THOMAS VISION CLINIC

Exceeding Your Expectations
in EYEcare

A MEMBER OF Vision Source

Dr. C. Mark Cowan OD
Dr. Cherri T. Cowan OD
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Office Use Only ☐ Optomap ☐ Dilation ☐ Refusal ☐ Refraction ☐ Eye Health ONLY

☐ Glasses ☐ Contact Lenses

☐ Male ☐ Female

Race: ☐Asian ☐African American ☐Hispanic ☐White ☐Native American ☐Pacific Islander ☐Other

First Name Mi Last Name Preferred Name

Mailing Address City State Zip

Social Security # Date of Birth E-mail address

Home Phone Day Phone Cell Phone

Patient Status: ☐ Minor (17&younger) ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Parent/Guardian/Responsible Party (if other than patient):

First Name MI Last Name Phone Number

Primary Insurance: ______________________________

Company Member/Sponser ID # Member Date of Birth

Secondary Insurance: ______________________________

Company Member/Sponser ID # Member Date of Birth

Primary Care Physician: ______________________________

Pharmacy: ______________________________

Contact Lenses

Please keep in mind that contact lenses are considered medical devices and require additional follow-up care to ensure proper fit. The professional fee for the fitting of contact lenses is **separate from & additional to** the eye health exam & refraction. This fee ranges from $70.00 & up. The cost is determined by prescription requirements and covers corneal assessment, all diagnostic contact lenses and all follow-up visits.

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Patient Name: ______________________________

AUTHORIZATION & ACKNOWLEDGEMENT

1. READ   2. CHECK ALL THAT YOU AUTHORIZE   3. SIGN & DATE

PLEASE READ

PLEASE READ

Eye Exam Part 1: Eye Health

Eye health reveals EARLY signs of high blood pressure, heart disease, diabetes, stroke, multiple sclerosis, cholesterol, arthritis, sight damaging eye diseases and certain cancers. FYI: Glasses DO NOT prevent blindness.

Select how you want this exam performed.

Patients 8 years & older

Please select one

☐ Optomap® (*recommended by Dr. Cowan*) **$32.00**

Digital photos are taken of your eyes for you to view with Dr. Cowan - eye drops are NOT used

☐ Dilation - no extra charge

Eye drops are used – eyes are examined without the use of photos

Patients 7 & younger

☐ Dilation is required to determine the need for corrective eyewear. – no extra charge

Eye Exam Part 2: Vision

☐ The **refraction** is the vision part of an eye exam. It determines your need & prescription powers for glasses or contact lenses. It is NOT covered by MEDICAL insurance because it is NOT MEDICAL. If you do not have a plan that allows for routine vision care, a **fee of $20.00** will be due in addition to any copays or deductibles. **All Bayou Health Plans & VSP cover this fee.**

☐ **Release of Information -** I hereby authorize Thomas Vision Clinic to release any information necessary to my insurance company for payment on my behalf. I authorize the release of medical information for the purpose of patient referral should I be referred. (If this is not marked, we will not file to your insurance company.)

☐ **Patient Financial Agreement -** I agree to be responsible for copays, deductibles & all non-covered procedures I elect to have performed. A copy of the financial disclosure statement is available to me upon request.

☐ **Medical Care Authorization -** I am authorizing Dr. Cowan to provide me with medical care that is thought to be in my best interest. I understand I may refuse in writing any service or services discussed with me.

☐ **Notice of Privacy Practices -** I have reviewed the Thomas Vision Clinic Privacy Practice Notice that describes how my information may be disclosed. A copy of this notice is available to me upon request.

☐ **Authorized Persons -** List person(s) you authorize to receive and discuss information regarding your personal health/medical information on your behalf

Name: ______________________________ Contact Number: ____________________

Name: ______________________________ Contact Number: ____________________

Signature: ______________________________ **Date:** ____________________

Expiration of Authorizations

These authorizations will expire 1 year from the date signed unless you or a guardian request that one or all be revoked prior to the expiration date of 1 year. Authorizations make be revoked in writing to the attention of Dr. Clifton M. Cowan, O.D. or Dr. Cherri T. Cowan, O.D. and brought directly to the clinic or mailed to Thomas Vision Clinic P.O. Box 681 Leesville, La. 71496

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Patient Name: ____

Medical & Health For Patient to Complete

Patient Weight: _______ lbs   Patient Height: _______ ft ______ inches

Do you consume alcoholic beverages: ☐ Never ☐ Occasionally ☐ 1 per day ☐ 2-3 per day ☐ 4+ per day

Smoking statues: ☐ Never ☐ Occasionally ☐ ½ pk daily ☐ 1 pk per day ☐ 1+ pks per day ☐ Quit in __________

Eye Surgeries:

☐ None ☐ On file / no changes
☐ Retinal Repair ☐ Eye Lid
☐ Lasik ☐ PRK
☐ Cataract ☐ Eye Muscle
☐ Other ____

Drug Allergies:

☐ No known drug allergies
☐ On file / no changes
☐ Other: ________________________________

Major Health Issues:

☐ None ☐ Multiple Sclerosis
☐ Fatigue ☐ Seizure
☐ Heart Disease ☐ Depression / Anxiety
☐ High Blood Pressure ☐ Diabetes Type 1
☐ Stroke ☐ Diabetes Type 2
☐ Asthma ☐ Cholesterol
☐ COPD ☐ Lupus
☐ GERD/Acid Reflux ☐ Allergies
☐ Arthritis ☐ Other ________________

Medications

☐ No medications taken
☐ On file / no changes
☐ See list or please list below

____
____
____
____
____
____
____

Family EYE History

Select relationship to PATIENT

☐ No known / None

Amblyopia: ☐ Father ☐ Mother ☐ Sibling ☐ Child
Blindness: ☐ Father ☐ Mother ☐ Sibling ☐ Child
Cataract: ☐ Father ☐ Mother ☐ Sibling ☐ Child
Color Blindness: ☐ Father ☐ Mother ☐ Sibling ☐ Child
Eye Tumors: ☐ Father ☐ Mother ☐ Sibling ☐ Child
Glaucoma: ☐ Father ☐ Mother ☐ Sibling ☐ Child
Macular Degeneration: ☐ Father ☐ Mother ☐ Sibling ☐ Child
Retinal Detachment: ☐ Father ☐ Mother ☐ Sibling ☐ Child
Eye Turn / Strabismus: ☐ Father ☐ Mother ☐ Sibling ☐ Child

Family HEALTH History

Select relationship to PATIENT

☐ No known / None

Arthritis: ☐ Father ☐ Mother ☐ Sibling ☐ Child
Cancer: ☐ Father ☐ Mother ☐ Sibling ☐ Child
Diabetes: ☐ Father ☐ Mother ☐ Sibling ☐ Child
Heart Disease: ☐ Father ☐ Mother ☐ Sibling ☐ Child
Blood Pressure: ☐ Father ☐ Mother ☐ Sibling ☐ Child
Kidney Disease: ☐ Father ☐ Mother ☐ Sibling ☐ Child
Lupus: ☐ Father ☐ Mother ☐ Sibling ☐ Child
Stroke: ☐ Father ☐ Mother ☐ Sibling ☐ Child
Thyroid Disease: ☐ Father ☐ Mother ☐ Sibling ☐ Child

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Patient Name: ____________________________________

Dry Eye Questionnaire

How **FREQUENTLY** do you experience the following dry eye symptoms?

Symptoms	Never (0)	Sometimes (1)	Often (2)	Constant (3)
Dryness, Grittiness or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye's Feeling Tired				

How **SEVERE** are your dry eye symptoms?

Symptoms	No problems (0)	Tolerable – not perfect but not uncomfortable (1)	Uncomfortable – irritating but does not interfere with my day (2)	Bothersome – irritating and interferes with my day (3)	Intolerable – unable to perform my daily tasks (4)
Dryness, Grittiness or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

WHEN have you experienced these symptoms?

( ) Today ( ) Within the past 72 hours ( ) Within the past 3 months

Activities	Yes	No
Do your eyes bother you when reading?		
Do your eyes bother you when using a computer?		
Do your eyes bother you when driving?		
Do your eyes bother when watching television?		
Do contact lenses irritate your eyes?		
Do your eyes bother you when you're outdoors?		
Do your symptoms worsen throughout the day?		

Do you use drops and/or ointment? Yes No (Circle)

If yes, which drops and/or ointment do you use? ____________________________________

How frequently do you use the drops and/or ointment? ____________________________________

For the following questions, CIRCLE ONLY ONE ANSWER AND ROUND TO THE NEAREST HOUR

How many hours of sleep did you get last night?

<3 3 4 5 6 7 8 9 10 >10

On average, how many hours of sleep do you get each night?

<3 3 4 5 6 7 8 9 10 >10

For office use only

Total SPEED score (Frequency + Severity) = ______/28

For Military Dependents Only

TRICARE NONCOVERED SERVICES WAIVER

Date: ______________________

Sponsor Name: ____ Sponsor ID: ______________

Patient Name: ____ Patient ID:________________

Service Description

Procedure: ____

Approximate Cost: _______________________

Diagnosis: ____

Date of Service: ____________________

Provider Name:____

TIN: _________________________________

Address: ____

Physician Signature:____

I hereby affirm that I have been informed and I understand that these services are excluded or excludable under the TRICARE Program and therefore all costs associated with these services are not an allowable expense under The TRICARE Program. By signing the TRICARE noncovered services waiver, I am hereby agreeing in advance, in writing, to accept full financial responsibility for all costs associated with the noncovered medical services, described in this document under **"Service Description"** and performed by the named TRICARE Network Provider.

Patient Signature:____ Date: ___________

Beneficiary's or Legal Guardian's Signature:_________________________________ Date: ___________

Witness Signature:____ Date: ___________

TRICARE OPERATIONS MANUAL 6010.51-M, AUGUST 1, 2002
CHAPTER 5, SECTION 1

2.5.1. A network provider may not require payment from the beneficiary for any excluded or excludable services that the beneficiary received from the network provider (i.e. the beneficiary will be held harmless) except as follows:

- If the beneficiary did not inform the provider that he or she was a TRICARE beneficiary, the provider may bill the beneficiary for services provided.
- If the beneficiary was informed that the services were excluded or excludable and he/she agreed in advance in writing to pay for the services, the provider may bill the beneficiary. An agreement to pay must be evidenced by the written consent of the beneficiary to pay for the excluded services. General agreements to pay, such as those signed by the beneficiary at the time of admission, are not evidence that the beneficiary knew specific services were excluded or excludable.
- If the beneficiary has been notified, in writing, that the service would not be covered for any reason.

For a list of excluded or excludable services refer to:
TRICARE POLICY MANUAL 6010.54-M, August 1, 2002 CHAPTER 1 SECTION 1.1
ISSUE DATE: June 1, 1999 AUTHORITY: 32 CFR 199.4(g)

TRICARE is a Department of Defense program offered by Humana Military
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