Mann Eye 2

Date: _____ Date of Birth: _____ Age: _____

Patient's Name: _____
Last First MI

Address: _____
Street City State Zip

SS#_____ Sex: □M □F E-mail:_____

Home Phone #_____ Work #_____ Cell #_____

Occupation: _____ Employer: _____

Check the applicable RACE below:

□ American Indian □ Asian □ Black/African American
□ Hispanic □ Native Hawaiian/Pacific Islander □ White
□ Other

Referring Eye Doctor/Physician _____ Phone: _____ Last Exam: _____

In case of emergency, please contact _____ Phone #_____

Name of **Insurance Company** to be filed _____ ID#_____

If other than patient, please complete the following: Name_____

Relationship to patient _____ DOB _____ Last 4 digits of SS#_____

I.D.#_____ Group #_____

Address _____ City _____ State _____ Zip _____

Co-pay / deductible / co-insurance / refraction to be paid by: cash credit/debit

Person Responsible for Payment: Self Spouse Parent Guardian

I hereby consent to a health examination, related diagnostic procedures and treatments provided by Mann Eye2. I also authorize the use of my clinical findings, photographs, and clinical data collected to document my ocular condition for routine care or use in research and professional publication. Photostatic copies of this authorization will be considered valid as the original.

*** Payment is due at the time services are rendered,**

For your convenience we accept the following forms of payment:
American Express, Discover, MasterCard, Visa, Cash

Signature_____
(Please circle one) Patient / Parent

How did you hear about us? Please be specific _____

Signature on File, Assignment of Benefits, Financial Agreement HIPAA Notice

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to **Mann Eye2** for services furnished me by **Doctor(s).** I authorize any holder of medical information about me to release

   to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or 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 CMS 1500 form, my signature authorizes releasing the information to the insurer or agency shown. **Mann Eye2** accepts the charge determination of the Medicare carrier as the full charge, and **I am responsible for the deductible, coinsurance and non-covered services.**
   Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

2. **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA1500 form, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to **Mann Eye2**, if possible or otherwise to me.

3. **OTHER INSURANCE:** I authorize payment of my medical and surgical insurance benefits to **Mann Eye2**.

   I understand I am financially responsible for any charges whether or not paid by said insurance. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to **Mann Eye2.** I authorize **Mann Eye2** to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

4. **NON-COVERED SERVICES:** I understand that **Mann Eye2's** contract with health care services plans (i.e., HMOs, PPOs) relates only to items and services which are "covered" by the health care service plans. Accordingly, **I accept full financial responsibility for all items or services, which are determined by the health care service plans not to be covered, including the refraction fee.** I agree to cooperate with **Mann Eye2** to obtain necessary health care service plan authorizations.

5. **FINANCIAL AGREEMENT: I agree that in return for the services provided to me by Mann Eye2, I will pay my account at the time service is rendered.** If my account is sent to an agency for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance are hereby assigned to **Mann Eye2**. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to **Mann Eye2**. However, I understand that I arm primarily responsible for the payment of my bill.

6. **HIPAA NOTICE OF PRIVACY PRACTICES:** I acknowledge that I have received the Notice of Privacy Practices Issued by **Mann Eye2** that was effective April 14, 2003. I agree to allow electronic communication as defined in security practices effective April 21st, 2005.

Please direct complaints to: Texas Department of State Health Services
110 West 49th Street, Austin, TX. 78756
Phone: 1.888.973.0022

I have read and understand these instructions and have a copy for my review.

Name (print): _____

Signature: _____ **Date:** _____

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GENERAL INTAKE INFORMATION

REASON FOR VISIT (Please check all that apply):

Annual check up: ▯ Glasses ▯ Contacts

▯ Blurred Distance Vision	▯ Headaches	▯ Flashes/Floater
▯ Blurred Near Vision	▯ Infection/Redness/Allergies	▯ Halos or Glare
▯ Interested in Lasik	▯ Dryness	▯ Cataracts

▯ Other unlisted problem: _____

REVIEW OF SYSTEMS **Please check mark if you are having problems in any of the following areas as many of these conditions have eye-related manifestations:**

SYSTEM	SYMPTOMS / PROBLEMS AREAS
Constitutional	▯ Fatigue ▯Fever ▯Night sweats
HEENT	▯ Ear drainage ▯ Hearing loss ▯ Nasal drainage
Respiratory	▯ Cough ▯ Dyspnea (difficulty breathing) ▯ Wheezing
Cardiovascular	▯ Chest pain ▯ Chest pressure or discomfort ▯ Irregular heartbeat / palpitations
Gastrointestinal (GI)	▯ Abdominal pain ▯ Constipation ▯ Diarrhea ▯ Vomiting ▯ Acid Reflux
Genitourinary (GU)	▯ Dysuria (painful urination) ▯ Hematuria (blood in urine) ▯ Polyuria (large volumn of dilute urine) ▯ STD
Reproductive	▯ Pregnant ▯ Nursing
Endocrine	▯ Type 1 Diabetes ▯ Type 2 Diabetes ▯ Polydipsia(excess thirst) ▯ Hormonal Dysfunction
Neuro	▯ Dizziness ▯ Gait (walking) disturbance ▯ Headache ▯ Migraine
Psych	▯ Anxiety ▯ Depression ▯ Emotional changes ▯ Bipolar Disorder
Musculoskeletal	▯ Arthralgias ▯ Joint swelling ▯ Muscle weakness
Hematologic	▯ Bruising ▯ Easy bleeding ▯ Easy bruising
Allergic / Immuno	▯ Environmental allergies ▯ Food allergies

MEDICATIONS/SUPPLEMENTS taken presently: (if none, please write **N/A**)

_____

_____

List all allergies to medications/specify how your body reacts (ie anaphylaxis, rash, etc): (if none, please write **N/A**)

_____

_____

--- CONTINUE TO BACK ---

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HISTORIES

Last eye exam _____

Primary care physician _____ Last physical exam _____

Drug usage: _____

Tobacco use? ▯ No ▯ Yes, type: _____ Light/heavy use: _____ Duration: _____ years

Computer use? ▯ No ▯Yes, usage: _____ hours per day

Ever diagnosed with ▯ AIDS ▯ HIV ▯ NO

PERSONAL AND FAMILY HEALTH HISTORY

Please check any condition that applies to yourself or any members of your *immediate* family.

Note: Immediate family refers to your parents, your siblings, and your children

	SELF	FAMILY		SELF	FAMILY
BLINDNESS	▯	▯	CANCER	▯	▯
CATARACTS	▯	▯	DIABETES	▯	▯
GLAUCOMA	▯	▯	HIGH CHOLESTEROL	▯	▯
KERATOCONUS	▯	▯	HEART DISEASE	▯	▯
LAZY EYE	▯	▯	HIGH BLOOD PRESSURE	▯	▯
MACULAR DEGENERATION	▯	▯	STROKE/CVA	▯	▯
RETINAL DETACHMENT	▯	▯	THYROID DISORDER	▯	▯
RETINAL DISEASE	▯	▯			

Any history of injury to the eye(s) or eye surgery? _____

Please continue if you wear CONTACT LENSES:

Brand: _____ Power: RT _____ LT _____

Age of current pair wearing today _____ days / weeks / months / years (circle one)

Average wear time _____ hours

How much do you sleep in your contacts? _____

Average replacement period _____ days / weeks / months / years (circle one)

Solution used _____

Mann Eye 2

Our goal is to set the standard in professional, quality eye care. We are committed to prevention of eye disease as well as early detection. The following tests are available at our office to help identify changes at early stages in conditions such as retinal holes, tears, detachments, macular degeneration, tumors, cataracts, and glaucoma as well as other retinal and optic nerve diseases and abnormalities.

Dilation is highly recommended annually if:

- it's your first eye exam or first visit at this office
- You are diabetic
- You are over age 45*
- You have glasses or contacts lens prescription over -4.00
- You have a previous diagnosis or family history of a condition in the back of the eye that needs yearly monitoring (ie glaucoma, macular degeneration, cataract, retinal defect)
- You are experiencing floaters and/or flashes of light
- You have not been dilated in two years*

*In these marked cases, you may opt to have retinal photos taken in place of dilation.

☐ **Yes, I would like to dilate my pupils today. Please note: you may experience light sensitivity and blurred near vision for approx. 4-6 hours.**
☐ **Yes, I would like to have retinal photos ($20) taken today.**
☐ **No, I do not want additional testing.**

Automated visual field screening aids in detecting early changes in glaucoma, retinal issues, and some neurological diseases (such as tumors and optic nerve disease). It is also highly recommended if:

- You have previous history (or family history) of stroke, vision loss, or glaucoma
- You have new, unusual, or persistent headache
- Your intraocular pressure is over 25mmHg in either eye or difference between each eye is >3 (the technician will check this)

☐ **Yes, I would like an automated visual field screening ($25)**
☐ **No, I do not want additional testing.**

Liability Release: I have been informed by my MannEye2 Optometrist (from the above or verbal explanations) and its staff of the importance of a visual field screening and pupil dilation. If I have chosen not to have one or both tests performed, or any other recommended test or referral, or I have given incomplete or inaccurate information, I will not hold my MannEye2 Optometrist and/or its staff responsible for any diseases or pathology that goes undetected due to the lack of diagnostic information that could have been obtained by these testing procedures.

x _____(initials) I understand that pertinent, with restrictions, follow-up appointments up to **45 days** for glasses and contact lenses are included in the exam fees. Office fee(s) will be charged after these time periods have expired. I understand if I decline both dilation and retinal photos against my physician's recommendation, I absolve my physician of any responsibility or liability for undiagnosed conditions.

PATIENT NAME (PLEASE PRINT): _____

Patient (or gaurdian) signature: _____ Date: _____