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 Demographic Form

Please PRINT

Patient Information

Name (Last, First, MI)	Preferred Name	Today's Date

Street 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

Financially Responsible Party

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)

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 Info

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

Physician Address

PCP Info

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: _____/_____/_____

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

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

If yes, please list _____

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

☐ Diabetes Type _____ ☐ Cataracts ☐ Retinal Detachment

☐ Glaucoma ☐ High blood pressure ☐ Macular Degeneration

Height __'____" Weight_____ Are you Pregnant/Nursing? Yes ☐ No ☐ If so, how many weeks? _____

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 ☐

Family Medical History

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

☐ Diabetes Type _____ ☐ Glaucoma ☐ High blood pressure

☐ Cataracts ☐ Retinal Detachment ☐ Macular Degeneration

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

☐ General/Constitutional ☐ Nervous System ☐ Psychiatric

☐ Ear/Nose/Throat ☐ Cancer ☐ Endocrine (Glands)

☐ Cardiovascular ☐ Musculoskeletal ☐ Blood/Lymphatic

☐ Respiratory ☐ Skin ☐ Sinus Trouble

☐ Headaches ☐ HIV/AIDS ☐ 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 _____/_____/_____

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, O.D.

_____ _____

Signature of Patient/Responsible Party Date

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 my signing 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 a copy of [Practice's] Notice of Privacy Practices effective [Date].

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

Signature: _____ Date: _____/_____/_____

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

Refraction and Contact Lens Fee Schedule and Explanation

Refraction: Current Charge $45 ($45 to be paid at the time of service)

One of the most important parts of your eye exam today is the refraction. That is the part of the exam by which we determine whether you can be helped in any way by a new glasses prescription. It is also how we determine the best possible visual acuity and function of your eye, which is essential information for us to have as we assess your eyes and look for problems. It is NOT a covered service by Medicare and many other insurance plans. These plans consider a refraction a "vision" service not a "medical" service. Our office fee for refraction is $45 ($45 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 your plan may require. Should your plan pay us for the refraction, we will reimburse you accordingly.

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. As a contact lens wearer, we provide your ongoing care to insure the best possible visual results, safety, and patient satisfaction.

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. All contact lens related follow up appointments for routine contact lens care for a full calendar year are included, as are the trial lenses that are dispensed.* **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:

Standard Spherical: $60.00	Multifocal Soft Toric: $110.00
Toric: $75.00	Gas Permeable Sphere: $90.00
Toric Custom: $80.00	Gas Permeable Toric/Bitoric: $100.00
Monovision: $75.00	Gas Permeable Bifocal: $120.00
Modified Monovision: $80.00	Gas Permeable Trifocal: $125.00
Multifocal Soft: $100.00	

The above fees include instruction on the proper care, insertion and removal of your contacts and follow-up *(Does not include consultations for 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 I may have are separate from and not included in the refraction fee, and are also due at the time of service.

_____ _____

Signature Date