FRISCO IN FOCUS
OUR FOCUS IS YOUR EYES

Office Policies

- **Financial Policy**
  - I acknowledge that my examination today may be billed to my medical insurance or vision care benefits as deemed appropriate by my doctor. I understand that I am responsible for paying all co-payments as well as known deductibles and coinsurance at the time of service prior to leaving. If my insurance determines that medical services and/or materials are not covered, I acknowledge that I have been notified and will assume full financial responsibility for the service(s) and/or materials provided. If my insurance determines that I have not met my deductible or owe coinsurance or a copay, I understand that I will be fully responsible for payment in a timely manner, no more than 30 days after I have been notified by the insurance and/or provider. I authorize Frisco In Focus to release information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.
  - Our policy is to collect payment in full at the time of the order for any materials (glasses, contacts, etc.). Please make every effort to pick up materials within 60 days or they may be considered abandoned.
  - We are not allowed to accept returns, refunds, or exchanges of materials. Glasses and contacts are considered restorative medical devices by the FDA, just like prosthetic limbs or dentures. As such, medical facilities are not allowed to re-sell "used" devices that have already been manufactured or taken home for use by a patient. Your prescription is customized for your eyes and cannot be returned for use by another patient.

- **Behavior Policy**
  - Cancellations/No Shows: I acknowledge that 24 business hours advanced notice **by phone** is required to cancel an appointment. Text messages and emails will not suffice as they may not be seen in a timely manner. Failure to do so will result in a $40 broken appointment fee and a restriction in appointment time availability to non-peak hours.
  - Arrival Time: I understand that arriving late will result in a shortened appointment. A greater than 10-minute late arrival time will be considered a no-show and will be subject to the broken appointment fee.
  - Office Conduct: We strive to provide a safe environment for our children, families, and staff. When in the clinic, it is important to behave in a manner that is respectful to the eyes and ears of everyone present. This respect should also be maintained when communicating on the phone. Inappropriate behavior may result in being dismissed from our practice. Thank you for keeping our office friendly and pleasant for all to visit.

- **Prescription Policy**
  - When you choose to have your glasses made at Frisco In Focus, we will give you the utmost in service and quality of materials, including a one-year scratch warranty on antireflective coatings and a one-year frame warranty. A $40 copay may be charged should you need to utilize the warranty. Our opticians are here to assist you with adjustment needs.
  - I am aware that Frisco In Focus will not assume any responsibility for the accuracy of the prescription filled or quality of any materials made outside of the office.
  - If I am supplying my own frame, I understand that many plastic and metal products may weaken over time and I will not hold Frisco In Focus or my vision carrier responsible for accidental laboratory breakage.
  - External Prescriptions: I understand that Frisco in Focus is more than happy to provide me with eyeglasses or contacts from a valid prescription from an outside provider. For outside prescriptions, I acknowledge there are no refunds or cancellations and the one-time remake policy within 90 days of a glasses order will apply.

I have read and will adhere to Frisco In Focus' Financial, Behavior, and Prescription Policies.

Patient Name _____ Date_____

Patient or Parent's Signature _____

- **Reason for Visit Determines Vision Insurance vs. Medical Insurance**

  One of the most challenging billing issues in an optometry office is determining if we should be billing a medical or vision plan. Optometrists are primary health care professionals who examine, diagnose, treat, and manage diseases, injuries, and disorders of the visual system, the eye, and associated structures as well as identify related systemic conditions affecting the eye. However, optometrists also provide routine well-vision exams for patients with no eye disorders. Our doctors and billers will determine the appropriate plan (medical or vision) to file your claim based on the primary reason you have presented for your examination.

  For patients with BOTH medical and vision coverage: Your vision plan is intended to provide you with a baseline, well-vision exam. If you present with a medical concern and are being evaluated for medical reasons (corneal disorder, diabetes, flashes and floaters, painful or red eyes, cataracts, glaucoma suspect, double vision, dry eyes, etc.), you are being provided with medical care, not vision. Therefore, we will file a claim with your medical insurance for visits related to medical complaints and problems. If a refraction (determination of glasses prescription) is performed on the same day as a medical visit, you may owe up to $45 for this non-covered service.

  For patients without vision coverage: If you are being seen for a routine well-vision exam and do not have vision coverage, your medical insurance will not pay for the exam.

  For patients with medical coverage: If you have a medical complaint (corneal disorder, diabetes, flashes and floaters, painful or red eyes, cataracts, glaucoma suspect, double vision, dry eyes, etc.), the medical portion of your exam can be billed to your medical insurance. However, refraction (measurement of your prescription) is not usually covered by major medical insurance and you will be charged $45 in addition to your medical deductible, copay, and coinsurance.

- **Acknowledgement of Notice of Privacy Practices(ANPP)** (attached to your clipboard and also available on our website)

The law requires that Clark Family Eye Care, d/b/a Frisco In Focus, make every effort to inform you of your rights related to your personal health information. By signing below, I acknowledge that: (please choose one)

____ I was given the opportunity to read, have read or had explained to me Clark Family Eye Care, PLLC's Notice of Privacy Practices prior to any services offered, OR

____ The Notice of Privacy Practices **could not be read** due to the emergent nature of the care and will be acquired as soon as possible.

I authorize Clark Family Eye Care, PLLC to release my personal health information to the following individuals:_____

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

____ I authorize the release of medical information to my vision plan, or

____ I do NOT authorize release of medical information to my vision plan.

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

_____ _____ _____

Patient Printed Name 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 you have the legal responsibility to make decisions for the minor.

_____ _____

Representative Name Relationship to Patient

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Wellness Screening Scan and Dilation

Vision-threatening diseases such as glaucoma, age-related macular degeneration, diabetic retinopathy, retinal tears or retinal detachments, and ocular tumors often have no outward signs or symptoms in the early stages, so our practice has begun using state-of-the-art technology to assess the health of your eyes.

Your doctor recommends a Wellness Screening Scan on all patients. This screening technology

***Is a quick, non-invasive scan that allows our doctor to document the inside of the back of your eye and screen for early signs of macular degeneration and glaucoma**
***Involves No Blur, No Dilation, No Light Sensitivity, No Stinging Drops**
***Provides a permanent record to compare and track eye disease**

In addition, I understand that patients with diabetes and certain medical eye complaints must be dilated at each medical visit. Dilation gives a wider view of the anterior portion of the eye and gives the best view of cataracts and retinal holes/detachments. Dilation drops will cause light sensitivity and difficulty reading up close for 3-5 hours. Your doctor will discuss if this is necessary in addition to the wellness screening at this visit.

*******I understand the $39 wellness screening copay is not covered by my vision or medical insurance and will be added into the cost of my visit today. *******

Patient's Printed Name: _____ Date:_____

ACCEPT $39 screening _____ or DECLINE _____

Patient or Parent's Signature Patient or Parent's Signature

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. **Contact lens wearers** – A contact lens and corneal health evaluation is required annually to renew a contact lens prescription. Do you plan to continue contact lens wear and need your contact lens prescription renewed this year? **Yes / No**

2. **Non-contact lens wearers**- Are you interested in learning about contact lens options? **Yes / No**

3. **All Patients**- Do you need to meet with an optician to order your glasses and/or contact lenses today? **Yes / No**

Medical History
Review of Systems Form

Date:_____ Name:_____ Date of Birth:_____

Address:_____Email Address:_____

Occupation: _____ Phone: _____ Primary Care Doctor:_____

Medical Ins Co_____ Member Name _____Member DOB_____Member ID # _____

Do you currently have:

Constitution:
- ◯ Developmental Disability
- ◯ Cancer
- ◯ Fatigue Syndrome

Ears, Nose, Throat:
- ◯ Hearing Loss
- ◯ Sinusitis
- ◯ Dry Mouth

Neurological:
- ◯ Multiple Sclerosis
- ◯ Epilepsy
- ◯ Tumor
- ◯ Migraine

Psychiatric:
- ◯ Anxiety
- ◯ Depression
- ◯ Attention Deficit
- ◯ Bipolar Disorder

Cardiovascular:
- ◯ Hypertension
- ◯ Stroke
- ◯ Heart Disease

Respiratory:
- ◯ Asthma
- ◯ Bronchitis
- ◯ Sleep Apnea

Gastrointestinal:
- ◯ Crohn's
- ◯ Ulcerative Colitis
- ◯ Ulcer
- ◯ Acid Reflux

Genitourinary:
- ◯ Kidney Disease
- ◯ Prostate Disease/Cancer
- ◯ Pregnant
- ◯ Nursing
- ◯ STD

Musculoskeletal:
- ◯ Arthritis
- ◯ Fibromyalgia
- ◯ Ankylosing Spondylitis
- ◯ Osteoporosis

Skin:
- ◯ Eczema
- ◯ Psoriasis
- ◯ Rosacea
- ◯ Cold Sores
- ◯ Shingles

Endocrine:
- ◯ Diabetes Type 1
- ◯ Diabetes Type 2
- ◯ Thyroid Dysfunction

Hematology/Lymph:
- ◯ Anemia
- ◯ High Cholesterol
- ◯ Other_____

Allergic/Immunologic:
- ◯ Lupus
- ◯ Sjogren's Syndrome

Ocular:
- ◯ LASIK Surgery: year_____
- ◯ Cataract Surgery: year_____
- ◯ Strabismus
- ◯ Other_____

Tobacco use: Yes /No/Former _____/Day

Alcohol use: Yes/No _____Per Day / Week / Month

Current Medications (including vitamins):

Allergies to Medications:

Family History:

Please specify WHO in your Family (Father, Mother, Sister, Brother, Son, Daughter) has these conditions:

◯ Diabetes Type 1	**Family Member:**	◯ Cataracts	**Family Member:**
◯ Diabetes Type 2	**Family Member:**	◯ Glaucoma	**Family Member:**
◯ High Blood Pressure	**Family Member:**	◯ Macular Degeneration	**Family Member:**
◯ Cancer	**Family Member:**	◯ Retinal Detachment	**Family Member:**
◯ Hyperthyroidism	**Family Member:**	◯ Diabetic Eye Disease	**Family Member:**
◯ Hypothyroidism	**Family Member:**	◯ Other	**Family Member:**