Vision Source! Greenspoint
WELCOME TO OUR OFFICE

Patient Name: _____ Date: _____

Address: _____ Apt. #_____ City: _____ St: _____ Zip: _____

Phone: (Home) _____ (Work) _____ (Cell) _____

Date of Birth: _____ Age: _____ Sex: _____ E-Mail:_____

Patient SSN: _____ Occupation: _____ Employer: _____

How did you hear about us? _____

What can we help you with today? _____Routine Eye Exam _____Glasses _____ Contacts _____Medical Eye Exam

If Medical, chief complaint is _____

Name of Primary Insurance: _____ Primary Member Name: _____

Primary Member ID#: _____ Primary Insurances Phone #: _____

Name of Vision Insurance: _____ Name of Primary Member: _____

Primary Member SSN: _____ Primary Member's Date of Birth: _____ Relationship to Patient: _____

EYE HISTORY: (Check all that apply)

_____Headache
_____Glare/Light Sensitivity
_____Tired Eyes
_____Burning
_____Lazy Eye
_____Dryness
_____Tearing/Watering
_____Eye Pain/Soreness
_____Foreign Body Sensation
_____Infection Eye/Lid
_____Itching
_____Mucous Discharge
_____Blurred Distance Vision
_____Blurred Near Vision
_____Distorted Vision
_____Double Vision
_____Floaters or Spots
_____Fluctuating Vision
_____Eye Trauma
_____Eye Surgery (specify)
_____Loss of Side Vision
_____Drooping Eyelid(s)
_____Redness
_____Sandy/Gritty Feeling
_____Crossed Eyes
_____Glaucoma
_____Cataracts
_____Retinal Disease
_____Macular Degeneration
_____Other: _____

FAMILY HISTORY:

_____Diabetes
_____Heart Disease
_____Thyroid Disease
_____Rheumatoid Arthritis
_____Glaucoma
_____Cataract
_____High Blood Pressure
_____High Cholesterol
_____Cancer
_____Other: _____

CURRENT & PAST MEDICAL HISTORY: (Check all that apply)

_____Fever
_____Weight Loss
_____Heart Disease
_____High Blood Pressure
_____Asthma/Bronchitis
_____Ulcers/Gastritis
_____Depression/Psychosis
_____Kidney/Renal Problems
_____Arthritis/Joint/Bone Disease
_____Acne/Skin Problems
_____Stroke/Neurological Problems
_____Diabetes
_____Thyroid Disease
_____Elevated Cholesterol
_____Seasonal Allergies
_____HIV
_____Disability (specify)
_____Cancer
_____Surgery in the past year: Specify_____
_____Other: _____

ALLERGIES TO DRUGS (List): _____

MEDICATIONS (include OTC):

_____

VISION SOURCE! GREENSPOINT

Dr. Khalil Marcha

12122 Greenspoint Drive, Houston, TX 77060
Phone 281-875-5439/ Fax 281-875-2266
www.visionsource-greenspoint.com

Patient Consent Form

PATIENT NAME: _____ DATE OF BIRTH: _____

I WILL ALLOW VISION SOURCE GREENSPOINT TO RELEASE MEDICAL RECORDS ONLY UNDER MY CONSENT. (This means my signature will be needed in writing for any of my medical records to be released)

PLEASE READ CAREFULLY: I UNDERSTAND THAT MY MEDICAL RECORDS ARE CONFIDENTIAL. I UNDERSTAND THAT BY SIGNING THIS FORM I AM ALLOWING MY MEDICAL INFORMATION TO BE RELEASED ONLY IN CASE OF AN EMERGENCY OR HEALTH CARE OPERATION(S).

I ALSO UNDERSTAND THAT I HAVE THE RIGHT TO RESTRICT THE DISCLOSURE OF SPECIFIC INFORMATION IN MY MEDICAL RECORDS IF I REQUEST SUCH RESTRICTIONS IN WRITING. I UNDERSTAND THAT MY REQUEST FOR RESTRICTION MAY BE DENIED IF THE INFORMATION RESTRICTED IS REQUIRED FOR HEALTH CARE OPERATION(S).

I HAVE READ THE ABOVE FOREGOING CONSENT FOR RELEASE OF INFORMATION, NOTICE OF PRIVACY PRACTICES SET FORTH BY THE HIPAA RULES AND AGREE TO ALL VISION SOURCE POLICIES. I DO HEREBY ACKNOWLEDGE THAT I AM FAMILIAR WITH AND FULLY UNDERSTAND THE TERMS AND CONDITIONS OF THE CONSENT.

Patient Signature or Guardian: _____ Date: _____

Vision Source! Greenspoint
Policies 2014

PROFESSIONAL SERVICES

Exam fee/copays must be paid in full at time of service. Professional fees (exams, refractions, contact lens evaluations, or any services performed by doctor) are not refundable.

Dilation is free of charge as it is included in your examination fee. However, if dilation occurs outside of the original appointment date and time, an additional $25 office visit fee will be charged if dilation occurs within the first thirty days from original appointment. After the thirty days have passed, dilation visit will be considered as a new office visit with new exam charges.

Within 30 days of original order date, if you are not fully satisfied with your frame and if the frame is in sellable condition, we will credit the full amount that was paid for the frame to use towards the purchase of a new frame. Due to fees for lab services already incurred, we will credit fifty percent of the amount originally paid for the lenses towards another purchase of eyewear.

If you feel that there is something wrong with the new prescription, we ask that you attempt to wear the glasses for at least one week so your eyes can adapt to the new prescription change. Please refrain from switching to your old prescription glasses during this time. If you are still experiencing any discomfort after this initial period, please give us a call at 281-875-5439.

15% Fee is charged for any cancelled order before lenses are made.

Frames/Lenses must have half down before processing and must be paid in full before dispensing. Contact Lenses must be paid in full before processing.

Any Lens order cancelled by the patient after it has been made within one month of original order date is responsible for half of the lens amount. After one month, patient is responsible for full amount.

Vision Source Greenspoint is not responsible for glasses that are purchased and not picked up within 90 days**.**

All designer frames automatically come with a one year manufacturer defect warranty. Abuse or loss is not covered under warranty. Frames that are received at no charge to the patient do not qualify for the one year manufacturer defect warranty. After dispensing frame to patient, patient is then responsible for their own frame. If a frame for any reason needs to be replaced with approval from optician and manufacturer, there is a one-time change with a service fee of $25.00.

Scratch resistance must be purchased to qualify for one time replacement warranty on scratches. Polycarbonate must be purchased to qualify for one time replacement warranty on chipping/breakage. If lenses are to be replaced under warranty, it's a one-time change with a service fee of $25.00.

Patient/Guardian_____ Date_____

Vision Source! Greenspoint
INSURANCE AND PAYMENT POLICIES

We often provide medical eye care services to our patients. Even for "routine" visits, a medical eye condition may be discovered during your examination, which falls under medical insurance rather than vision insurance. Examples include evaluation and treatment for conditions such as "pink eye", sties, dry eyes, foreign body removal, etc. In such cases, we may submit a claim to your medical insurance for payment. Therefore, it is important that we have any optical and/or medical insurance you may be covered by on file.
We make every effort to keep down the cost of your medical care. You can help by paying in full upon the completion of each visit. If you have any vision and/or medical insurance, we will be glad to fill out the proper forms or file the claim for you, but please complete the identifying information within this paperwork.

Your insurance is a method for you to receive reimbursement for fees you have paid to the optometrist for services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on your contract with them, not our office. It is your responsibility to pay in advance for the deductible, coinsurance, or any other balances not paid for by your insurance. We will assist you in receiving reimbursement as much as possible, but you are responsible in advance for your bill. Copays, as dictated by the insurances, only apply if the information was obtained before services were rendered. Under any circumstances, we do not reimburse if you failed to provide accurate insurance information by the time services were provided.

I certify that the insurance information that is on this form or provided to this office is accurate. I understand I am financially liable for any deductible amount, co-insurance and non-covered services or any other balance not paid by my insurance company. If my insurance company denies payment, I agree to be personally responsible for payment. If I have no insurance, I understand that I am responsible for the entire balance of services and products provided.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. This assignment will remain in effect until revoked in writing. A photocopy of this assignment is considered to be as valid as the original.

Signature of patient (*Parent or Guardian if minor*):_____

Date: _____

Printed name of signature above: _____DOB_____

Relationship (*to minor child*):_____

Vision Source! Greenspoint
Contact Lens Service Agreement

Dr. Khalil Marcha

Important information, please read carefully

- 30 Day Trial Period- The fee you paid for the Contact lens evaluation covers all disposable trial lenses and contact lens follow-ups for a 30 day period from the day of the initial exam. If a medical visit is necessary within that period, the medical visit will not be included in the trial period, and will be filed with your medical insurance if available or subject to self-pay charges. If for any reason the patient goes beyond the 30 day trial period, additional fees may be incurred.
- Return Policy- If you are not satisfied with your contact lens purchase and they are undamaged, unopened and not expired, you may return them within 60 day of original purchase date. We can either exchange or credit the amount towards eyeglasses or other materials**. Fees for services are <u>non-refundable.</u>**
- **Vision Source is not responsible for contact lenses that are purchased and not picked up within 90 days.**
- We recommend **new wearers** gradually adjust their eyes to contact lenses by starting with 6 hours of wear and add 2 hours each day until the normal wear time is reached.

Notice to patient: Contact lenses are <u>federally regulated medical devices that can only be dispensed by prescription.</u> They must be regarded with the same caution given to prescription drugs, which includes recognizing prescription expiration dates, number of refills and follow-up visits with your eye doctor. Your eyes go through gradual changes in size, shape and physiological requirements (such as oxygen) over time, which can change the contact lens fir and affect the health of your eyes. You should understand the importance of regular examination and as recommended by your doctor to preserve your sight.

If questions or problems arise related to contacts obtained outside this office, the Dr. may charge service fees for temporary lenses as well as fees for doctor's time related to problem solving. This office cannot be responsible for negative outcomes if the Rx is filled beyond expiration limits, filled incorrectly by outside sources or if the lenses are worn improperly by the patient such as sleeping in them, disposing contact lens as prescribed. In the event of eye redness, discomfort or vision changes, discontinue contact lens wear and call the office @ 281-875-5439.

In efforts to maintain your ocular health we suggest that any contact lens patients purchase a pair of ophthalmic sunglasses to wear. Please see optician for details.

Patient/Guardian: _____ Date: _____

DIGITAL EYE EXAM

CIRRUS HIGH DEFINITION OPTICAL COHERENCE TOMOGRAPHY

This retinal scanner captures high definition images of the retina in just **2.4 seconds**! With the latest technology, the Cirrus HD-OCT is essentially **a CT scan of the back of your eyes**. Many eye care specialists believe this instrument is the **gold standard** for detecting, diagnosing and managing glaucoma and macular degeneration.

Dilation may or may not be required to perform this procedure (depending on your pupil size). Many retinal diseases have been diagnosed with the OCT including but not limited to **brain tumors, macular holes, macular degeneration, glaucoma and retinal lesions.**

FUNDUS PHOTOGRAPHY WITH TOP OF THE LINE TOPCON RETINAL CAMERA

Digital Retinal Imaging is an improved technology in which your doctor can take **high-resolution digital photographs** of the interior portion of your eye called the retina. The color photograph, taken by means of a specialized retinal camera, shows detailed images of the various structures of the retina including the optic nerve, blood vessels, nerve fiber layer, and the macula. It can **show abnormalities that may threaten normal vision.** It **provides a baseline for comparison** with previous and future visits, which aids in **monitoring disease progression** and response to therapy.

- **Your images are available immediately**
- Specialized software can help a family member understand in what way your vision may be affected and how you see your world
- Digital photographs can be sent electronically to a co-managing doctor, if appropriate, allowing for more timely diagnosis and treatment

These tests are generally **NOT COVERED** by insurance companies. However, if a medical diagnosis is made, these tests can be submitted to the patient's medical insurance carrier (BCBS, Aetna, Cigna, etc.) but the insurance companies do not guarantee reimbursement. In such cases, the patient is still responsible for the payment.

SPECIAL PRICE FOR BOTH EXAMINATIONS: $70.00

I wish to have the retinal health evaluation performed today: **YES** **NO**

_____	_____	_____
SIGNATURE	PATIENT NAME	DATE