WILLOW BEND VISION CARE

ESTABLISHED PATIENT

Patient Name: _____Birth Date: _____

Phone #:_____ Email: _____

Currently experiencing eye symptoms (please check all that apply):

- ☐ Blurred Distance Vision (with current glasses/contacts)
- ☐ Blurred Near (with current glasses/contacts)
- ☐ Flashes of light
- ☐ Headaches
- ☐ Dryness
- ☐ Excess Tearing/Watering
- ☐ Double Vision
- ☐ Itching
- ☐ Floaters
- ☐ Foreign Body Sensation
- ☐ Loss of Side Vision
- ☐ Excessive Redness
- ☐ Light Sensitivity
- ☐ Eye Pain or Soreness
- ☐ Irritation
- ☐ Eye Strain
- ☐ Burning
- ☐ Discharge/Matting
- ☐ Other_____

PATIENT and FAMILY MEDICAL HISTORY

Please check the box ☐ for your **self** (the patient) and the circle ○ for a **family** history.

S F

- ☐ ○ Glaucoma
- ☐ ○ Macular Degeneration
- ☐ ○ Retinal Detachment
- ☐ ○ Color Deficiency
- ☐ ○ Strabismus (crossed eyes)
- ☐ ○ Amblyopia (lazy eye)
- ☐ ○ Diabetic Retinopathy
- ☐ ○ Cataract
- ☐ Pinguecula/ pterygium
- ☐ Previous Eye Injuries
- ☐ Lasik / PRK
- ☐ Eye Surgery

- ☐ ○ Developmental Disorder
- ☐ ○ Cancer _____
- ☐ ○ Fatigue Syndrome
- ☐ Fever

- ☐ Sinusitis
- ☐ Dry Mouth
- ☐ Hearing Loss
- ☐ Laryngitis

- ☐ ○ Epilepsy/ Seizures
- ☐ ○ Cerebral Palsy
- ☐ ○ Stroke_____
- ☐ Migraines

- ☐ ○ Depression
- ☐ ○ Bipolar
- ☐ ○ Anxiety
- ☐ ○ Attention Deficit

- ☐ ○ Heart Disease
- ☐ ○ Vascular Disease
- ☐ ○ High Blood Pressure

- ☐ ○ Asthma
- ☐ ○ Emphysema
- ☐ ○ COPD
- ☐ Bronchitis
- ☐ Sleep Apnea
- ☐ ○ Liver Problems
- ☐ ○ Celiac Disease
- ☐ Acid Reflux
- ☐ Ulcer

- ☐ ○ Kidneys disease
- ☐ ○ Bladder Disease
- ☐ ○ STD-Herpetic/ Chlamydia
- ☐ Pregnant _____ weeks
- ☐ Planning Pregnancy
- ☐ Nursing

- ☐ ○ Arthritis
- ☐ ○ Ankylosing-Spondylitis
- ☐ ○ Fibromyalgia
- ☐ ○ Muscular Dystrophy
- ☐ ○ Osteoarthritis
- ☐ ○ Osteoporosis
- ☐ ○ Gout
- ☐ ○Herpes Simplex/Cold Sores
- ☐ ○ Herpes Zoster/ Shingles
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Eczema

- ☐ ○ Diabetes type I
- ☐ ○ Diabetes type II
- ☐ ○ Hormonal Dysfunction
- ☐ ○ Thyroid Dysfunction

- ☐ ○ Anemia
- ☐ ○ High Cholesterol

- ☐ ○ Lupus
- ☐ ○ Rheumatoid Arthritis
- ☐ ○ Sjogren Syndrome
- ☐ Environmental Allergies
- ☐ HIV/AIDS
- ☐ Drug Allergies_____

Smoke: ☐ No ☐ Daily_____ Alcohol Use: ☐ None ☐ Rarely ☐ Occasionally ☐ Daily _____

Comments_____

_____

Previous Surgeries_____

Current medication (include eye drops) _____

_____

_____ Initial if no changes in medical history since last vision

Signature _____Date _____

If patient is a minor – Guardian Name and relation _____

HYEJON KO, O.D. ~~ ELLEN S. CHAIT, O.D. ~~TAM VO, O.D. ~~ ROSHANAK MOSTAGHFARD, O.D. ~~ PETER CHAO, O.D.
~ 6121 W. PARK BLVD. STE. D-120 ~ PLANO, TX 75093 ~ PHONE: (972)202-5632 ~ FAX: (972)202-5630

WILLOW BEND VISION CARE

PATIENT INFORMATION

PLEASE FILL OUT IF THERE IS ANY CHANGES SINCE YOUR LAST VISIT

Street Address: _____

City, State, Zip Code: _____

Occupation: _____ Employer or School: _____

INSURANCE INFORMATION

VISION Insurance: _____

ID# (if you have one): _____

Subscriber Name:_____

Subscriber SS#: _____

Subscriber Birth Date: _____

Subscriber Employer: _____

Subscriber Phone#: _____

☐ No VISION Insurance

MEDICAL Insurance: _____

ID#: _____

Group#:_____

Subscriber Name: _____

Subscriber SS#: _____

Subscriber Birth Date: _____

Subscriber Employer: _____

Subscriber Phone#: _____

WILLOW BEND
VISION CARE

AUTHORIZATION OF INSURANCE ASSIGNMENTS
I authorize the release of medical and other information necessary to process and receive payment on health insurance claims. I hereby authorize my insurance provider to make payments directly to Willow Bend Vision Care/ Hyejon Ko, OD, PA. A copy of this authorization may be used in lieu of the original.

Initial: _____

FINANCIAL AGREEMENT
All professional services and/or treatments, once rendered, are NOT refundable.
Patient(s) without insurance:
I understand that I am expected to pay in full for services at the time they are rendered.

Patient(s) with insurance:
I understand that I am financially responsible for any deductible amount, co-insurance, co-pay, or any other balance not paid by my insurance company.
I understand that it is my responsibility to know my insurance coverage. I am aware that unless my insurance plan has coverage for contact lens fitting, I am responsible for the cost.
I understand that any out-of-pocket expenses collected at the time of service are estimates only. My insurance will determine my final out-of-pocket costs after claims are processed.

Initial: _____

HIPAA PRIVACY ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES
I hereby acknowledge that I have been provided with a copy of Willow Bend Vision Care's Notice of Privacy Practices, and that I have read, understand, and agree to the policies.

Initial: _____

AUTHORIZATION TO RELEASE PRESCRIPTON
I hereby authorize the release of my eyewear and/or contact lens prescription(s) upon verbal and/or written request by phone, mail, email, or fax.

Initial: _____

EMAIL CONSENT
I consent to receiving a digital copy of my glasses and/or contact lenses prescription(s) via unencrypted email once the exam process is complete and prescription(s) has been finalized.

Email: _____

CANCELLATION & MISSED POLICY

We reserve time in our schedule for you in advance to accommodate your schedule. We ask that you give us the same consideration when needing to change or cancel your appointments. Missed/No-show appointments and late cancellations inconvenience other individuals who need access to eye care in a timely manner.

We require a 24-hour advanced notice to change, cancel and/or reschedule a single appointment, and a 48-hour notice for multiple appointments scheduled together.

*We charge a **$50** fee for patients who do not show for their scheduled appointment and for patients who fail to give sufficient notice.*

If you are 10 minutes past your scheduled appointment time, you have MISSED your appointment. You may be asked to reschedule for a later time and be charged according to our cancellation policy.

EYEGLASS PRECRIPTIONS POLICY

The doctors are available to review your prescription and recheck your vision if you are having any difficulties. Our office will recheck the prescription at no cost within 30 days from the original exam date. *A fee of $30 will be charged for any additional recheck/visit after 30 days.* Prescription rechecks will not be performed after 5 months from the original exam date and a new exam will be necessary.

CONTACT LENS POLICY

You may return for a contact lens evaluation within 60 days from the original exam date and only be charged for contact lens evaluation. After 60 days, we will charge for a new exam plus the cost of the contact lens evaluation

Your contact lens prescription will not be finalized until the doctor has determined that your contact lens trials fit properly. *A fee of $30 will be charged for any additional follow- up visit after 30 days***.** Contact lens follow-ups will not be performed after 5 months from original exam date and a new exam will be necessary.

You have 30 days from your exam date to finalize your contact lens prescription. Expiration dates for contact lens prescriptions are to be determined by the doctor. Once the prescription expires, a re-evaluation will be necessary in order to renew your prescription

Signature _____Date _____

Patient Name _____

If patient is a minor – Guardian Name and relation_____

HYEJON KO, O.D. ~~ ELLEN S. CHAIT, O.D. ~~TAM VO, O.D.
~ 6121 W. PARK BLVD. STE. D-120 ~ PLANO, TX 75093 ~ PHONE: (972)202-5632 ~ FAX: (972)202-5630

WILLOW BEND
VISION CARE

OPTOMAP or DILATION CONSENT

We are pleased to be able to offer the Optomap Retinal Image Exam which allows our doctors to review an ultra-widefield view of the retina. Your retina (located in the back of your eye) is the only place in the body where blood vessels can be seen directly. This means that in addition to eye conditions (example: glaucoma, macular degeneration, retinal detachment), signs of other systemic disorders (example: diabetes, hypertension, stroke) can also be seen in the retina. Early signs of these conditions can show on your retina long before you notice any changes to your vision or feel pain. Getting an Optomap image is fast, painless and comfortable. Nothing touches your eye and is suitable for the whole family. Under normal circumstances, dilation drops are not necessary, but your eye care practitioner will decide if your pupils need to be dilated depending on your conditions.

Please Initial One:

_____I CONSENT to the Optomap retinal imaging and agree to the charge for the procedure of $44 or less depending on insurance.

_____I CONSENT to have my eyes dilated and decline Optomap retinal image. I understand dilation will cause blurry vision for approximately 6 hours and light sensitivity. (no additional charge with most insurance).

_____I DECLINE both the dilation and Optomap against my doctor's recommendation. In refusing, I understand and accept all risks associated with failure to diagnose eye conditions/diseases due to lack of information.

Patient Name: _____

Signature: _____ Date: _____

COVID-19 PANDEMIC CONSENT FORM

I, _____ (Print name), knowingly and willingly consent to have an eye exam completed during the COVID-19 pandemic. I understand that the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. While Willow Bend Vision Care doctors and staff will be following safety protocols as to best protect myself and the staff during the exam; I acknowledge and understand that there is an increased risk that COVID-19 can be transmitted in any place of public accommodation, including an optometry office.

I have confirmed that I have no symptoms commonly associated with COVID-19, including fever, shortness of breath, dry cough, running nose or sore throat and that I have not, within the past 14 days, travelled by airplane, been in close proximity (less than 6 feet proximity) at a gathering of 20 or more persons, or had close contact with a person who has confirmed positive or suspected to be positive for COVID-19

Signature: _____ Date: _____

HYEJON KO, O.D. ~~ ELLEN S. CHAIT, O.D. ~~TAM VO, O.D.
~ 6121 W. PARK BLVD. STE. D-120 ~ PLANO, TX 75093 ~ PHONE: (972)202-5632 ~ FAX: (972)202-5630