Thank you for choosing Premier Vision, Dr. Kent Wilson and staff, as your eye care provider. We appreciate the opportunity to provide you with the highest quality eye care and service.

Enclosed you will find forms to print out, complete, and bring with you to your appointment.

When completing the medications list, please include all medications, over the counter medications and drops.

Items to bring with you:

* Your insurance cards and photo ID.
* A complete list of prescription and over-the-counter medications, including eye drops.
* Your current eyewear, including sunglasses, and/or contact lenses.

During your examination, you will likely be dilated. Please remember to bring your sunglasses and arrange for a driver if you feel it is necessary.

Please arrive 15 minutes prior to your appointment to allow us to gather additional data needed for our electronic medical records.

If you would like to view our NOTICE OF PRIVACY PRACTICE, please click on the button labeled "HIPPA POLICY MANUAL." There is no need to print this unless you would like a copy, as it is 24 pages.

If you have any questions, please do not hesitate to give us a call at 972-563-5533.
Our address is..... * 152 Ninth Street, Terrell, Texas.

We look forward to "SEEING" you soon!

WELCOME TO PREMIER VISION

Dr. Kent A. Wilson
Therapeutic Optometrist

OUR MISSION: It is our goal to provide our patients with the highest quality eye care and service. We are devoted to our community in and out of the office. Our knowledgeable staff and doctors are committed to excellence in meeting each patient's unique visual and eye health needs with the highest ethics and integrity.

PLEASE PRINT:

First Name ____________________ MI _____ Last Name ____________________ Today's Date ____________

Date of Birth ___/___/_____ Age _____ Sex: ☐M ☐F Spouse's Name ________________________

Check appropriate selection: ☐Minor ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Address ___________________________________ City ____________________ State______ Zip ____________

Home Phone _____________________ Cell Phone ___________________ E-mail _________________________

Current Height ______________ Current Weight _________________

Our Office uses text messaging to remind you of appointments and to alert you when glasses and contacts are ready for dispense. May we contact you by text? ☐Yes ☐No

☐Employed ☐Not Employed ☐Student ☐Retired............................ ☐Full Time ☐Part Time

Occupation ___________________________________ Employer ____

Ethnicity/Race: ☐White/Caucasian ☐Hispanic/Latino ☐Black/African American ☐Asian ☐American Indian/Alaskan Native ☐Native Hawaiian/Pacific Islander ☐European ☐Other ________

Last Eye Exam: ☐Never ☐0-12 months ☐1-2 years ☐3-4 years ☐5+ years

Primary Care Physician ______________________________ Date of Last Physical Exam __________________

How Did You Hear About Us? ☐Friend ☐Family ☐Doctor ☐Insurance Company ☐Internet ☐Website ☐FaceBook ☐Other _________ Who referred you? ________________

How will you settle your account today? ☐Credit Card ☐Cash ☐Check ☐Care Credit

PERSON RESPONSIBLE FOR PAYMENT

Patient/Guardian/Parent: ____ Relationship: _____________________________

Address ____ City ____________________ State _________ Zip ___________

Date of Birth ____/_____/______ Home Number ________________Cell Number _______________ Email______________

REASON FOR "TODAY'S" VISIT

☐Loss of Vision	☐Blurred Vision	☐Distorted Vision/Halos	☐Loss of Side Vision
☐Double Vision	☐Glare/Light Sensitivity	☐Eye Pain/Soreness	☐Stys/Chalazion
☐Eye Injury	☐Flashes/Floaters in vision	☐Retinal Disease	☐ Cataract
☐Dryness	☐Mucous Discharge	☐Redness	☐Sandy/Gritty Feeling
☐Itching	☐Burning	☐Glaucoma	☐Excess Tears/Watering
☐Foreign Body Sensation	☐ Chronic Infection of eye or lid		☐Other _______________

Using Tobacco products may increase the risk of Macular Degeneration and Dry Eyes.

Social History: (Mark all that apply.)

Smoking:
- ☐ never smoked
- ☐ light tobacco smoker
- ☐ former smoker
- ☐ heavy tobacco smoker
- ☐ current every day smoker
- ☐ current smokeless tobacco user/vape/dip

Alcohol Use: ☐ No ☐ Social ☐ Daily

Drug Use: ☐ No ☐Recreational Use ☐ Chemical Dependence

Have you ever been exposed to/ infected with: ☐Gonorrhea ☐Hepatitis ☐HIV/AIDS ☐Syphilis ☐No

REVIEW OF SYSTEMS: ***Many health issues may affect the eyes/vision.*** (Please mark ALL that apply.)

EYES
- ☐ Dry Eyes
- ☐ Pain
- ☐ Double Vision
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Diabetic Retinopathy
- ☐ Floaters
- ☐ Flashes of Light
- ☐ Other ______________

EAR, NOSE AND THROAT
- ☐ Vertigo
- ☐ Menier's Syndrome
- ☐ Hard of Hearing/Loss
- ☐ Dry Mouth
- ☐ Other ______________

CARDIOVASCULAR
- ☐ High Blood Pressure
- ☐ Irregular Heartbeat/Arrhythmia
- ☐ Chest Pain
- ☐ Dizziness
- ☐ Fainting Spells
- ☐ Shortness of Breath
- ☐ High Cholesterol
- ☐ Congestive Heart Failure
- ☐ Vascular Disease
- ☐ Stroke
- ☐ Other ____________

CONSTITUTIONAL
- ☐ Fatigue/Weakness
- ☐ Fever
- ☐ Weight Gain/Loss
- ☐ Cancer: Type ________
- ☐ Other _____________

RESPIRATORY
- ☐ Chronic cough
- ☐ Congestion
- ☐ Wheezing
- ☐ Asthma
- ☐ Seasonal Allergies
- ☐ COPD
- ☐ Lung Disease
- ☐ Histoplasmosis
- ☐ Other ____________

GASTROINTESTINAL
- ☐ Heartburn
- ☐ Nausea/Vomiting
- ☐ Liver Disease (Hepatitis A/B/C)
- ☐ Other _____________

GENITO-URINARY
- ☐ History of STD's
- ☐ Kidney Disease
- ☐ Other ____________

PSYCHIATRIC
- ☐ Anxiety/Depression
- ☐ Mood Swings
- ☐ Difficulty Sleeping
- ☐ Dementia
- ☐ Bi-Polar Disorder
- ☐ Other ____________

ENDOCRINE
- ☐ Increased Thirst/Hunger
- ☐ Thyroid Disease
- ☐ Increased Urination
- ☐ Increased Sweating
- ☐ Other ______________

Do You have Diabetes? ☐Yes ☐No

Date Diagnosed? ___________ A1C____

Is blood sugar controlled? ☐Yes ☐ No

Name of doctor treating: ________________

BLOOD/ LYMPHATIC
- ☐ Easy Bruising/Bleeds
- ☐ Anemia
- ☐ Sickle Cell
- ☐ Blood Clotting Disorder
- ☐ Other ______________

MUSCULOSKELETAL
- ☐ Arthritis
- ☐ Joint Pain/Swelling
- ☐ Fibromyalgia
- ☐ Other ______________

SKIN
- ☐ Lupus
- ☐ Hives/Eczema
- ☐ MRSA
- ☐ Psoriasis
- ☐ Cancer ____________
- ☐ Other _____________

NEUROLOGICAL
- ☐ Seizures
- ☐ Weakness/Paralysis
- ☐ Numbness
- ☐ Tremors
- ☐ Headaches
- ☐ Migraines
- ☐ Meningitis
- ☐ Other _____________

IMMUNOLOGICAL
- ☐ Itching
- ☐ Runny Nose
- ☐ Sinus Pressure
- ☐ HIV/AIDS
- ☐ Shingles (H. Zoster)
- ☐ Fever Blisters (H. Simplex)
- ☐ Other _____________

PAST OCULAR HISTORY: (Mark ALL that apply)

☐No history of eye problems ☐Cataracts ☐Amblyopia (Lazy eye) ☐Iritis
☐Diabetic Retinopathy ☐ Optic Neuritis ☐ Aphakia ☐Dry Eyes ☐Glaucoma
☐Keratoconus ☐ Retinal Detachment ☐Macular Degeneration ☐Other ______

OCULAR SURGERIES: (Mark ALL that apply) ☐ No prior ocular surgeries.

☐Foreign Body Removal ☐Punctal Plugs ☐Laser ☐Cataract Surgery
☐Blepharoplasty/Eye Lid ☐Retinal Laser Surgery ☐RK ☐LASIK
☐Strabismus/ Eye Turn ☐Corneal Transplant ☐Vitrectomy ☐PRK

CURRENT <u>"EYE"</u> MEDICATIONS: (Please List) ☐ I am not using eye medications.

____
____

Have you had any MAJOR Surgeries? ☐Yes ☐No If yes, please explain________________________
____

Are you pregnant or nursing? ☐Yes ☐No
Are you allergic to any medications? ☐Yes ☐ No If yes, please explain ____________________
____

FAMILY HISTORY AND RELATIONSHIP (Father, Mother, Maternal Grandparent, Paternal Grandparent, etc.)

☐Glaucoma ____________ ☐Macular Degeneration ______________ ☐Diabetes _____________
☐Diabetic Retinopathy __________________ ☐Blindness ___________________

GLASSES/CONTACTS HISTORY:

Do you wear glasses? ☐Yes ☐No Are they for… ☐Full Time ☐Reading ☐Computer ☐Driving
Computer/Screen Time: ☐1-2 hours ☐3-4 hours ☐6-8 hours ☐8+ hours
Do any of the following bother you?☐Computer Screen ☐Sun ☐Oncoming Traffic ☐Glare Problems
Do you wear contacts? ☐Yes ☐No … If yes, are they comfortable? ☐Yes ☐No
Type: ☐Daily ☐Overnight Wear ☐Rigid ☐Soft How often do you dispose of them? __________
Brand of Lenses: ______________________________

CURRENT MEDICATIONS : <u>**Prescription and/or Over-the-Counter medications may affect the Eyes/Vision**</u>.
PLEASE LIST ALL.

☐I am not currently taking any medications.

<u>**Ex. Medication.**</u> **Lisinopril** <u>**Ex. Dosage/Frequency**</u>**: 5 mg (Once daily)** <u>**Ex. Reason**</u>**: High Blood Pressure**

MEDICATION	DOSAGE/FREQUENCY	REASON

PREMIER VISION FINANCIAL POLICIES AGREEMENT

FINANCIAL RESPONSIBILITY

As a member of a vision care plan and/or medical insurance, I acknowledge that I will assume full financial responsibility for services rendered to me if my vision or medical insurance carrier denies or does not cover my claim for these services. I understand that my personal insurance coverage is a contract between me and my insurance company not Premier Vision. **All co-pays, deductibles, and/or co-insurance, and any non-covered services are due at the time of the appointment**, as outlined by my chosen plan contract with my insurance provider. All benefits quoted are not a guarantee of payment by my insurance company and final determination can only be made when the claim is processed. If my insurance company has not reimbursed Premier Vision in full, **I am responsible for payment of any remaining fees owed.**

NO SHOW/CANCELLATION POLICY

It is important to be present for your appointment. Please call at least 24 hours in advance if you need to move your appointment time or date in order to avoid a **$15 cancellation fee.** We understand emergencies happen. However, if a patient does not show up for their appointment for 3 consecutive visits or cancels up to 3 times in a row, cancellation fees will accrue and must be paid before given a new appointment time.

CONTACT LENS POLICY

Contact lens and/or service fees not covered by insurance must be paid in full at the time of service and are not refundable. For your benefit, please make a final decision on the success of your contact lenses within **30 days.** Contact lens prescriptions will only be released after the initial fitting period is successfully completed and after all fees are paid. Contact lenses are to be paid in full before being ordered. Open and/or damaged boxes of contact lenses are not returnable.

Trial lenses will only be dispensed during the fitting process, as needed, to reach a final prescription.

LAB REFUND, PRESCRIPTION CHANGE POLICY

New frames normally have a 1–2-year warranty from the original date for manufacturer defects only. This warranty does not cover loss. If a patient is unable to adapt to his/her new prescription, please let us know within **30 days**. We will make adjustments, but this does not entitle the patient to a refund. First time recheck within **30 days** will be at no charge. After that, patient will be responsible for the cost of an office visit.

REFRACTION POLICY and ACKNOWLEDGEMENT

Refraction is the process of determining the eye's refractive error, or need for corrective lenses (glasses). Refraction is part of an eye exam but is NOT a covered service by Medicare or most managed care plans. Our office fee for the refraction (glasses prescription) is **$40.00**. This refraction fee is in addition to the patient's co-pay. (Please check box.)

☐ I have read the above statement and understand the refraction is a non-covered service. I accept full financial responsibility for the cost of the service. The co-pay is separate from and not included in the refraction fee.

CONSENT FOR USE OF INSURANCE INFORMATION AND FINANCIAL RESPONSIBILITY

I authorize Dr. Wilson to release any information required to process my insurance claim, or insurance claim for my child. I also authorize my insurance benefits to be paid directly to Dr. Wilson and understand that I am responsible for any non-covered or denied services.

I have read and understand my financial responsibilities and the above policies and have accurately answered all medical questions on the previous pages to the best of my knowledge. Any copy of this authorization shall be as valid as the original.

Signed ______________________________ Date ______________

Acknowledgement of HIPAA Notice of Privacy Practice

This form is available to you in our office and we will gladly provide you a copy of this notice if you would like to keep one for your personal records. This notice describes how your personal health record information may be used and disclosed and how you may gain access to this information.

The law requires that Premier Vision, PC make every effort to inform you of your rights related to your personal health information. Examples of uses of your health record may include patient recall, prescription verification or request, co-management with other health professionals, and/or ordering glasses or contacts for you. We will use and communicate your health information only for the purpose of providing your treatment, obtaining payments and conducting care operations.

By my signing below, I acknowledge that: (Please check box.)

☐ I was given the opportunity to read, have read, or had explained to me Premier Vision's Notice of Privacy Practice prior to any services offered.

☐ The Notice of Privacy Practice could not be read due to the emergent nature of the care and will be acquired when possible.

I authorize Premier Vision to release my personal health information to the following individuals:

Name	Relationship
______________________	______________________
______________________	______________________
______________________	______________________

My vision plan requests that all diagnoses related to any medical condition be released to them. As a non-traditional disclosure, release of this information requires my specific authorization: (Please check box.)

☐ I authorize the release of medical information to my vision plan.

☐ I do not authorize release of medical information to my vision plan.

Our office may use standard email to communicate with you. Standard email is NOT SECURE and does not guarantee privacy. (Please check box)

☐ I authorize Premier Vision to use standard email, in spite of the known risk involved, to communicate with me.

☐ I do not authorize the use of standard email to communicate with me.

I HAVE READ AND UNDERSTAND THIS INFORMATION. I AM SIGNING IT VOLUNTARILY.

______________________________ ______________________

Patient Signature Date

If you are signing as a personal representative of the patient, please indicate your relationship. If you are signing for a minor, you attest that you have legal authority to make medical decisions for the minor.

______________________________ ______________________________

Representative Signature Relationship to Patient