THOMAS VISION CLINIC

Exceeding Your Expectations

Dr. C. Mark Cowan OD
Dr. Cherri T. Cowan OD
1100 North 5th Street
P.O. Box 681
Leesville, La. 71446
(337)239-2020 ph
(337)239-0755 fax

Office Use Only ☐ Optomap ☐ Dilation ☐ Refusal ☐ Refraction ☐ Eye Health ONLY

☐ Male ☐ Female

Race: ☐Asian ☐African American ☐Hispanic ☐White ☐Native American ☐Pacific Islander ☐Other

First Name Mi Last Name Preferred Name

Mailing Address City State Zip

Social Security # Date of Birth E-mail address

Home Phone Day Phone Cell Phone

Patient Status: ☐ Minor (17&younger) ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Parent/Guardian/Responsible Party (if other than patient):

First Name MI Last Name Phone Number

Primary Insurance: _____
Company Member/Sponser ID # Member Date of Birth

Secondary Insurance: _____
Company Member/Sponser ID # Member Date of Birth

Primary Care Physician: _____

Pharmacy: _____

Contact Lens Exams

Please keep in mind that contact lenses are considered medical devices and require additional follow-up care to ensure proper fit. The professional fee for the fitting of contact lenses is separate from & additional to the eye health exam. If you opt to have an eye exam without a contact lens fitting, you will receive a prescription for glasses only.

Patient Name: _____

AUTHORIZATION & ACKNOWLEDGEMENT

Release of Information
I hereby authorize Thomas Vision Clinic to release any information necessary to my insurance company to expedite claims for payment. I authorize the release of medical information for the purpose of patient referral should I be referred.

Signature: _____ Date: _____

Patient Financial Agreement
I agree to be responsible for my financial portion of today's services including copays, deductibles & all non-covered procedures I elect to have performed. A copy of the financial disclosure statement is available to me upon request.

Signature: _____ Date: _____

Medical Authorizations
If discussed, I authorize the provision of medical services which are determined by Dr. Cowan to be in my best interest of care other than those I have previously refused in writing.

Signature: _____ Date: _____

Notice of Privacy Practices
I have reviewed the Thomas Vision Clinic Privacy Practice Notice that describes how my information may be disclosed. A copy of this notice is available to me upon request.

Signature: _____ Date: _____

Refraction Authorization
Refraction is the process of determining one's need for corrective eyewear (glasses & contact lenses). This procedure is not covered by Medicare or most insurances. **A fee of $20.00** is to be collected from the patient in addition to any copays or deductibles. Patients who are primarily covered by VSP, Tricare PRIME, or children 20& younger with Medicaid are not responsible for this fee, as these plans allow for the refraction.

I understand my financial responsibility and choose to have the refraction performed.

Signature: _____ Date: _____

Retinal Exam Authorization
Retinal Examinations are essential when evaluating eye health, visual development, progression of eye diseases, & systematic diseases such as hypertension, diabetes, stroke, & MS. These conditions are near impossible to detect without dilation or the Optomap.

Please select the retinal exam you want performed:

☐ Children 7 & younger must be dilated in order to determine the need for vision correction. No extra charge.

☐ Optomap Imaging – Scan that allows for a wider view of the retina without dilation. No visual aftereffects. The cost for this service is **$29.00** in addition to any copay& refraction fee. NOT COVERED BY INSURANCE

☐ Dilation - Manual examination through the pupil with the use of dilating eye drops. Aftereffects include short term blurred vision & light sensitivity. No extra charge

Signature: _____ Date: _____

Patient Name: _____

Eye & Visual Assessment

Reason for your visit? □ Glasses □ Contacts □ Eye Injury □ Yearly Eye Health Exam

Eye History

Check all that apply

- □ Glaucoma
- □ Cataract
- □ Macular Degeneration
- □ Retinal Detachment
- □ Eye Trauma
- □ Infections
- □ Eye Surgery
- □ Diabetic Retinopathy

Current Visual Problems

Check all that apply

- □ Distance Blurry
- □ Up Close reading Blurry
- □ Headaches
- □ Burning
- □ Tearing/watering
- □ Dry/Sandy/Gritty feeling
- □ Cloudy Vision
- □ Floaters/Spots
- □ Loss of side vision
- □ Loss of vision
- □ Light/Glare sensitivity
- □ Double vision
- □ Color vision

Family Eye History

Check all that apply

- □ Glaucoma
- □ Macular Degeneration
- □ Retinal Detachment
- □ Color Blindness
- □ Blindness
- □ Diabetic Retinopathy

Medical Assessment

Patient Weight: _____ lbs Patient Height: _____ ft _____ inches

Past Major Surgeries: □ None

_____

Current Medications: □ None

_____

_____

Current Health Issues (i.e. high bp, diabetes, cholesterol, depression, etc): □ None

_____

_____

Drug or Food Allergies: □ None

_____

Do you consume alcoholic beverages: □ Never □ Occasionally □ 1 per day □ 2-3 per day □ 4+ per day

Smoking statues: □ Never □ Occasionally □ ½ pk daily □ 1 pk per day □ 1+ pks per day □ Quit in _____

Humana Military

TRICARE

TRICARE NONCOVERED SERVICES WAIVER

Date: _____

Sponsor Name: _____ Sponsor ID: _____

Patient Name: _____ Patient ID:_____

Service Description

Procedure: _____

Approximate Cost: _____

Diagnosis: _____

Date of Service: _____

Provider Name:_____

TIN: _____

Address: _____

Physician Signature:_____

I hereby affirm that I have been informed and I understand that these services are excluded or excludable under the TRICARE Program and therefore all costs associated with these services are not an allowable expense under The TRICARE Program. By signing the TRICARE noncovered services waiver, I am hereby agreeing in advance, in writing, to accept full financial responsibility for all costs associated with the noncovered medical services, described in this document under **"Service Description"** and performed by the named TRICARE Network Provider.

Patient Signature:_____Date: _____

Beneficiary's or Legal Guardian's Signature:_____Date: _____

Witness Signature:_____Date: _____

TRICARE OPERATIONS MANUAL 6010.51-M, AUGUST 1, 2002
CHAPTER 5, SECTION 1

2.5.1. A network provider may not require payment from the beneficiary for any excluded or excludable services that the beneficiary received from the network provider (i.e. the beneficiary will be held harmless) except as follows:

- If the beneficiary did not inform the provider that he or she was a TRICARE beneficiary, the provider may bill the beneficiary for services provided.
- If the beneficiary was informed that the services were excluded or excludable and he/she agreed in advance in writing to pay for the services, the provider may bill the beneficiary. An agreement to pay must be evidenced by the written consent of the beneficiary to pay for the excluded services. General agreements to pay, such as those signed by the beneficiary at the time of admission, are not evidence that the beneficiary knew specific services were excluded or excludable.
- If the beneficiary has been notified, in writing, that the service would not be covered for any reason.

For a list of excluded or excludable services refer to:
TRICARE POLICY MANUAL 6010.54-M, August 1, 2002 CHAPTER 1 SECTION 1.1
ISSUE DATE: June 1, 1999 AUTHORITY: 32 CFR 199.4(g)