WILLOW BEND VISION CARE

HYEJON KO, O.D. ~~ Roshanak Moshtaghfard, O.D. ~~BHAVINI PATEL, O.D. FAAO ~~ HELEN HEALEY, O.D.
~ 6121 W. PARK BLVD. STE. D-120 ~ PLANO, TX 75093 ~ PHONE: (972)202-5632 ~ FAX: (469)443-3174

PATIENT INFORMATION

First Name: _____Last: _____ MI: _____ ☐ Male ☐ Female

Nickname: _____Date of Birth: _____Age: _____Social Security#: _____

Street Address: _____

City, State, Zip Code: _____

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. Home Phone: _____ Cell Phone: _____

Marital Status: _____ Occupation: _____Employer: _____

Email: _____ Referred by: _____

Primary Care Physician: _____ Phone: _____Location: _____

INSURANCE INFORMATION

VISION Insurance: _____ ID#: _____Group#: _____

Primary (complete if other than you) Name: _____ Relation to patient: _____

Birth Date: _____SS#: _____ Phone#: _____

MEDICAL Insurance: _____ ID#: _____ Group#: _____

Primary (complete if other than you) Name: _____ Relation to patient: _____

Birth Date: _____SS#: _____ Phone#: _____

PATIENT CONSENT TO RELEASE MEDICAL INFORMATION TO OTHERS

I grant my permission to release and discuss all information, which includes appointments, medications, current medical statuses & treatment plans, billing and any other information pertinent to my medical care with the person(s) listed below:

Name: _____ Phone#: _____ Relationship: _____

Name: _____ Phone#: _____ Relationship: _____

Name: _____ Phone#: _____ Relationship: _____

EMAIL CONSENT

I consent to receiving a digital copy of my glasses and/or contact lenses prescription(s) via unencrypted email once the exam process is complete and prescription(s) has been finalized. I would like it to be sent to the email listed above.

I understand that there are risks involved with using email with WBVC and I accept those risks. I agree that WBVC (and their physicians, staff, or agents) shall not be responsible for any personal injury, and/or privacy breach, and/or other damages because of my choice to receive emails from WBVC and I release WBVC (and their physicians, staff, or agents) from any liability relating to communicating with me by email.

Patient or guardian signature: _____Date: _____

If patient is a minor – Guardian Name and relation: _____

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EYE HISTORY

Reason for visit: ☐ Glasses ☐ Contact Lens ☐ Eye infection or injury ☐ Medical ☐ Other: _____

Last Eye Exam: _____ Hours on computer/ digital devices: ____daily

Have you ever worn contact lenses? ☐ No ☐ Yes Current Contact Lens Brand: _____

Current glasses: ☐ Single Vision ☐ Progressive ☐ Bifocal ☐ Tri-focal Age of glasses: _____

Currently experiencing eye symptoms (please check all that apply):

☐ Blurred Distance Vision (with current glasses/contacts)		☐ Blurred Near (with current glasses/contacts)	
☐ Flashes of light	☐ Headaches	☐ Dryness	☐ Excess Tearing/Watering
☐ Double Vision	☐ Itching	☐ Floaters	☐ Foreign Body Sensation
☐ Loss of Side Vision	☐ Excessive Redness	☐ Light Sensitivity	☐ Eye Pain or Soreness
☐ Irritation	☐ Eye Strain	☐ Burning	☐ Discharge/Matting

☐ Other_____

PATIENT and FAMILY MEDICAL HISTORY

Please check the box ☐ for your **self** (the patient) and the circle ○ for a **family** history.

S F			
☐ ○ Glaucoma	☐ Hearing Loss	☐ Sleep Apnea	☐ ○Herpes Simplex/Cold Sores
☐ ○ Macular Degeneration	☐ Laryngitis	☐ ○ Liver Problems	☐ ○ Herpes Zoster/ Shingles
☐ ○ Retinal Detachment		☐ ○ Celiac Disease	☐ Rosacea
☐ ○ Color Deficiency	☐ ○ Epilepsy/ Seizures	☐ Acid Reflux	☐ Psoriasis
☐ ○ Strabismus (crossed eyes)	☐ ○ Cerebral Palsy	☐ Ulcer	☐ Eczema
☐ ○ Amblyopia (lazy eye)	☐ ○ Stroke_____		
☐ ○ Diabetic Retinopathy	☐ Migraines	☐ ○ Kidneys disease	☐ ○ Diabetes type I
☐ ○ Cataract		☐ ○ Bladder Disease	☐ ○ Diabetes type II
☐ Pinguecula/ pterygium	☐ ○ Depression	☐ ○ STD-Herpetic/ Chlamydia	☐ ○ Hormonal Dysfunction
☐ Previous Eye Injuries	☐ ○ Bipolar	☐ Pregnant _____ weeks	☐ ○ Thyroid Dysfunction
☐ Lasik / PRK	☐ ○ Anxiety	☐ Planning Pregnancy	
☐ Eye Surgery	☐ ○ Attention Deficit	☐ Nursing	☐ ○ Anemia
			☐ ○ High Cholesterol
	☐ ○ Heart Disease	☐ ○ Arthritis	
☐ ○ Developmental Disorder	☐ ○ Vascular Disease	☐ ○ Ankylosing-Spondylitis	☐ ○ Lupus
☐ ○ Cancer _____	☐ ○ High Blood Pressure	☐ ○ Fibromyalgia	☐ ○ Rheumatoid Arthritis
☐ ○ Fatigue Syndrome		☐ ○ Muscular Dystrophy	☐ ○ Sjogren Syndrome
☐ Fever	☐ ○ Asthma	☐ ○ Osteoarthritis	☐ Environmental Allergies
	☐ ○ Emphysema	☐ ○ Osteoporosis	☐ HIV/AIDS
☐ Sinusitis	☐ ○ COPD	☐ ○ Gout	☐ Drug Allergies_____
☐ Dry Mouth	☐ Bronchitis		

Smoke: ☐ No ☐ Daily_____ Alcohol Use: ☐ None ☐ Rarely ☐ Occasionally ☐ Daily _____

Comments_____

_____

Previous Surgeries_____

Current medication (include eye drops) _____

_____

Signature _____Date _____

Patient Name _____

If patient is a minor – Guardian Name and relation_____

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AUTHORIZATION OF INSURANCE ASSIGNMENTS
I authorize the release of medical and other information necessary to process and receive payment on health insurance claims. I hereby authorize my insurance provider to make payments directly to Willow Bend Vision Care/ Hyejon Ko, OD, PA. A copy of this authorization may be used in lieu of the original.

Initial: _____

FINANCIAL AGREEMENT
All professional services and/or treatments, once rendered, are NOT refundable.

Patient(s) without insurance:
I understand that I am expected to pay in full for services at the time they are rendered.

Patient(s) with insurance:
I understand that I am financially responsible for any deductible amount, co-insurance, co-pay, or any other balance not paid by my insurance company.
I understand that it is my responsibility to know my insurance coverage. I am aware that unless my insurance plan has coverage for contact lens fitting, I am responsible for the cost.
I understand that any out-of-pocket expenses collected at the time of service are estimates only. My insurance will determine my final out-of-pocket costs after claims are processed.

Initial: _____

HIPAA PRIVACY ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES
I hereby acknowledge that I have been provided with a copy of Willow Bend Vision Care's Notice of Privacy Practices, and that I have read, understand, and agree to the policies.

Initial: _____

AUTHORIZATION TO RELEASE PRESCRIPTON
I hereby authorize the release of my eyewear and/or contact lens prescription(s) upon verbal and/or written request by phone, mail, email or fax.

Initial: _____

CANCELLATION & MISSED POLICY
We reserve time in our schedule for you in advance to accommodate your schedule. We ask that you give us the same consideration when needing to change or cancel your appointments. Missed/No-show appointments and late cancellations inconvenience other individuals who need access to eye care in a timely manner.

We require a 24-hour advanced notice to change, cancel and/or reschedule a single appointment, and a 48-hour notice for multiple appointments scheduled together.

We charge a $30 fee for patients who do not show for their scheduled appointment and for patients who fail to give sufficient notice.

If you are 10 minutes past your scheduled appointment time, you have MISSED your appointment. You may be asked to reschedule for a later time and be charged according to our cancellation policy.

EYEGLASS PRECRIPTIONS POLICY
The doctors are available to review your prescription and recheck your vision if you are having any difficulties. Our office will recheck the prescription at no cost within 30 days from the original exam date. *A fee of $30 will be charged for any additional recheck/visit after 30 days.* Prescription rechecks will not be performed after 6 months from the original exam date and a new exam will be necessary.

CONTACT LENS POLICY
You may return for a contact lens evaluation within 60 days from the original exam date and only be charged for contact lens evaluation. After 60 days, we will charge for a new exam plus the cost of the contact lens evaluation

Your contact lens prescription will not be finalized until the doctor has determined that your contact lens trials fit properly. *A fee of $30 will be charged for any additional follow- up visit after 30 days***.** Contact lens follow-ups will not be performed after 6 months from original exam date and a new exam will be necessary.

You have 30 days from your exam date to finalize your contact lens prescription. Expiration dates for contact lens prescriptions are to be determined by the doctor. Once the prescription expires, a re-evaluation will be necessary in order to renew your prescription.

Signature _____Date _____

Patient Name _____

If patient is a minor – Guardian Name and relation_____

WILLOW BEND VISION CARE

DILATION OR OPTOMAP CONSENT

We are pleased to be able to offer the Optomap Retinal Image Exam which allows our doctors to review an ultra-widefield view of the retina. Your retina (located in the back of your eye) is the only place in the body where blood vessels can be seen directly. This means that in addition to eye conditions (example: glaucoma, macular degeneration, retinal detachment), signs of other systemic disorders (example: diabetes, hypertension, stroke) can also be seen in the retina. Early signs of these conditions can show on your retina long before you notice any changes to your vision or feel pain. Getting an Optomap image is fast, painless and comfortable. Nothing touches your eye and is suitable for the whole family. Under normal circumstances, dilation drops are not necessary, but your eye care practitioner will decide if your pupils need to be dilated depending on your conditions.

Please Initial one:

_____I CONSENT to the Optomap retinal imaging and agree to the charge for the procedure of $44 or less depending on insurance.

_____I CONSENT to have my eyes dilated and decline Optomap retinal image. I understand dilation will cause blurry vision for approximately 6 hours and light sensitivity. (no additional charge with most insurance).

_____I DECLINE both the dilation and Optomap against my doctor's recommendation. In refusing, I understand and accept all risks associated with failure to diagnose eye conditions/diseases due to lack of information.

Patient Name: _____

Signature: _____ Date: _____