THOMAS VISION CLINIC

A MEMBER OF VISION SOURCE

Exceeding Your Expectations
in EYEcare

Dr. C. Mark Cowan OD
Dr. Cherri T. Cowan OD
1100 North 5th Street
P.O. Box 681
Leesville, La. 71446
(337)239-2020 ph
(337)239-0755 fax

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: _____

1. How do you want your eye health checked (we'll check for eye diseases, high blood pressure, heart disease, diabetes, stroke, multiple sclerosis, cholesterol, etc.)? **PLEASE NOTE: Dr. Cowan strongly recommends that patients with diabetes have their eyes dilated.**

☐ Digital Imaging/Retinal Scanning (no eyedrops) = **$32.00 (NOT COVERED BY ANY INSURANCE)**

☐ Dilation (eyedrops used) = **$0** (ages 7 & younger MUST BE dilated to have an eye exam)

2. Do you want to be tested for a new prescription (for glasses or contact lenses)?

☐ Yes – $25.00 (some insurances will cover this service. Please ask if you are unsure about your plan.)

☐ No – I understand I will not receive a new prescription for glasses or contact lenses.

✓ **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 Portal –** Please provide your email address in order to create a secure patient portal for electronic communication between you & Dr. Cowan regarding your medical care.

Email: _____

✓ **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 -** The Thomas Vision Clinic Privacy Practice Notice has been made available for me to review which 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: _____ Phone Number: _____

Name: _____ Phone 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. & 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 per day ☐ 3 per day ☐ 4+ per day

Smoking status: ☐ Never ☐ Occasionall

Eye Surgeries:

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

Do you experience:

Light Sensitivity? ☐ Yes ☐ No
Burning? ☐ Yes ☐ No
Dryness? ☐ Yes ☐ No
Watering? ☐ Yes ☐ No
Eye Pain or Soreness? ☐ Yes ☐ No
Foreign Body Sensation / Irritation? ☐ Yes ☐ No
Itching? ☐ Yes ☐ No
Discharge? ☐ Yes ☐ No
Redness? ☐ Yes ☐ No
Grittiness or Scratchiness? ☐ Yes ☐ No

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:

_____
_____
_____

Drug Allergies:

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

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

OFFICE USE ONLY

☐ **External Photos** & ☐ **TearLab** *initial when completed ____

<table>
<tr>
<td rowspan="8">Reason:
☐ Keratitis
☐ Glaucoma
☐ Inflammation of the eyelids
☐ Other disorders of the eyelid
☐ Disorders of the conjunctiva
☐ Corneal scars & opacities
☐ Other disorders of the cornea
☐ Disorders of the iris & ciliary body
☐ Disorders of the lacrimal system
☐ Disorders of the orbit
☐ Other disorders of the eye
☐ Neoplasm of the eye
☐ Injury to the eye</td>
<td>Test Ordered For:
☐ OD ☐ OS ☐ OU</td>
<td>Decision Making
☐ Stable ☐ Worsening</td>
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<tr>
<td>Test Format
☐ Digital Image ☐ Slides
☐ Videotape ☐ Photographs</td>
<td>Clinical Issues
☐ Initiate Treatment
☐ Change Treatment</td>
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<tr>
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</tr>
<tr>
<td>Exam Technique
☐ Slit Lamp Photography
☐ Close-Up Photography</td>
<td>Narrative:</td>
</tr>
<tr>
<td colspan="2">TearLab Performed: ☐ Yes ☐ No
Results: _____ Right Eye _____ Left Eye
Tech: _____</td>
</tr>
</table>

Office Notes: _____

_____

_____

_____

_____

_____

Humana Military

TRICARE

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)