

**WELCOME TO OUR OFFICE**

PATIENT INFORMATION	LIFESTYLE QUESTIONS																																	
<p>Today's Date: _____ Preferred Name: _____</p> <p>Circle One: Mr. Mrs. Ms. Other: _____ Gender: M F</p> <p>Name: _____  <small style="display: flex; justify-content: space-around; width: 100%;"> <span>First</span> <span>Initial</span> <span>Last</span> </small></p> <p>Date of Birth: _____ Height: _____ Weight: _____</p> <p>Address: _____</p> <p>City: _____ State: _____ Zip: _____</p> <p>Phone Numbers: Home: _____</p> <p>Work: _____ Cell: _____</p> <p>E-Mail: _____</p> <p>Marital Status: S M W Spouse's Name: _____</p> <p>Race:</p> <p> <input type="checkbox"/> American Indian/Alaska Native      <input type="checkbox"/> Asian  <input type="checkbox"/> Black/African American                <input type="checkbox"/> Hispanic or Latino  <input type="checkbox"/> Native Hawaiian/Other Pacific Islander    <input type="checkbox"/> White         </p> <p>Other Race: _____</p> <p>Preferred Language: _____</p> <p>Occupation: _____</p> <p>Employer: _____</p> <p>Insured/Parent: _____</p> <p>Ins. ID/SS #: _____</p> <p>Are other members of your family patients here? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Their Names: _____</p> <p>_____</p>	<p>Do you smoke: <input type="checkbox"/> Yes      <input type="checkbox"/> No</p> <p>Alcohol use: <input type="checkbox"/> None      <input type="checkbox"/> Daily      <input type="checkbox"/> Occasionally</p> <p>Computer use: <input type="checkbox"/> None      <input type="checkbox"/> Daily      <input type="checkbox"/> Occasionally</p> <p>Hours per day: _____</p> <p><input type="checkbox"/> Wear glasses                      <input type="checkbox"/> Wear sunglasses</p> <p><input type="checkbox"/> Wear contact lenses      <input type="checkbox"/> Solutions used: _____</p> <p>What are your hobbies? _____</p> <p>_____</p> <p>What sports do you play? _____</p> <p>_____</p>																																	
<b>HOW DID YOU FIND OUT ABOUT OUR OFFICE?</b>																																		
<p><input type="checkbox"/> Another Patient: Who? _____</p> <p><input type="checkbox"/> Insurance Website      <input type="checkbox"/> Insurance List</p> <p><input type="checkbox"/> Internet: Which website? _____</p> <p><input type="checkbox"/> Advertisement: Which one? _____</p> <p><input type="checkbox"/> Yellow Pages                      <input type="checkbox"/> Direct Mail</p> <p><input type="checkbox"/> Other: _____</p>																																		
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## MEDICAL HISTORY

(check those that apply)	SELF	FAMILY	(check those that apply)	SELF	FAMILY
High Blood Pressure			Neurological/Psychological		
Heart Disease			Diabetes		
Ear, Nose, Throat			Thyroid		
Respiratory			Allergies/Asthma		
Gastrointestinal			Arthritis/Lupus		
Genitourinary			Cancer		
Muscles, Bones, Joints			Weight Loss		
Skin Disorders			Other		

Medications: \_\_\_\_\_

Drug Allergies: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

### SIGNATURE ON FILE/ ASSIGNMENT OF BENEFITS

I authorize this form as a record of signature to be used on all my insurance submissions.

I request that payment of authorized Medicare benefits and that of other insurance companies be made on my behalf to Westheimer Vision Associates for services they furnished me.

I authorize the use of this form on all my insurance submissions for all my insurance companies.

Westheimer Vision Associates accepts the Medicare charge determination as the full charge. I am responsible only for the deductible, co-insurance and non-covered services. My deductible and co-insurance are based upon the charge determination of Medicare and other insurance companies indicated by me.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

\_\_\_\_\_  
Patient Name (Please Print)

\_\_\_\_\_  
Insurance ID #

\_\_\_\_\_  
Patient Signature or Guardian

\_\_\_\_\_  
Date

## POLICIES

### FINANCIAL POLICY

The following is a statement of our Financial Policy, which we require that you read and sign prior to any treatment.

Payment is expected at the time services are rendered. This includes services provided for a minor patient. We prefer payment in full when ordering glasses or contacts. However, a deposit of 50% can be made to initiate the order. The remaining balance will be due at dispensing. The exception to this policy is when ordering through third party plans. All copayments and overages must be paid before glasses or contact lenses can be ordered.

We accept cash, checks, and credit cards. There is a \$25 collection fee for returned checks.

Patient balances are expected to be paid within 30 days after billed. Balances not paid within 120 days will be forwarded for collection.

If you have Medicare or are enrolled in a plan we participate in, we will file a claim on your behalf. However, payment of applicable deductibles and co-pay amounts are due at the time services are rendered. If you have a plan in which we do not participate, vision or medical, we can give you a statement for submission to your insurance company. We would be glad to complete any forms required by your insurance company. For specific policy questions, please refer to your policy manual or call the phone number listed on your insurance card.

Not all services are a covered benefit and routine eye care and other procedures may be specifically excluded, depending on the insurance carrier, making the patient responsible for all charges. We will furnish you with as much information as possible before you select a treatment option so that you can make an informed decision.

## CONTACT LENS POLICY

Current contact lens technology offers successful contact lens wear to most of our patients. Because contact lenses are medical devices placed on the eyes, they require expert fitting and careful instruction, as well as conscientious care and compliance with recommended follow-up examinations to maintain the healthy functioning of your eyes.

### THE EYE EXAM

Before you can be fitted for contact lenses, a complete eye examination is necessary. The cost of this exam is separate from any charges for contact lenses or contact lens services. This exam is critical for determining the health of your eyes and ruling out the possibility of an underlying condition, which may inhibit contact lens use.

### CONTACT LENS EVALUATION

The goal of a contact lens fitting is to find the most appropriate contact lens for each patient's optimal comfort and vision. An enormous variety of materials, sizes, and prescriptions are available. We are committed to taking the time to fit you properly. Although many patients will need only one fitting session, sometimes this process requires additional appointments. In our experience the extra time, effort, and patience are well-merited for your ultimate satisfaction and the health of your eyes.

### INSERTION AND REMOVAL TRAINING SESSION

The patient will be provided with personalized instruction in the safe care and usage of your new lenses. Upon completion of a successful insertion and removal session, you may begin wearing your lenses. A follow up appointment will then be scheduled.

### FOLLOW-UP APPOINTMENTS

Additional follow-up appointments are sometimes necessary to assure that your contact lenses provide you with optimal vision and comfort. Charges for follow-up visits during the first 90 days are included in the initial contact lens evaluation unless your lens type changes during the fitting process where additional fees will be added. Lens types include: sphere, astigmatism correction, monovision or multifocal, specialty, and therapeutic.

After 90 days additional contact lens fees will apply.

### PAYMENT

The evaluation fee is due at time of service. The payment for contact lenses is due at the time of order.

### LENS CHANGES

If a patient originally fit with one lens type requires a change to a another lens type, the difference in the evaluation price will be due. For example, a patient switched from a spherical lens to a multifocal lens will incur additional fees.

### REFUNDS

There are very few patients who are unable to wear contact lenses. However, if you or your doctor decide to discontinue contact lenses, a refund of the cost of the lenses may be given within the first 30 days (provided the contacts are returned in good condition). Opened boxes of contact lenses are not returnable. There will be no refund of the evaluation fee.

### CONTACT LENS RETURN POLICY

All products must be returned in the original unopened packaging.

Defective blister packs will be replaced with trials.

Vial lenses must be returned within 30 days of original invoice date.

### YEARLY CONTACT LENS EXAMS

Yearly eye examinations are required for good eye health and to safeguard your vision. Texas law mandates a contact lens prescription expire after one year of the date of issue. If it has been a year since your contact lens examination or fitting then you will need a new examination to order contact lenses.

I have read, understand and agree to Financial and Contact Lens Policies.

\_\_\_\_\_  
Patient Name (Please Print)

\_\_\_\_\_  
Patient Signature or Guardian

\_\_\_\_\_  
Date

## NOTICE OF PRIVACY PRACTICES

I acknowledge that I received the Notice of Privacy Practices from Westheimer Vision Associates.

\_\_\_\_\_  
Patient Signature or Guardian

\_\_\_\_\_  
Date