal Eye Information

Date of last eye examination_____Last eye doctor or clinic _____
Do you have any eye conditions or problems? Yes/No What kind? _____
Have you had any eye operations? Yes/No Type_____Date_____
Have you had an eye injury? Yes/No Type_____Date_____
Do you use any eye medications (incl. over-the-counter drops)? _____

Wear glasses?	Yes/No	Cataracts?	Yes/No	Retinal detachment?	Yes/No
Wear contacts?	Yes/No	Glaucoma?	Yes/No	Blurred vision?	Yes/No
Dry eyes?	Yes/No	Macular degeneration?	Yes/No	Distance ___ Near ___ Both ___	

Additional information_____

Other concerns about your eyes or vision _____

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Today's Vision - Beaumont, P.A. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

Our Privacy Principles:

- The privacy of your health information is important to us.
- We maintain physical, electronic, and procedural safeguards that comply with federal regulations to protect your health information.
- We do not share your health information unless permitted or required by law for treatment, payment, or health care operations, or unless you authorize it.

I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Today's Vision - Beaumont, P.A. is not required to agree to the additional restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I wish to have the following restrictions to the use or disclosure of my health information:
_____

I wish to be contacted in the following manner (check all that apply):

□ Home Telephone _____
□ OK to leave message with detailed information
□ Leave message with call-back number only

□ Cell Telephone _____
□ OK to leave message with detailed information
□ Leave message with call-back number only

□ OK to e-mail □ home e-mail address: _____
□ work e-mail address: _____

□ I DO authorize the release of prescription information / materials to family members or the following persons:
Name(s)_____
or
□ I do NOT authorize the release of prescription information / materials to family members.

I understand and have been provided with a *Notice of Privacy Policies* that provides a more complete description of information uses and disclosures.

_____ _____

Patient's Signature **Date**

TODAY'S VISION - BEAUMONT

Dr. John P.S.Yu & Associates, O.D., P.A.
4159 North Dowlen Road
Beaumont, TX 77706
Telephone: 409-899-4449

Name:_____DOB _____

Daytime phone_____E-mail _____

Payment Policy: It is customary to pay for professional services when rendered. **Checks: Dishonored checks will be assessed to your account for the check amount plus a processing fee of $35.00. Subsequent payments must be made in cash, cashier's check or credit card but credit cards are assessed an additional 5% fee.**

Consent to Treatment and Authorization of Charges: I am an adult 18 years of age or older, or am the parent/guardian of the minor child whose name appears above and hereby authorize TODAY'S VISION - BEAUMONT, P.A. to perform such eye care and treatment on me or my minor child as it deems appropriate and consent to such care and treatment. I further authorize my child to order and purchase goods and services and agree to pay for them whether performed on my child or me.

Signature Date

Assignment of Benefits: I hereby assign payment of authorized insurance (Medicare, Medicaid or any other third-party payor) to which I am entitled to be made to TODAY'S VISION - BEAUMONT, P.A. for any goods or services furnished. I also authorize Today's Vision to release medical information to my insurance company(ies) now or in the future for claim consideration purposes. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that the filing of a claim for any services rendered **does not guarantee payment** from my insurance company. I fully understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature Date

Medicare: Medicare will only pay for services that it determines to be reasonable and necessary under Section 1862(a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is not reasonable and necessary under Medicare program standards, Medicare will deny payment for that service. We believe that, in your case, Medicare is likely to deny payment for: _____
for the following reason: _____

Beneficiary Agreement: I have been notified by my provider that he or she believes, that in my case, Medicare is likely to deny payment for the services identified above. If Medicare denies payment I agree to be personally and fully responsible for payment.

Signature Date

Patients with Insurance: Our staff will assist you in dealing with your insurance company by verifying your benefits using the member services phone number given on your insurance card. However, **this verification is not a guarantee of payment. It is your responsibility to know and understand your own insurance benefits, coverage and authorization requirements.** Additionally, all amounts owed by patients under contracted insurance plans (co-pays, deductibles, and non-covered services) are payable at the time of service. **Any service that is rendered by this office, which is not a covered benefit under your insurance policy, is your responsibility to pay**. 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.

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4159 North Dowlen Road
Beaumont, TX 77706
Telephone: 409-899-4449

Date:_____ Name: _____

REASON FOR TODAY'S VISIT:

_____

_____

Would you like to be fitted for contacts? YES NO (Circle one) Do you wear contacts now? YES NO

ADDITIONAL TESTING PROCEDURES PER DOCTOR'S DISCRETION

Dr. Yu will utilize all testing procedures necessary to assess the health of the eyes regardless of your insurance coverage. If you would like to return to the office at another time to have these procedures performed, please inform the front desk to schedule a second visit.

The **PUPIL DILATION** procedure is a standard procedure which allows a more thorough evaluation of the health of the eye. We can better view the crystalline lens in the eye, as well as, a much greater area of the retina. In certain refractive conditions, unstable focusing can alter the glasses prescription and dilation results in a more accurate measurement of the glasses prescription. Usually there will be light sensitivity and problems with reading vision. Some individuals will also experience distance vision blur. The effects of the dilation last 8-12 hours although it begins to reverse in about 4-6 hours. We encourage everyone to be dilated routinely especially if this is the first time to our office. Our office charges $20 for dilation if not covered by your insurance company.

The **OPTOMAP Screening** procedure utilizes state-of-the-art laser technology to capture a digital image of the retina quickly and easily without dilation of the pupil. The doctor will then review your images with you during your visit thereby providing you with valuable information about your eye health. The OPTOMAP Screening will also provide a permanent image of your retina for future reference. The OPTOMAP Screening fee is in addition to the fee for the eye exam and the co-pay. In most cases, it is considered to be doing a NON-COVERED service by insurance companies. Our office charges $35 for the OPTOMAP Screening procedure.

By declining both the **OPTOMAP Screening** and **PUPIL DILATION** you are limiting our ability to accurately determine the health of your eyes.

The **VISUAL FIELD Screening** procedure helps to detect defects in the peripheral visual field. Loss of peripheral vision can go unnoticed by an individual and may indicate serious problems with the health of the eye, optic nerve, or the neurological system. This sophisticated automated computer procedure assist in detecting subtle defects which may be associated with glaucoma, retinal disease, diabetes, other vascular diseases such as hypertension, or compression lesions such as tumors or aneurysms. We recommend having this procedure routinely. Our office charges $15 for the VISUAL FIELD Screen and most insurances do not cover unless the eye examination is medical in nature.