VISIONComfort
EYE CARE

ESTABLISHED PATIENT

*****PLEASE VERIFY ADDRESS AND PHONE NUMBERS AT FRONT DESK****

Patient's Name _____ Date of Birth_____

E-Mail Address _____

**Do you give us permission to email you, your prescriptions through regular unencrypted email? YES NO

Circle the health conditions that apply to you today:

Diabetes Hypertension High Cholesterol Thyroid Cancer Glaucoma Cataract Macular Degeneration

Have you had any changes to your medical or ocular history since your last visit? (ex. Cataract surgery, LASIK, new medications, new treatments, etc.) Please explain:_____

_____

Are you experiencing any of the following?

				Double vision	Y	N	Blurred vision	Y	N		
				Droopy eyelids	Y	N	Blindness	Y	N		
				Dry eyes	Y	N	Brown spot on eye	Y	N		
Halos around lights	Y	N	Eye discharge	Y	N	Bulging eye	Y	N			
Headache	Y	N	Eye injury	Y	N	Chronic eye infections	Y	N			
Irritation	Y	N	Eye pain	Y	N	Cloudy vision	Y	N			
Itchy eye	Y	N	Eye twitching	Y	N	Crossed eyes	Y	N			
Lid lesion	Y	N	Eyes burning	Y	N	Difficulty driving	Y	N			
Light sensitivity	Y	N	Flashes	Y	N	Difficulty reading	Y	N			
Photophobia	Y	N	Floaters	Y	N	Difficulty using computers	Y	N			
Red eye	Y	N	Foreign body sensation	Y	N	Distorted vision	Y	N			
Red spot on eye	Y	N	Glare								

OFFICE POLICIES

Our opticians will work with you to select the best frames and lenses. There are no refunds unless it is requested on the same day of purchase since glasses are custom made. Once your order is placed there are no cancellations; if we make an exception to this policy, within 30 days of purchase, a 25% restocking fee will be applied. Vision Comfort is not liable for any damage when using your own frame. If you decide to change your frame that you purchased here, you can replace the frame within 30 days from the date of dispense. It must be in original and undamaged condition. *Eyemed Vision Insurance does not allow a frame change.

If you have insurance coverage, it is your responsibility to tell us before your exam. We cannot submit claims for you if you did not notify us about your insurance coverage before your exam or the day of. All co-payments are due in full on initial visit. Certain charges will be assessed to the patient but will be billed to your major insurance provider. 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 the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Responsible Party Signature Relationship Date

MEDICAL RETINA TESTING/IMAGING

The Optomap:

The Optomap Retinal Exam is a non-dilating camera that captures a digital image of the retina. It shows the doctor a view of the retina without dilation drops. It is highly recommended to see early signs of diseases such as retinal detachments and diabetic retinopathy. This instrument is recommended for all ages especially children.

The OCT:

Optical coherence tomography (OCT) uses light to take a ultrasound of your retina. Your optometrist can see all 10 layers of your retina. This instrument is state of the art in detecting early glaucoma, macular degeneration, optic nerve swelling and/or other eye diseases.

BOTH are HIGHLY recommended by our optometrists especially if you have diabetes, high blood pressure, over 50 years old, you have any family history of an eye disease or this is your child's first eye exam.

- ☐ Optomap Fee $39
- ☐ OCT Fee $39
- ☐ BOTH. Fee is $55.00 (highly recommended by Dr. Iqbal and Dr. Alvarado)*

Select one of the above and sign below to acknowledge that you are aware that you are responsible for the fee above.

X_____

Contact Lens Exam Fee

The comprehensive eye exam you will receive today includes refraction (spectacle lens evaluation) and a thorough evaluation of the health of your eyes. Evaluating the fit, condition, and prescription of your current or future contact lenses is not included in the comprehensive eye exam. In order to render this service to you an additional fee will be charged. This fee is due the day services are rendered. The contact lens service fee includes up to 4 follow ups visits within 90 days if needed. The contact lens service fee is usually not covered by insurance; it will normally be an out-of-pocket expense. The contact lens service fee ranges from $95-$135.

- ❑ Yes, I understand my contacts lens fitting is a separate fee from my routine eye exam.
- ❑ No, I do not want a contact lens fitting

_____ _____

PRINT NAME **DATE**

_____

SIGNATURE

VISIONComfort
EYE CARE

Acknowledge of Receipt

8751 Hwy. 6 S. Ste. A
Houston, TX 77083
(281) 498-1381

I acknowledge that I have been given the following options related to communicating with Vision Comfort, its doctors, and staff members:

> I agree to allow Vision Comfort's doctors and staff to leave messages on my answering machine, answering service, or with an individual at my home or workplace that identifies the message as originating from Vision Comfort. I understand that clinical information will not be part of this message.
>
> I agree to allow Vision Comfort to send me marketing materials (i.e. recalls), clinical information concerning services, and/or products available at Vision Comfort. Such information will be mailed, emailed, or otherwise delivered in an envelope, postcard, or electronic communications method that may contain my name and that of Vision Comfort, an individual optician, or an optometrist providing care at Vision Comfort.

I acknowledge that I received a copy of Vision Comfort's Notice of Privacy Practices.

Patient Name: _____

Signature: _____ Date: _____

I agree to allow Vision Comfort's doctors and staff to disclose my private information including personal, financial, and medical information to the people listed below.

I agree to notify Vision Comfort in writing should this list need to be amended.

Name: _____ Relationship: _____ DOB: _____

Name: _____ Relationship: _____ DOB: _____

Name: _____ Relationship: _____ DOB: _____