Office of J. E. Gundersheimer .O.D.

600 E. Taylor St., Ste 210
Sherman, TX 75090
Phone: (903) 868-1135
Fax: (903) 891-0181

Patient Information

Name (Last, First, MI)		Preferred Name	Today's Date
Address	City	State	Zip
Home Phone ( ) Preferred ☐	Work Phone ( ) Preferred ☐	Cell Phone ( ) Preferred ☐	
SSN	Date of Birth	Gender ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Partner ☐ Other
Race	Ethnicity	Preferred Language	Email address

Is patient responsible party/guarantor? ☐ Yes ☐ No (If you are over the age of 18 and not in the care of an institution you are the guarantor as you are the person financially responsible for any charges you may incur during your visit).

Financially Responsible Party

Name	Address	City/State/Zip	Relationship to Patient
Occupation	Employer	Email Address	Date of Birth
Home Phone ( ) Preferred ☐	Work Phone ( ) Preferred ☐	Cell Phone ( ) Preferred ☐	

Emergency Contact

Name	Relationship to Patient
Home Phone ( ) Preferred ☐	Work Phone ( ) Preferred ☐	Cell Phone ( ) Preferred ☐

Referral Information

Referring Physician's Name	Physician Phone/Fax (if known) ( )
Physician Address	

Primary Care Physician

Primary Care Physician's Name (Check if same as Referring Physician above ☐)	Physician Phone/Fax (if known) ( )
Physician Address	

Insurance Information

Primary Insurance Company	Policy #	Group #
Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____	Name of Subscriber (if other than patient)	
Subscriber's Social Security #	Gender ☐ Male ☐ Female	Date of Birth	Employer of Subscriber	Work Phone ( )
Secondary Insurance Company	Policy #	Group #
Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____	Name of Subscriber (if other than patient)	
Subscriber's Social Security #	Gender ☐ Male ☐ Female	Date of Birth	Employer of Subscriber	Work Phone ( )

By signing below, I acknowledge that the information I provided is correct to the best of my ability.

Patient Signature: _____ Date: ___/___/___

Guarantor Signature (if other than patient): _____ Date: ___/___/___

Turn page over →

Medical History Information

For faster service, please complete the following form upon arrival at our office.

Appointment Date:_____

Please check box

Today Exam is for: ☐ Glasses ☐ Contacts ☐ Both

Do you wear glasses? ☐ Yes ☐ No If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? ☐ Soft ☐ Extended ☐ Other

Present Medications

List Prescription Medication only

Height__" __ Weight_____ lbs.

Any allergic reactions to medications or other substances? ☐ Yes ☐ No

If yes, please list _____.

Are you Pregnant/Nursing? Yes or No

Please check Yes or No

Do you smoke? ☐ Yes ☐ No How Much? _____

Do you drink alcohol ☐ Yes ☐ No How Much? _____

Do you use other Substances? ☐ Yes ☐ No

Do you have any of the following? If yes, please check box.

- ☐ Diabetes Type ____
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Retinal Detachment
- ☐ High blood pressure
- ☐ Macular Degeneration

Family Medical History

Does any of the family have the following? If yes, please check box.

- ☐ Diabetes Type ____
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Retinal Detachment
- ☐ High blood pressure
- ☐ Macular Degeneration

Personal Medical Information: Which of the following conditions do you experience? Please check all that apply.

- ☐ Diabetes Type ____
- ☐ Ear/Nose/Throat
- ☐ Cardiovascular
- ☐ Respiratory
- ☐ Headaches
- ☐ Nervous System
- ☐ Cancer
- ☐ Musculoskeletal
- ☐ Skin
- ☐ HIV/AIDS
- ☐ Psychiatric
- ☐ Endocrine (Glands)
- ☐ Blood/Lymphatic
- ☐ Sinus Trouble
- ☐ Hepatitis A, B or C

Have you considered Laser Vision Correction? ☐ Yes ☐ No

Please sign below that you have reviewed all information above and it is correct to the best of your knowledge.

_____ _____

Signature Date

Office of J. E. Gundersheimer, O.D.

Refraction and Contact Lens Fee Schedule and Explanation

Refraction: Current Charge $75 ($75 to be paid at the time of service)

Thank you for choosing Eye-do Optical for your eye care needs. We **WILL** need to perform a vision test called a **"Refraction"** to check your vision today. This is an essential part of ophthalmologic evaluations. Our office fee for refraction is $75 ($75 if it is billed to you) and unless your plan automatically covers the refraction charge, **this fee is due at the time of service** in addition to any co-payment or deductible you plan requires.

Most insurance companies including Medicare DO NOT COVER the refraction portion of the eye exam.

Contact Lens Fitting and Evaluation (if applicable)

Contact lenses are an alternative to glasses which often provide both functional and cosmetic advantages. They are, however, medical devices which can potentially cause eye problems if they are poorly fit, or cared for improperly.

Contact lens fittings and subsequent regular evaluations are additional services and are not included in the cost of your eye exam. Medical insurance does not cover these contact lens related services, but some vision plans do pay for part of the contact fees.

Contact Lens Prescriptions are valid for one year by state law. Payment is required at the time your contacts are dispensed.

Current Standard Annual Contact Lens Fitting Fees are as follows:

Spherical/Aspherical: $100.00	Multifocal Soft: $150.00	RGP Trifocal: $180.00
Toric: $115.00	Multifocal Soft Toric: $170.00	Standard Tint: $110.00
Toric Custom: $125.00	RGP Spherical: $125.00	Custom Tint: $135.00
Monovision: $115.00	RGP Toric $145.00	
Modified Monovision: $125.00	RGP Bifocal: $170.00	

The above fees include instruction on the proper care, insertion and removal of your contacts and follow-up for a full calendar year with the following exclusions: eye infections or non-contact lens related issues.

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service and understand it is due at the time of service.
I also understand that any co-payment, coinsurance, or deductible it may have been separate from and not included in the refraction fee, and are also due at the time of service.

_____ _____

Signature Date

Consent for Digital Wellness Screening Test

As part of our commitment to provide you with the most comprehensive eyecare, weare pleased to announce a new and exciting screening service which allows Dr. Gundersheimer to diagnose certain medical conditions (Glaucoma, Macular Degeneration, Diabetic Retinopathy, Retinal tumors, holes, tears, and detachments, etc.) much earlier than in a standard comprehensive eye exam! These are conditionswhich can develop without warning and potentially impair or rob you of your vision permanently.

The Maestro 2 allows us to take a high-definition photograph plus the equivalent of an "MRI" of the back of the eye. This scan, an OCT, allows Dr. Gundersheimer to examine the microcellular layers of your retinas. The test is easy, rapid, non-invasive,radiation-free, and totally painless.

Dr. Gundersheimer strongly encourages the test on all patients at their initial exam, and thereafter every couple of years, especially for any of the following:

- Spots, flashes, or floaters
- Family history of glaucoma
- High blood pressure
- Family history of macular degeneration
- Diabetes
- Strong eyeglass prescription
- Eye pain/Headaches
- History of head or eye trauma

The screening exam is not covered under insurance and costs only $49. Should their indications during the rest of your eye examination which require a medical diagnosis and/or more extensive testing, medical insurance will likely cover those expenses when scheduled for a later date. The opt-in screening fee will be applied to your examination charges and due at checkout.

☐ **I DO** wish to participate in the **Maestro 2** advanced vision screening to assist in early detection of eye disease and understand that I am responsible for the above feesince it is not covered by my insurance.

☐ **I DO NOT** wish to participate in the **Maestro 2** screening imaging at this time.

Print Name: _____

Signature: _____ Date: ___/___/_____

Collection/Payment Policy

We are committed to providing our patients with the best possible vision/medical care and minimizing administrative costs. This Financial Policy has been established with these objectives in mind, and to avoid any misunderstanding or disagreement concerning payment for professional services.

- Our office participates insurance companies and managed health care programs. For patients that are members of these plans, our business office will submit a claim for services rendered. If a patient as insurance that we do not participate in, our office is happy to provide you with the proper paperwork for you to file a claim: however, payment in full is expected at the time of service.
- It is the patient's responsibility to pay any deductible, co-payment, or any portion of the charges as specified by the plan at the time of visit. Any services not covered by an individual's insurance plan are the patient's responsibility and payment in full is due at the time of the visit.
- Payment for professional services can be made with Cash, Check, MasterCard, Visa, Discover or American Express.
- Patient's that do not have insurance are expected to pay for professional services at the time of service unless prior arrangements have been made.
- I understand that I will be legally responsible for all collection costs involved with the collection of this account including court cost, reasonable attorney fees, and all other expenses incurred with collection if I default on any unpaid balance.
- it is the patient's responsibility to provide us with current insurance information and to bring their insurance card to each visit.
- Our staff will be happy to answer questions relating to how a claim was filed, or regarding additional information requested from the insurance carrier. However, specific coverage issues will need to be addressed by the insurance company's member services department with the number on your insurance card.

Responsible Party for Minors (under 18 years of age)

- We assign all financial responsibility to the parent/guardian that completes and signs the patient registration form. Any amount due at the time of service is expected from the parent/guardian accompanying the minor at the visit. In the event that a divorce decree assigns distinct financial responsibility for medical bills to another individual, we still hold the registering parent/guardian responsible.

Our practice firmly believes that a good physician/patient relationship is based upon understanding, and good communications. Questions about financial arrangements should be directed to the physician's office. We are here to help you.

Please sign and date that you have read and agree with the Financial Policy of J. E. Gundersheimer, C.D.

_____ _____

Signature of Patient/Responsible Party Date

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ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

The law requires that J.E. Gundersheimer, O.D. Doctor of Optometry make every effort to inform you of your rights related to your personal health information. By mysigning below, I acknowledge that:

- ☐ I have read or had had explained to me J.E. Gundersheimer, O.D. Doctor of Optometry's Notice of Privacy Practice and agree to continue my care with J.E.Gundersheimer, O.D. Doctor of Optometry under said terms.

- ☐ I have read or had explained to me J. E. Gundersheimer, O.D. Doctor of Optometry's Notice of Privacy Practice and do not wish to continue my care with J.E. Gundersheimer, O.D. Doctor of Optometry under said terms.

- ☐ The Notice of Privacy Practice could not be read due to the emergent nature of the care of other reason described as: _____
  _____

I have received a copy of [Practice's] Notice of Privacy Practices effective [Date].

Name (please print): _____
Signature:_____ Date: ___/___/_____

I am a parent or legal guardian of _____ (patient name). I have received acopy of [Practice's] Notice of Privacy Practices effective [Date].

Name (please print): _____
Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____ Date: ___/___/____