THIBODAUX VISION CENTER • Mark J. Roy, III, O.D. 640 St. Charles Street • Thibodaux, Louisiana 70301 • 985-446-1717

WELCOME

PLEASE COMPLETE BOTH SIDES OF THIS QUESTIONNAIRE BY FOLLOWING THE THREE EASY STEPS IN BLACK INK.

Step 1 PATIENT REGISTRATION

Patient _____

Address _____

_____
City State Zip

Home phone number _____

Cell / Work phone number _____

Email Address _____

Sex ☐ M ☐ F Birthdate _____

Social Security number _____

OPTIONAL

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Phone number H _____ W _____

Step 2 INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Birthdate _____ SS# _____

Insurance Company _____

Group number _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Company _____

Group number _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Thibodaux Vision Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____
Responsible Party Signature Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Thibodaux Vision Center for services furnished me by Thibodaux Vision Center. I authorize any holder of medical information about me to release to the Division of Medicare and Medicaid Services and its agents any information needed to determine those benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Beneficiary Signature Date

Step 3 MEDICAL HISTORY QUESTIONNAIRE

PAST PERSONAL HISTORY

MEDICATIONS

☐ _____ ☐ _____

☐ _____ ☐ _____

☐ _____ ☐ _____

Drug Allergies _____

PRIMARY CARE PHYSICIAN INFORMATION

Name _____

Address _____

_____

Phone Number _____ **FAX** _____

Describe all serious illnesses, injuries and surgeries:

_____

_____

_____

Step 3	MEDICAL HISTORY QUESTIONNAIRE (cont.)

FAMILY HISTORY

Please note any family member with the following diseases/conditions: M-mother F-father S-sibling GP-grandparent

		YES	NO			YES	NO
Arthritis	___	☐	☐	Diabetes	___	☐	☐
Blindness	___	☐	☐	Glaucoma	___	☐	☐
Cancer	___	☐	☐	Heart Disease	___	☐	☐
Cataracts	___	☐	☐	Hypertension	___	☐	☐
Crossed Eyes	___	☐	☐	Retinal Dz.	___	☐	☐

SOCIAL HISTORY

Health Habits

Check which substances you use and the consumption.

	YES	NO
Alcohol	☐	☐
Quantity: _____		
Drugs	☐	☐
Quantity: _____		
Tobacco	☐	☐
Quantity: _____		

Social History

Please indicate hobbies and interest:

	YES	NO
Computers	☐	☐
Fishing	☐	☐
Golfing	☐	☐
Hunting	☐	☐
Music	☐	☐
Reading	☐	☐

REVIEW OF SYSTEMS

Check the symptoms and/or conditions you currently have or have had in the past.

	YES	NO	UNKNOWN
EYES			
Blurred Vision	☐	☐	☐
Burning	☐	☐	☐
Cataracts	☐	☐	☐
Crossed Eyes	☐	☐	☐
Distorted Vision (Halos)	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Excess Tearing/Watering	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Flashes/Floaters in Vision	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐
Glaucoma	☐	☐	☐
Infection of Eye or Lid	☐	☐	☐
Itching	☐	☐	☐
Lazy Eye	☐	☐	☐
Loss of Vision	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Retinal Disease	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Styes or Chalazion	☐	☐	☐
BONE/JOINT/MUSCLE			
Arthritis	☐	☐	☐
Joint/Muscle Pain	☐	☐	☐
Polio	☐	☐	☐
CANCER			
Breast	☐	☐	☐
Lung	☐	☐	☐
Prostate	☐	☐	☐
Skin	☐	☐	☐
CONSTITUTIONAL			
Fever	☐	☐	☐
Weight Gain/Loss (Sudden)	☐	☐	☐
ENDOCRINE			
Thyroid Abnormalities	☐	☐	☐
EAR, NOSE, AND THROAT			
Allergies	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Mouth/Throat	☐	☐	☐
Hay Fever	☐	☐	☐
Runny Nose	☐	☐	☐
Sinus Congestion	☐	☐	☐

	YES	NO	UNKNOWN
GASTROINTESTINAL (Stomach)			
Constipation	☐	☐	☐
Diarrhea	☐	☐	☐
Ulcers	☐	☐	☐
GENITOURINARY			
Chlamydia	☐	☐	☐
Gonorrhea	☐	☐	☐
Kidney Disease	☐	☐	☐
Syphilis	☐	☐	☐
INTEGUMENTARY (Skin)			
Eczema	☐	☐	☐
Psoriasis	☐	☐	☐
LYMPHATIC/HEMATOLOGIC			
AIDS	☐	☐	☐
Anemia	☐	☐	☐
Bleeding Disorders	☐	☐	☐
Hepatitis	☐	☐	☐
Herpes	☐	☐	☐
HIV Positive	☐	☐	☐
Liver Disease	☐	☐	☐
NEUROLOGIC			
Epilepsy	☐	☐	☐
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Multiple Sclerosis	☐	☐	☐
Seizures	☐	☐	☐
PSYCHIATRIC			
Depression	☐	☐	☐
High Anxiety	☐	☐	☐
REPRODUCTIVE			
Nursing Mother	☐	☐	☐
Pregnant	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Pneumonia	☐	☐	☐
Tuberculosis	☐	☐	☐
VASCULAR			
Diabetes	☐	☐	☐
Heart Disease	☐	☐	☐
High Blood Pressure	☐	☐	☐
High Cholesterol	☐	☐	☐
Stroke	☐	☐	☐

Patient Signature	Date	Initial and Date if No Change

VISION SOURCE™

Thibodaux Vision Center Mark J Roy, III, OD

Financial Policy

We are dedicated to providing the best possible care and service, and regard the understanding of our financial policies as an essential element of care and treatment. To assist, we present the following financial policy. If you have any questions, please do not hesitate to discuss them with any member of our staff.

INSURANCE COVERAGE

It is your responsibility to provide our office with accurate information for billing your insurance plan properly at the time of service. It is also your responsibility to know whether your visit with us is covered by your insurance plan fully, partially, or not at all and whether your plan requires a referral from your primary physician before your visit. **For example, you may be covered under your primary healthcare plan for additional vision care services under a different carrier. It is your responsibility to know whether you have this separate coverage.** If at the time of service you only notify us of your primary healthcare plan and later make us aware of additional coverage under another plan, you will be responsible for any and all charges. We will gladly provide you with an itemized receipt to submit to your insurance for reimbursement. Information of this type is 100% accurate only if you obtain it directly from your health plan, not from our office staff. **In the event you do not confirm this information and the insurer refuses full or partial payment, you will be held personally responsible for the cost of the services provided. Initial_____**

ROUTINE AND MEDICAL EYE EXAMS

Our office participates with certain vision plans for "routine eye exams." A routine eye exam is, by definition, a "regular check-up" for someone with no eye problems. If the doctor detects any medical condition, (dry eyes, floaters, etc.) the exam may become a medical eye exam and will be submitted to your medical insurance. If your insurance plan requires a referral, you will need to obtain one for the exam. Due to insurance company regulations, routine and medical exams may not be performed on the same day. If you desire only the routine portion of the exam on your visit, the doctor may ask you to return another day for a medical eye exam. **Please note that some insurance plans consider a routine eye exam to be a non-covered service.**

Vision Plan Patients: I have read and understand the above routine eye care policy. **Initial_____**

SPECTACLE AND CONTACT LENS EXAMS

Exam for spectacles and contact lenses are separate exams. If you desire both exams on your visit, you will be charged an evaluation fee for a contact lens exam. We will be happy to submit this charge to your insurance company. However, if this charge is determined to be a "non-covered" service, you will be responsible for this charge. If your vision plan offers a contact lens material benefit, the cost of the exam will be deducted from this benefit. **Initial_____**

AMOUNTS DUE FROM THE PATIENT

We gladly accept cash, personal checks, care credit, and most major credit cards. **Insurance co-payments will be collected at the time of service.** If we do not participate with your insurance plan, you are to provide payment in full at the time of service. We will provide you with an itemized statement of services and amounts paid which you may submit to your insurance. The insurance is then responsible for reimbursing you. If using insurance, we will make every effort to collect full and accurate fees specific to your plan. However, if there is a fee that your insurance charges and we did not collect it at the time the order was placed, it must be paid in full before glasses and/or contacts will be dispensed. **Initial_____**

AMOUNTS DETERMINED "NOT COVERED"

In the event a health plan determines a service of ours to be "not covered," you will then be responsible for the complete charge. An important example of this is our charge for checking eyes for changes in eyeglasses prescription and/or contact lens prescription (a procedure called refraction). We charge for this service and many insurances, including Medicare, deem this service "not covered." **If we check your eyes for a change in glasses, you are personally responsible for this charge. If you do not desire a refraction, please inform our office staff. Please note that some insurance plans consider a routine eye exam to be a non-covered service. Initial_____**

I have read and understand the financial policies of Thibodaux Vision Center, Inc. and also understand that Thibodaux Vision Center, Inc. reserves the right to change any and all fees at any time.

_____ _____

Signature of Patient (or Responsible Party if Patient is a Minor) **Date**

_____

Print Name of Patient & Date of Birth PLEASE PRINT LEGIBILITY

I acknowledge receipt of the Notice of Privacy Practices from the office of Dr Mark J Roy, III – Vision Source:

_____ print patient name _____date

_____ patient or guardian's signature

_____ print guardian's name _____relation to patient

YOUR PRIVACY IS PROTECTED! THE FOLLOWING INFORMATION IS NEVER SHARED WITH OTHERS WITHOUT YOUR CONSENT:

We need to communicate with you from time to time regarding appointments, status of glasses / contact lens orders, payment information, and new optical products, services, or technologies that may be of benefit to you. Please complete the following and indicate how you prefer to be contacted by numbering your preferences (1=first or best contact, 7=least preferred contact):

Preference	Communication	Address, number, or e-mail
____	US Postal Mail	_____address
		_____city, state, zip
____	Home Phone	_____ - _____
____	Work Phone	_____ - _____
____	Cell Phone	_____ - _____
____	Text Message to Cell Phone Listed Above	
____	e-mail _____@ _____ . _____	
____	other (alternate phone, etc.) _____	

THANK YOU FOR CHOOSING DR. ROY'S OFFICE!!!