VISIONARY EYE CARE

Welcome to Our Office

PATIENT INFORMATION

We are pleased to welcome you to our practice.
Please take a few minutes to fill out this form. If you have questions, we will be glad to help you.

Visionary Eye Care would like your permission to obtain a photo for the sole purpose of identification for your chart

Please circle: YES or NO

Name:____ Date____________________

Birth date:____________________ SS#______________________________ Sex: □ FEMALE □ MALE

Home Phone: ____________________ Cell Phone: ______________________ **Text: YES / NO**

STATUS: □ MARRIED □ WIDOWED □ SINGLE □ MINOR □ SEPARATED

Please enter your current **email address** below:

Mailing Address:____________________________________ City, State, Zip________________________

Physical Address:____________________________________ City, State, Zip________________________

Employer/Student:____________________________full-time | part-time Occupation:____________________

Employer Address:____Phone:____________________

Spouse's/Guardian name:____Phone:____________________

Spouse's/Guardian Employer_____________________________________Phone:____________________

Emergency Contact:____Phone:____________________

ETHNICITY INFORMATION

RACE: □ Asian □ Caucasian □ Hispanic or Latino □ American Indian/Alaska Native

□ Black or African American □ Native Hawaiian or Pacific Islander

PRIMARY LANGUAGE SPOKEN

□ ENGLISH □ SPANISH □ TAGALOG □ OTHER: ____________________

I permit VISIONARY EYE CARE to communicate & remind me about my appointments by texting & e-mail.

Communication Preference □Phone □Email □Text

Whom may we thank for referring you to our office? ____

PRIMARY INSURANCE: □ YES □ NO	**SECONDARY INSURANCE: □ YES □ NO**
SUBSCRIBER'S NAME: ____________________________	SUBSCRIBER'S NAME: ________________________
RELATIONSHIP TO PATIENT: ______________________	RELATIONSHIP TO PATIENT: ____________________
BIRTH DATE: ______/_______/_______	BIRTH DATE: ______/_______/______
SS#: ______-_______-_______	SS#: ______-_______-_______
INSURANCE COMPANY: __________________________	**INSURANCE COMPANY**: __________________________

ASSIGNMENT AND RELEASE: I authorize Visionary Eye Care to act as my agent in applying for insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Visionary Eye Care on my behalf for any services and materials provided. I authorize any holder of my medical information to release such information as needed to determine benefits payable for related services. If I have additional insurance, my signature authorizes release of the above medical information to any insurer or agency I have given, and authorizes my doctor to act as my representative above. If my insurance does not cover any portion of this visit or any materials or portion of materials, I further acknowledge that I am responsible for payment of these services or materials. This authorization will remain in effect until revoked by me in writing.

SIGNATURE OF PATIENT/GUARDIAN: ________________________________ **DATE:** ________________________________

PRINT NAME OF PATIENT/GUARDIAN: ________________________________ **RELATION TO PATIENT:** ______________________

A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE VALID AS THE ORIGINAL.

Medicare/ Medicaid:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Tam Nguyen, Visionary Eye Care for any services furnished to me by my provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers of Medicare and Medicaid Services and their agents any information needed to determine these benefits or benefits for related services.

SIGNATURE OF PATIENT/GUARDIAN: ______________________________ DATE: ____

PRINT NAME OF PATIENT/GUARDIAN: _____________________________ RELATION TO PATIENT: ______________________________

EYEWEAR POLICY

FRAMES: *VISIONARY EYE CARE CARRIES THE LATEST STYLES AND TRENDS IN FASHION FRAMES. ALL OF OUR FRAMES HAVE A ONE OR TWO YEAR WARRANTY DEPENDING ON THE MANUFACTURER. IF YOUR NEW FRAME BREAKS UNDER NORMAL WEARING CONDITIONS, WE WILL REPAIR OR REPLACE IT, ONE TIME FOR FREE. SHOULD A PRODUCT BECOME DISCONTINUED WITHIN WARRANTY WE WILL REPLACE THE DISCONTINUED FRAME WITH A NEW ONE OF EQUAL OR LESSER VALUE. THIS WARRANTY DOES NOT COVER ACCIDENTAL DAMAGE, SCRATCHES, LOSS OR THEFT.*

LENSES: *LENSES ARE CUSTOM MADE FOR YOU,* ***THEY ARE NON-REFUNDABLE.*** *IT IS OUR POLICY TO REMAKE YOUR LENSES (AT NO COST TO YOU) IF THE ORIGINAL PRESCRIPTION IS IN ERROR OR IF THE PATIENT IS NON-ADAPT TO A PROGRESSIVE LENS. FOR NON-ADAPT PROGRESSIVE LENSES WE WILL MAKE NEW LENSES IN ANY OTHER DESIGN THAT YOU WISH AT NO CHARGE,* ***WITHIN 90 DAYS OF DISPENSING****. ORIGINAL LENSES ARE A CUSTOM PRESCRIPTION ITEM WHICH MUST BE DISCARDED. NO REFUNDS ARE ISSUED IF THE DIFFERENCE IN COST IF THE REMAKE PAIR IS OF LESSER VALUE. OUR LENS TREATMENTS ARE THE HARDEST, MOST DURABLE SURFACE PROTECTION AVAILABLE. HOWEVER, ANY LENS CAN SCRATCH OR BREAK. PLEASE FOLLOW RECOMMENDED PROCEDURES FOR CARE AND CLEANING. REPLACEMENT OF POLYCARBONATE LENSES PURCHASED WITH SCRATCH RESISTANT COATING IS LIMITED TO ONCE IN A 12 MONTH PERIOD. LENS REPLACEMENT MUST BE IN THE ORIGINAL PRESCRIPTION. THIS WARRANTY DOES NOT COVER LOSS, THEFT, OR HAIRLINE SCRATCHES WHICH HAVE NO EFFECT ON VISION.*

YOU MAY RETURN TO OUR OFFICE FOR AS MANY ADJUSTMENTS TO YOUR GLASSES AS NEEDED. THIS SERVICE INCLUDES REPLACEMENT OF SCREWS, LOST OR BROKEN NOSE PADS, AND STRINGING OF NYLOR FRAMES.

FINANCIAL POLICY

The goal of Visionary Eye Care is to provide the best possible eye health and vision care with high quality products. In an effort to minimize the cost to our patients, Visionary Eye Care has established the following financial policy.

We accept cash, debit cards, VISA, Master Card, and American Express for your convenience. All prescription eyeglasses are considered to be custom orders and are not refundable. The orders are processed automatically at the time of purchase and cannot be altered in any way or canceled once the order has been submitted. Please choose your purchase wisely and consider the advice of our trained professionals.

We will gladly bill your primary vision and medical insurance carriers, with whom we have a contract, as a courtesy to you. If we are not contracted with your insurance company, we will provide you with the information needed so that you may submit your statement to them for reimbursement. In order for us to bill your insurance, we must be provided with a copy of your current insurance card at the time of service. We will not bill your insurance after 30 days from the date of service. Every insurance plan is different, we recommend that you contact your insurance company prior to your visit to verify eligibility and plan coverage. Visionary Eye Care cannot accept responsibility for knowing your insurance coverage. We will make every effort to verify your vision coverage prior to your visit. ***The benefits quoted are an estimate only****. Any difference after the claim has been processed will be your responsibility.* ***You are ultimately responsible for your account regardless of your insurance coverage****. The estimated fees are due at the time of service. Please remember that insurance coverage is typically a defined benefit and is not intended to cover the cost of examinations or optical goods in full.*
A service charge of 1.50% per month will be added to my unpaid balance after 30 days (equal to an 18% APR). After 120 days, the account will be turned over to a third party for collection. The guarantor will also be responsible for any legal fees that may incur.

My signature below confirms I have been informed of and understand the above outlined policies.

Patient's Signature: ____ ***Date:*** ______________________________

Receipt of Notice of Privacy Policies & Consent Form

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.
The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our ***Notice of Privacy Practices***, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our ***Notice of Privacy Practices***. Our ***Notice of Privacy Practices*** will be updated whenever our privacy practices change. You can get an updated copy here at the office.
When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our ***Notice of Privacy Practices***. You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our ***Notice of Privacy Practices***, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our ***Notice of Privacy Practices*** describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices* from VISIONARY EYECARE.

Signature ____ ***Date***______________________________

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

Relationship to Patient____ Print Name__________________________

Source of Authority:____

3850 Conlon Way Suite F, Elizabeth City, NC ◊ Phone: 252-512-5004 ◊ Fax: 252-888-1442

MEDICAL HISTORY QUESTIONNAIRE

NAME: ______________________________________ BIRTHDATE: _______________Date:_____________

Name of Medical Doctor ________________ Dr's Phone # ____________ Date of last medical exam______________

Pharmacy: ___________________

Your reason(s) for visiting our office today: ____

SO WE MAY BETTER SERVE YOUR VISION NEEDS, PLEASE ANSWER THE FOLLOWING QUESTIONS.

OCCUPATION: __________________ Visual demands? ☐ Distance ☐ Reading ☐ Computer ☐ Welding ☐ Power Tools

♦Do you work on a computer? If so, how many hours a day? ____

♦ Hobbies and Interests: ____

OCULAR CONDITIONS- Do you currently have or have you been diagnosed with the following:

Condition	Yes	No	Condition	Yes	No
Cataracts	☐ Yes	☐ No	Infection of eye or Lid	☐ Yes	☐ No
Crossed eye	☐ Yes	☐ No	Lazy Eye	☐ Yes	☐ No
Drooping Eyelid	☐ Yes	☐ No	Retinal Diseases	☐ Yes	☐ No
Eye Injury	☐ Yes	☐ No	Styes or Chalazion	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No			

MEDICAL HISTORY:

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? ☐ NO ☐ YES If yes, explain: ___________________________
____

LIST ANY CURRENT MEDICATIONS (include over the counter & ocular medications) ________________________
____
____

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

Nursing/Pregnant: ☐ **YES** ☐ **NO**

Do you wear glasses? ☐ **YES** ☐ **NO** If yes, how old is your present pair of lenses? ________________________

Do you wear contact lenses? ☐ **YES** ☐ **NO** If yes, how old is your present pair of lenses? ___________________

Type of contact lenses: ☐ Rigid ☐ Soft ☐ Extended Wear ☐ Other Are they comfortable? ☐ YES ☐ NO

FAMILY HISTORY:

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

OCULAR:	YES	NO	RELATIONSHIP TO YOU (**please indicate maternal/paternal)**
BLINDNESS	☐	☐	____________________
CATARACT	☐	☐	____________________
CROSSED EYES	☐	☐	____________________
GLAUCOMA	☐	☐	____________________
MACULAR DEGENERATION	☐	☐	____________________
RETINAL DETACHMENT/DISEASE	☐	☐	____________________
SYSTEMIC:			
ARTHRITIS	☐	☐	____________________
CANCER	☐	☐	____________________
DIABETES	☐	☐	____________________
HEART DISEASE	☐	☐	____________________
HIGH BLOOD PRESSURE	☐	☐	____________________
KIDNEY DISEASE	☐	☐	____________________
LUPUS	☐	☐	____________________
THYROID DISEASE	☐	☐	____________________
OTHER: ______________	☐	☐	____________________

CONTINUE ON THE BACK

PERSONAL/SOCIAL HISTORY:

Do you use tobacco products? ◻ YES ◻ NO TYPE / AMOUNT: ______________________________

Do you drink alcohol? ◻ YES ◻ NO TYPE / AMOUNT: ______________________________

Do you use illegal drugs? ◻ YES ◻ NO TYPE / AMOUNT: ______________________________

Have you ever been exposed to or infected with: ◻ Gonorrhea ◻ HIV ◻ Syphilis ◻ Hepatitis (type): ____________

REVIEW OF SYSTEMS (Please mark if you experience any of the following):

CONSTITUTIONAL	YES	NO	EARS, NOSE, MOUTH, THROAT	YES	NO
Fever, Weight Loss / Gain	◻	◻	Allergies / Hay Fever	◻	◻
NEUROLOGICAL			Sinus Congestion	◻	◻
Headaches / Migraines	◻	◻	Chronic Cough	◻	◻
Seizures	◻	◻	RESPIRATORY		
EYES			Asthma	◻	◻
Loss of Vision	◻	◻	Chronic Bronchitis	◻	◻
Blurred Vision	◻	◻	Emphysema	◻	◻
Distorted Vision / Halos	◻	◻	VASCULAR / CARDIOVASCULAR		
Loss of Side Vision	◻	◻	Diabetes	◻	◻
Double Vision	◻	◻	Heart Pain	◻	◻
Dryness	◻	◻	High Cholesterol	◻	◻
Mucous Discharge	◻	◻	High Blood Pressure	◻	◻
Redness / Itching	◻	◻	Vascular Disease	◻	◻
Sandy / Gritty Feeling	◻	◻	GASTROINTESTINAL (Constipation / Diarrhea)	◻	◻
Tired Eyes	◻	◻	GENITOURINARY (Bladder / kidney)	◻	◻
Burning	◻	◻	BONES / JOINTS / MUSCLES		
Foreign Body Sensation	◻	◻	Rheumatoid Arthritis	◻	◻
Excess Tearing / Watering	◻	◻	Muscle Pain	◻	◻
Glare / Sensitivity to Light	◻	◻	Joint Pain	◻	◻
Eye Pain or Soreness	◻	◻	LYMPHATIC / HEMATOLOGIC		
Chronic Infection of Eye or Lid	◻	◻	Anemia / Bleeding Problems	◻	◻
Styes or Chalazion	◻	◻	ALLERGIC / IMMUNOLOGIC	◻	◻
Flashes / Floaters in Vision	◻	◻	PSYCHIATRIC	◻	◻
ENDOCRINE (Thyroid/Glands / Hormones)	◻	◻	INTEGUMENTARY (Skin)	◻	◻

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

____

____

____

PATIENT'S SIGNATURE (or parent/legal guardian):______________________ **Date:** __________________

I certify that I have read and understand the above information to the best of my knowledge.

Doctor's Signature____ Date_______________

Doctor's Signature____ Date_______________

Doctor's Signature____ Date_______________

Internal Examination

1. **FUNDUS PHOTOGRAPH:** All new patients are **required** to receive a fundus photograph to thoroughly evaluate the ocular health of the back of your eye. This test is a non-invasive procedure that uses ultrasound technology to assist the doctor in examining the internal structures of your eyes. A fundus photograph enhances the doctor's ability to earlier detect certain ocular pathology such as macular degeneration, diabetic eye disease, or Glaucoma. It is also used as a baseline photograph by the doctor to see if there are any changes with the health of your eyes when you return for your annual checkup.

   A fundus photograph can be taken *without being dilated*, as long as the pupil is naturally large enough. There is a **$39 FEE** for this service. Insurance does not usually cover this service. For self-pay patients, this test/fee is already included into the cost of the exam.

HIGHLY RECOMMENDED FOR RETURNING PATIENTS WITH:
**** DIABETES**
**** HIGH BLOOD PRESSURE**
**** NO EXAM WITHIN THE PAST 2 YEARS**
**** A FAMILY HISTORY OF GLAUCOMA OR MACULAR DEGENERATION**

2. **DILATION:** A dilated eye exam is strongly recommended, but not mandatory. Our office can schedule a follow up visit for dilation if needed. Eye dilation enables the doctor to thoroughly examine the internal health of your eyes. Dilation enhances the doctor's ability to detect certain ocular pathology that could potentially cause visual impairment/blindness such as retinal detachment, tumors, or diabetic eye disease. Eye dilation has two main side effects: blurry vision at near distances (ex. texting on a cell phone) and increased sensitivity to light for which we will provide sun shades. These side effects may last for 4-6 hours.

___YES, I give my permission for the eye dilation to be performed. My signature below acknowledges that I understand the side effects of dilation.

___NO, I do not give my permission for the eye dilation to be performed. My signature below acknowledges that, although I fully understand the importance of a dilated eye exam, I refuse to have my eyes dilated and accordingly, release Visionary Eye Care from any and all liability that may arise from this refusal. If I decide to return for dilation, I understand that it will be an additional charge.

My signature below acknowledges that I have read and understand both parts of this form and consent to having the fundus photo performed. I understand that this test is required for new patients and if I refuse this service, I will not be able to maintain my appointment.

Patient/Legal Guardian Signature: ____

Date: ______/______/_____