Texas State Optical Magnolia
6519 FM 1488, Suite 503
Magnolia, Texas 77354
Phone: (281) 946-2020 Fax: (281) 946-2025

Dr. Christy Y. Jew
Therapeutic Optometrist
Optometric Glaucoma Specialist

Patient Information

Mr.
Mrs. / Ms.
Dr. / Rev. Last Name: _____ First Name: _____ MI: _____ Suffix: _____
(Jr., Sr., etc.)

Today's Date: _____

Address: _____
City: _____ State: _____ Zip Code: _____-_____ Patient's SS#: _____-_____-_____
(if using insurance)

Cell Phone: (_____)_____ Work Phone: (_____)_____ DL#: _____ State: _____
(if paying by check)

Home Phone: (_____)_____ Email: _____
Other Phone: (_____)_____
Preferred Contact Method: cell phone home phone work phone email other: _____
(please circle one)

Date of Birth: _____/_____/_____ Occupation (or Grade in School): _____
Gender: male female Employer (or School Name): _____
(please circle one)

Marital Status: single married Parent/Guardian Name (if patient is a minor): _____
(please circle one) separated widowed

How did you find out about our office? _____
Is there anyone we can thank for referring you? _____

What is the purpose of today's visit? Eye Examination Contact Lens Evaluation Annual Diabetic Eye Exam
(please circle one) Glasses Purchase Contact Lens Purchase Other: _____

Insurance Information

Please note that routine Eye Examination insurance coverage does NOT automatically cover the contact lens fitting and evaluation fees.

VISION Insurance: _____
ID Number: _____
Policy/Group #: _____

If the patient is NOT the primary insured, please fill out information below.

Primary Insured Name: _____
Relationship to Insured: spouse child other
(please circle one)
Gender: male female
(please circle one)
Primary Insured's Address: ☐ SAME as patient
_____
City: _____ State: ___ Zip Code: _____
Phone #: (_____)_____ SS#: _____-_____-_____
Date of Birth (of primary insured): _____/_____/_____

MEDICAL Insurance: _____
ID Number: _____
Policy/Group #: _____

If the patient is NOT the primary insured, please fill out information below.

Primary Insured Name: _____
Relationship to Insured: spouse child other
(please circle one)
Gender: male female
(please circle one)
Primary Insured's Address: ☐ SAME as patient
_____
City: _____ State: ___ Zip Code: _____
Phone #: (_____)_____ SS#: _____-_____-_____
Date of Birth (of primary insured): _____/_____/_____

Please turn over and complete the next page →

Patient Vision & Medical History

Current Prescribed medications *(prescription eye drops, blood pressure, diabetes, cholesterol, thyroid, birth control, etc.):*

_____

_____

Current over-the-counter medications *(vitamins, eye drops, allergy, pain, sleep aid, etc.):*

_____

_____

Allergies to medications? ☐ Yes ☐ No If yes, please list: _____

Do you use cigarettes/tobacco, alcohol, or other substances? ☐ Yes ☐ No

If so, how much/how often? _____

Are you pregnant or nursing at this time? ☐ Yes ☐ No

Date of Last Eye Exam: _____

Name of Previous Eye Doctor: _____

Date of Last Physical Check-up: _____

Name of Family Physician: _____

Are **YOU** currently experiencing or have been previously diagnosed or treated for any of the following eye conditions? *(check all that apply)*

- ☐ Blurry vision (near or far)
- ☐ NONE
- ☐ Squinting
- ☐ Eye soreness or fatigue
- ☐ Double vision
- ☐ Headaches (vision related)
- ☐ Burning sensation
- ☐ Excess watering
- ☐ Dry/gritty feeling
- ☐ Redness
- ☐ Itching
- ☐ Glare/light sensitivity
- ☐ Floaters
- ☐ Flashes of light (sudden onset)
- ☐ Mucous discharge
- ☐ Chronic eye infections
- ☐ Eye Turn/Crossed Eye (Strabismus)
- ☐ Lazy Eye (Amblyopia)
- ☐ Eye injury _____
- ☐ Iritis/Uveitis
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Eye surgery (cataract, LASIK, RK, etc.) _____
- ☐ Other: _____

Have **YOU** ever been diagnosed or treated for any of the following health conditions? *(check all that apply)*

- ☐ Asthma
- ☐ Bronchitis
- ☐ NONE
- ☐ Emphysema
- ☐ Rosacea
- ☐ Stroke
- ☐ Diabetes *(Type 1 or Type 2)*
- ☐ Unusual weight loss/gain
- ☐ High blood pressure
- ☐ Fever
- ☐ High cholesterol
- ☐ Allergies/hay fever
- ☐ Rheumatoid arthritis
- ☐ Sinus infections
- ☐ Hearing loss
- ☐ Thyroid *(hyperactive or hypoactive)*
- ☐ Gastrointestinal problems _____
- ☐ Genitourinary problems _____
- ☐ Neurological problems _____
- ☐ Psychological problems _____
- ☐ Cancer _____
- ☐ OTHER _____

Is there any **FAMILY** medical history of any of the following? *(check all that apply --- list who in the family has the condition)*

- ☐ NONE
- ☐ Blindness _____
- ☐ Lazy eye _____
- ☐ Cataracts _____
- ☐ Glaucoma _____
- ☐ Macular Degeneration _____
- ☐ Corneal problems _____
- ☐ Retinal problems _____
- ☐ High blood pressure _____
- ☐ Diabetes _____

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Lifestyle Questionnaire

Thank you for taking the time to complete our Lifestyle Questionnaire.
It will help us better service your eyewear needs.

Name: _____ Age: _____

Occupation: _____

1.) How much time do you spend on the computer? (Please circle one)

1-3 hours 4-7 hours 8 or more hours

☐ YES ☐ NO 2.) Do you spend a lot of time in areas with low lighting?

☐ YES ☐ NO 3.) Do you work around hazardous materials (bio or chemical hazards)?

☐ YES ☐ NO 4.) Are you aware that glare (from fluorescent lighting, night driving, etc.) is a common source for eye strain and decreases the amount of light entering your eye?

☐ YES ☐ NO 5.) Are you interested in lenses that darken in sunlight?

☐ YES ☐ NO 6.) Do you have sunglasses?

☐ YES ☐ NO 7.) Are they polarized?

☐ YES ☐ NO 8.) Are you aware of the serious eye conditions that can develop from over-exposure to UV radiation?

9.) Do you participate in any sports or recreational activities?
If so, please circle all that apply

Football	Basketball	Baseball
Golf	Gardening	Jogging
Biking	Snow Sports	Boating/Water sports

Other _____

☐ YES ☐ NO 10.) Do your lenses ever fog up?
If so, are you interested in our NEW anti-fog & anti-glare lenses?

☐ YES ☐ NO 11.) Are you interested in learning about the NEW "electronic eyeglasses"?

Please turn over and complete the next page →

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Medical vs. Vision Benefits

We often have patients that carry BOTH medical and vision insurances. These types of insurances are very different in terms of services covered. Your vision plan provides you with a "routine" screening exam. This assumes perfectly healthy eyes that only suffer from problems like nearsightedness, farsightedness, astigmatism, and presbyopia. Your vision insurance will NOT pay for medical problems. Medical insurance allows us to provide a "comprehensive" exam including the refractive status and overall health of the eye and adnexa. If a medical diagnosis is determined at the end of your exam today, your medical insurance WILL be billed and you will be responsible for the medical office visit specialist co-pay, in lieu of the routine vision screening co-pay.

ROUTINE VISION EXAM	MEDICAL EXAM
Patient has no complaints.	Dry eyes, itchy eyes, blurry vision, floaters, red eyes, foreign body, CL complications, etc.
The eye is perfectly healthy.	Diagnosis of: diabetes, cataracts, contact lens overwear, glaucoma, macular degeneration, etc.
No prescriptions for medications are written.	Prescriptions for medications written if necessary.
VISION INSURANCE is BILLED *(The patient is responsible for the routine vision exam co-pay.)*	**MEDICAL INSURANCE is BILLED** *(The patient is responsible for the specialist office visit co-pay and any unmet insurance deductible.)*

By signing this agreement you are stating that you understand the vision vs. medical insurance policy and do hereby agree to be financially responsible for all charges for products and/or services rendered to you at Texas State Optical Magnolia.

Patient's Name (please print)**: _____**
Patient's Signature _____ **Date _____**
(Parent or Legal Guardian if patient is a minor)

TSO SATISFACTION GUARANTEE

6-WEEK DOCTOR PRESCRIPTION GUARANTEE
If you had your eyes examined by Dr. Christy Y. Jew and you experience visual discomfort after an initial adaptation period with your new prescription eyewear, your eyes will be re-examined within six weeks of the initial visit at no additional charge. If a change is necessary due to a doctor's or optician's error, TSO Magnolia will replace the lenses and/or frame at no additional charge to you.

6-WEEK CONTACT LENS GUARANTEE FIT
If you are not satisfied with your contact lenses, you may return them within six weeks of the initial visit for a refund on any unopened boxes, minus a 10% contact lens restocking fee. However, the Doctor's exam and contact lens fitting fees are non-refundable.

FREE LIFETIME SERVICE ON GLASSES
TSO Magnolia will provide FREE cleaning and adjustments for the life of your glasses.

BASIC FRAME AND LENS WARRANTY* **FRAME AND LENS WARRANTIES ARE ALSO SUBJECT TO THE SPECIFIC REQUIREMENTS OF SOME INSURANCE PLANS.*
Should your frames break or your lenses scratch within the first year after purchase, we will replace them. This warranty DOES NOT cover budget or closeout frames, TSO special frame and lens packages, uncoated lenses, loss, theft, damage by pets, or abuse of the eyewear.

PREMIUM WARRANTY* **FRAME AND LENS WARRANTIES ARE ALSO SUBJECT TO THE SPECIFIC REQUIREMENTS OF SOME INSURANCE PLANS.*
Should your premium lenses (Crizal, transitions, Varilux progressive lenses) or frames become unserviceable within two years of purchase, TSO Magnolia will replace them one time at no charge. This warranty DOES NOT cover budget or closeout frames, TSO special frame and lens packages, uncoated lenses, loss, theft, damage by pets, or abuse of the eyewear.

PROGRESSIVE ("NO-LINE") MULTIFOCALS
If you are unable to adjust to your progressive lenses, TSO Magnolia will exchange them for either Single Vision, lined Bi-focal or Tri-focal lenses at no additional charge within 60 days of initial purchase.

45-DAY SATISFACTION GUARANTEE ON GLASSES
If within 45 days from date of purchase you are not satisfied with your glasses, we will adjust or replace your glasses. A 50% restocking fee will be accessed on all frame and/or lens changes. Accidental damage such as scratches or broken parts, is not covered under this 45-Day Satisfaction Guarantee, but is covered under the TSO of Magnolia Basic Frame and Lens Warranty Plan as stated above.

I understand the TSO Satisfaction Guarantee and agree to the warranties as stated above. _____
(initial here)

Dilation of the Pupils

Dilation of the pupils is included as a part of your full annual eye exam. If you have a condition such as diabetes, high blood pressure, cataracts, headaches, high myopia (nearsightedness), symptoms of flashes of lights or floaters, glaucoma or a family history of glaucoma, dilation is even more an important part of your eye exam. By dilating your pupils, many diseases both in your eyes and body can be detected long before any signs or symptoms arise. Dilation involves placing drops in your eyes to enlarge the pupil size.

When an eye is dilated, we are able to get a much broader and fuller view of the inside of the eye. This aids the doctor in determining if diseases (such as macular degeneration, glaucoma and tumors) are present, if there is damage to the retina (such as holes or tears) and also in the evaluation of cataracts.

With dilation of the eyes you may experience the following effects:

- Increased sensitivity to light
- Inability to focus up close
- A slight blurring of your distance vision

These effects may last from 1 to 4 hours.

Please *check one* of the following options and sign below:

_____ I **DO** consent to having my eyes dilated.

_____ I do understand the importance of the dilation, yet I **DO NOT** wish to have it performed at this time. I release Dr. Christy Y. Jew from any liabilities related to the failure to diagnose or treat any eye condition due to the lack of diagnostic information which could have been obtained by the test.

Patient's Name (please print)**: _____**
Patient's Signature _____ Date _____
(Parent or Legal Guardian if patient is a minor)

Payment Policy

PAYMENT POLICY: Payment is expected at the time services are rendered. Glasses and contacts require complete prepay before the order is made. Uncollected fees, either from insurance, insufficient funds check, stop payment, credit card charge-backs, etc. remain the responsibility of the patient (parent or legal guardian, if a minor). When insurance benefits are verified, the information provided by the customer service representative is NOT a guarantee of payment. There may be additional fees for co-pays, deductibles, and other non-covered services after payment if received from the insurance company. If a credit card was used to pay for services initially, you agree to allow us to charge that credit card for any unpaid balances. In addition you agree to pay all fees incurred to collect on your account, if necessary. Unpaid balances accrue interest at the rate of 1.5% monthly (18% APR) and are sent to a Collection Agency after 45 days.

By signing this agreement you do hereby agree to be financially responsible for all charges for products and/or services rendered to you at our office.

Patient's Signature: _____ Date: _____
(Person responsible for payment, if patient is a minor)

Assignment of Benefits

ASSIGNMENT OF BENEFITS: *(Only applicable if we are filing with a Vision or Medical Insurance for you.)*
"I hereby authorize my insurance/medical benefits to be paid directly to Dr. Christy Y. Jew. I further authorize release of any medical records or information necessary to process this claim". This assignment of benefits may be revoked by the patient at anytime, with prior written notice.

It is our pleasure to help you file your insurance claim forms or take assignment of your benefits as designated by the vision plan of which you have indicated you are a member. We provide this service at no additional cost to you and will do all that we can to help you receive the maximum benefits allowable under your plan.

In the event the Plan Sponsor determines that you were not eligible at the time of service or makes a determination that you were eligible for a reduced level of coverage, by signing this agreement, you do hereby agree to be financially responsible for any and all of the charges incurred by you and not paid by the Plan Sponsor.

Patient's Signature: _____ Date: _____
(Person responsible for payment, if patient is a minor)

Please turn over and complete the next page →

Authorization and Consent

I certify that I have read and understand the **Patient Information Sheet** dated _____*(today's date)* to the best of my knowledge. The questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the eye doctor to release any information including the diagnosis and the records of any treatment of examination rendered to my child or me during the period of such eye care to third party payers and/or health practitioners. I further authorize any holder of any medical information about me to release to any medical benefits provider information necessary to determine my eligibility and/or benefits.

I authorize and request my insurance company to pay directly to the eye doctor or ophthalmic group insurance benefits otherwise payable to me. I understand that my eye care insurance carrier may pay less than the actual bill for services; therefore, I agree to be responsible for payment of the balance of all services rendered on my behalf or that of my dependants. Upon future visits to this practice, I will review the **Patient Information Sheet,** make all necessary changes and sign, and date a new Authorization. I have the right to revoke this Authorization at any time by providing the practice with a signed written request. Until such a request is received, the Authorization will be in effect for six years from the date of the most recent signed Authorization.

I have the right to expect my personal health information to be protected as outlined in the Notice of Privacy Practices below. The terms of the notice may change. If I desire, a copy of the new notice will be provided to me by requesting one in writing from this practice. I can request to have my consent to use my Protected Health Information revoked at any time with a signed written request to this practice.

General Consent:

Can we leave confidential messages such as appointment reminders on your home phone answering machine or voicemail? Or, if you gave us another phone number to call, can we do the same on that phone number? ☐ Yes ☐ No

If you do not have an answering machine or voicemail, can a confidential message be left at your place of employment? ☐ Yes ☐ No

Patient's Name (please print)**: _____**

X _____ _____
SIGNATURE OF PATIENT (or parent/guardian if patient is a minor) **DATE**

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your point of contact about your rights to access your Health Records or complaints and comments about your health record privacy is:

TSO HIPAA Director
6519 FM 1488, Suite 503
Magnolia, Texas 77354

You may file a complaint with the Director of HHS. We will use your Protected Health Information to provide appointment reminders, describe or recommend treatment alternatives and provide information about health related benefits and services that may be of interest to you. We will maintain the privacy of your health records, provide this notice to you, abide by the terms of this notice and reserve the right to revise the privacy practices of this office.

You have the right to review or to copy your health records, request changes or offer amendments to your records, obtain a accounting of to whom we have disclosed information from your records and request restrictions on certain uses and disclosures from your health records. You also have the right to revoke our ability to disclose your health information by providing the practice with a signed written request. Until such a request is received, this notice will be in effect for six years from the date of the most recently signed notice.

Patient's Name (please print)**: _____**

X _____ _____
SIGNATURE OF PATIENT (or parent/guardian if patient is a minor) **DATE**