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 Bth
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 C] 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

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: __/__/____

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

Refraction and Contact Lens Fee Schedule and Explanation

Refraction: Current Charge $50 ($50 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 $50 ($50 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 payus 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: $65.00
Colored Spherical: $75.00
Toric: $80.00
Toric Custom: $85.00
MonoVision: $80.00
Modified Monovision: $85.00

Multifocal Soft: $105.00
Multifocal Soft Toric: $115.00
Gas Permeable Sphere: $95
Gas Permeable Bifocal: $125
Permeable Trifocal: $130.00

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 notincluded in the refraction fee, and are also due at the time of service.

______________________ Signature

______________________ Date

Notice of Privacy Practices

Jerome E. Gundersheimer, O. D. - Doctor of Optometry
600 E. Taylor St., Ste. 210 Sherman, TX 75090
(903) 868-1135 ***www.eye-do-texoma.com***
Jerome E. Gundersheimer, O.D., Privacy Official

IN COMPLIANCE WITH THE FEDERAL REGULATIONS OF HIPAA'S PRIVACY RULE, THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO IT

We respect our legal obligation to keep health information that might identify you private. We are obligated by law to provide you with this notice of our privacy practices. This notice describes how we will protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS:

The most common reasons we would use or disclose your health information are for treatment, payment, or business operations. We routinely use and disclose your medical information within the office on a daily basis. We do not need specific permission to use or disclose your medical information in the following matters, although you have the right to request that we do not.

Examples of how we might use or disclose health information for treatment purposes might include:

Setting up or changing appointments including leaving messages with those at your home or office who may answer the phone or leaving messages on answering machines; voice mails or e-mails; calling your name out in a reception room environment; prescribing glasses, contact lenses, or medications as well as relaying this information to suppliers by phone, fax or other electronic means including initial prescriptions and requests from suppliers for refills; notifying you that your ophthalmic goods are ready, including leaving messages with those at your home or office who may answer the phone, or leaving messages on answering machines, voice mails, text messages, or emails; referring you to another doctor for care not provided by this office; obtaining copies of health information from doctors you have seen before us; discussing your care with you directly or with family or friends you have inferred or agreed may listen to information about your health; sending you postcards or letters or leaving messages with those at your home who may answer the phone or on answering machines; voice mails, text messages, or e-mails reminding you it is time for continued care; e-mails regarding topics related specifically to eye care.

Examples of how we might use or disclose health information for payment purposes might include:

Asking you about your vision or medical insurance plans or other sources of payment; preparing and sending bills to your insurance provider or to you; providing any information required by third party payors in order to insure payment for services rendered to you; collecting unpaid balances either ourselves or through a collection agency, attorney, or district attorney's office.

Examples of how we might use or disclose health information for business operations might include:

Financial or billing audits; internal quality assurance programs; participation in managed care plans; defense of legal matters; business planning; certain research functions; informing you by mail, text message, or e-mail of special savings promotions, new products, or services offered by our office; compliance with local, state, or federal government agencies' requests for information; oversight activities such as licensing of our doctors; Medicare or Medicaid audits.

USES AND DISCLOSURES FOR OTHER REASONS NOT NEEDING PERMISSION

In some other limited situations, the law allows us to use or disclose your medical information without your specific permission. Most of these situations will never apply to you but they could:

- When a state or federal law mandates that certain health information be reported for a specific purpose.
- For public health reasons, such as reporting of a contagious disease, investigations or surveillance, and notices to and from the federal Food and Drug Administration regarding drugs or medical devices.
- Disclosures to government or law authorities about victims of suspected abuse, neglect, domestic violence, or when someone is or suspected to be a victim of a crime.
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative hearings.
- Disclosures to a medical examiner to identify a deceased person or determine cause of death or to funeral directors to aid in burial
- Disclosures to organizations that handle organ or tissue donations.
- Uses or disclosures for health related research.
- Uses or disclosures to prevent a serious threat to health or safety of an individual or individuals.
- Uses or disclosures to aid military purposes such as recruitment physicals, or lawful national intelligence activities.
- Disclosures of de-identified information.
- Disclosure of examination findings for employment-related purposes.
- Disclosures related to a workman's compensation claim.
- Disclosures of a "limited data set" for research, public health, or health care operations.
- Incidental disclosures that are an unavoidable by-product of permitted uses and disclosures.
- Disclosure of information needed in completing form from a school related vision screening, information to the Department of Public Safety such as a driver's license, information related to certification for occupational or recreational licenses such as a pilot's license.
- Disclosures to business associates who perform health care operations for Jerome E. Gundersheimer, O. D. - Doctor of Optometry and who commit to respect the privacy of your information.

- Unless you object, disclosure of relevant information to family members or friends who are helping you with your care or by their allowed presence cause us to assume you approve their exposure to relevant information about your health.

USES OR DISCLOSURES TO PATIENT REPRESENTATIVES

It is the policy of Jerome E. Gundersheimer, O. D. - Doctor of Optometry for our staff to take phone calls from individuals on a patients behalf requesting information about making or changing an appointment; the status of eyeglasses, contact lenses, or other optical goods ordered by or for the patient. Jerome E. Gundersheimer, O. D. - Doctor of Optometry staff will also assist individuals on a patient's behalf in the delivery of eyeglasses, contact lenses, or other optical goods. During a telephone or in person contact, every effort will be made to limit the encounter to only the specifics needed to complete the transaction required. No information about the patient's vision or health status may be disclosed without proper patient consent. Jerome E. Gundersheimer, O. D. - Doctor of Optometry staff and doctors will also infer that if you allow another person in an examination or treatment room with you while testing is performed or discussions held about your vision or health care that you consent to the presence of that individual.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written *Authorization for Release of Identifying Health Information*. The content of this authorization is determined by federal law. The request for signing an authorization may be initiated by Jerome E. Gundersheimer, O. D. - Doctor of Optometry or by you as the patient. We will comply with your request if it is applicable to the federal policies regarding authorizations. If we ask you to sign an authorization, you may decline to do so. If you do not sign the authorization, we may not use or disclose the information we intended to use. If you do elect to sign the authorization, you may revoke it at any time. Revocation requests must be made in writing to the Privacy Officer named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your personal health information:

You may ask us to restrict our uses and disclosures for purposes of treatment (except in emergency care), payment, or business operations. This request must be made in writing to Privacy Officer named at the beginning of this Notice. We do not have to agree to your request, but if we agree, must honor the restrictions you ask for.

You may ask us to communicate with you in a confidential manner. Examples might be only contacting you by telephone at your home or using a special email address. We will accommodate these requests if they are reasonable and if you agree to pay any additional cost, if any, incurred in accommodating your request. Requests for special communication must be made to the Privacy Officer named at the beginning of this Notice.

You may ask to review or get copies of your health information. There are a very few limited situations in which we may refuse your access to your health information. For the most part we are happy to provide you with the opportunity to either review or obtain a copy of your medical information. All requests for review or copy of medical information must be made in writing to the Privacy Officer named at the beginning of this Notice. While we usually respond to these requests in just a day or so, by law we have fifteen (15) days to respond to your request. We may request an additional thirty (30) day extension in certain situations.

You may ask us to amend or change your health care information if you think it is incorrect or incomplete. If we agree, we will make the amendment to your medical record within thirty (30) days of your written request for change sent to the Privacy Officer named at the beginning of this Notice. We will then send the corrected information to you or any other individual you feel needs a copy of the corrected information. If we do not agree, you will be notified in writing of our decision. You may then write a statement of your position and we will include it in your medical record along with any rebuttal statement we may wish to include.

You may request a list of any non-routine disclosures of your health information that we might have made within the past six (6) years (or a shorter period if you wish). Routine disclosures would include those used your treatment, payment, and business operations of Jerome E. Gundersheimer, O. D. - Doctor of Optometry. These routine disclosures will not be included in your list of disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you must pay for them in advance at a fee of $5.00 per list. We will usually respond to your written request (made to the Privacy Officer named at the beginning of this Notice) within thirty (30) days but we are allowed one thirty (30) day extension if we need the time to complete your request.

You may obtain additional copies of this Notice of Privacy Practices from our business office or online at our website address shown at the beginning of this Notice.

CHANGING OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change the Notice. We reserve the right to change this Notice at any time. If we change this Notice, the new privacy practices will apply to your existing health information as well as any additional information generated in the future. If we change this Notice, we will post a new Notice in our office and on our website.

COMPLAINTS

If you think that anyone at Jerome E. Gundersheimer, O. D. - Doctor of Optometry has not respected the privacy of your health information, you are free to complain to the Privacy Officer named at the beginning of this Notice. We are more than happy to try to resolve any concern you may have in writing. If we cannot resolve your concern at that level, you may also file a complaint with the U.S. Department of Health and Human Services, Office of Civil Rights or the Texas Attorney General's Office. We will not retaliate against you if you make such a complaint.

Consent for Digital Wellness Screening Test

As part of our commitment to provide you with *the most comprehensive eyecare*, we are 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 conditions which 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 **$39**. Should there be 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 fee since 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: ___/___/___