❑ Gulfgate Vision
❑ Gulf Vision, PLLC

NEW PATIENT REGISTRATION

DR. ZEINEP O. ECHETEBU, O.D., Ph.D., P.C.
Therapeutic Optometrist

Exam Date: ___ / ___ / _____

PATIENT INFORMATION

❑ Mr. ❑ Miss ❑ Ms. ❑ Mrs. **Marital status (circle one):** Single / Mar. / Div. / Sep. / Wid.

LAST NAME:	FIRST NAME	M.I.

HOME ADDRESS	APT. #	CITY	STATE	ZIP	SEX:
					☐Male ☐Female

HOME PHONE NUMBER	DATE OF BIRTH	AGE	SOCIAL SECURITY NUMBER	DRIVERS LICENSE #
(___) ___-____	__/__/____	_____	____-__-_____	_____

WORK PHONE NUMBER	CELL PHONE NUMBER	EMAIL ADDRESS:
(___) ___-____ ext. ____	(___) ___-____	_____

WOULD YOU LIKE US TO SEND YOU A REMINDER FOR YOUR ANNUAL EXAM?	HOW WERE YOU REFERRED TO US?
☐ Yes ☐ No ☐ Please E-mail me instead.	☐ Doctor: _____ ☐ Patient Full Name: _____ ☐ Voucher: _____ ☐ Other: _____

ETHNICITY:	RACE:	LANGUAGES SPOKEN:
☐ Hispanic/Latino ☐ Non-Hispanic/Latino	☐ Black/ African-American ☐ White/Caucasian ☐ Asian/Pacific Islander ☐ American Indian or Alaska Native	☐ English ☐ Spanish ☐ Other: _____

(PCP) / PRIMARY CARE PHYSICIAN'S NAME:	PCP'S ADDRESS:

CITY	STATE	ZIPE CODE	PCP'S PHONE NUMBER
			(___) ___-____

GUARDIAN'S LAST NAME	GUARDIAN'S FIRST NAME	M.I.	RELATIONSHIP TO PATIENT

GUARDIAN'S HOME ADDRESS:	APT. #:	CITY:	STATE	ZIP

HOME PHONE NO.:	DATE OF BIRTH:	SOCIAL SECURITY NO.:	DRIVERS LICENSE:
(___) ___-____	___/___/_____	____-__-_____	_____

EMERGENCY CONTACT NAME:	PHONE NO.:	RELATIONSHIP:
	(___) ___-____	

Patient Name: _____ Date: __ __ / __ __ / _____

Patient/Guardian Signature: _____ Date: __ __ / __ __ / _____

****Patients under 18 years of age must have Parent/Legal Guardian sign for them****

PLEASE TAKE A MOMENT TO FILL OUT THIS QUESTIONNAIRE SO THAT WE MAY BETTER MEET YOUR EYE CARE NEEDS:

PLEASE LIST ALL MEDICATIONS THAT YOUR ARE CURRENTLY TAKING:

_____

_____

_____

DO YOU HAVE ANY ALLERGIES? ❑ *YES ❑ NO

*If yes, please list: _____

_____

_____

PATIENT EYE HISTORY:

Do you have a history of:

Cataracts	❑ Yes	❑ No
Glaucoma	❑ Yes	❑ No
Lazy eye (amblyopia)	❑ Yes	❑ No
Crossed eyes (strabismus)	❑ Yes	❑ No
Iritis (iris inflammation)	❑ Yes	❑ No
Eye Operations (any)	❑ Yes	❑ No
Eye Injury (any)	❑ Yes	❑ No
Severe Eye Disease	❑ Yes	❑ No
Laser Eye Surgery / LASIK	❑ Yes	❑ No
Refractive Surgery	❑ Yes	❑ No

PATIENT MEDICAL HISTORY:

Do you have a history of:

Diabetes	❑ Yes	❑ No
High Blood Pressure	❑ Yes	❑ No
Heart Disease	❑ Yes	❑ No
HIV / AIDs / other STDs	❑ Yes	❑ No
Thyroid Problems	❑ Yes	❑ No
Asthma	❑ Yes	❑ No
Cancer	❑ Yes	❑ No

Other: _____

_____

_____

FAMILY MEDICAL HISTORY:

Do any of your blood relatives have a history of?

	Mother	Father	Grandparents
Glaucoma ❑ Yes ❑ No			
Diabetes ❑ Yes ❑ No			
HBP ❑ Yes ❑ No			
Cataracts ❑ Yes ❑ No			

ARE YOU INTERESTED IN:

Refractive surgery	❑ Yes	❑ No
Cosmetic eyelid surgery	❑ Yes	❑ No
Contact lenses	❑ Yes	❑ No
Eyeglass lens or frame options	❑ Yes	❑ No

DO YOU USE A COMPUTER/TABLET? ❑ YES ❑ NO

Number of hours per day? _____

Do you have computer related vision problems? ❑ Yes ❑ No

*If yes, please list: _____

_____

_____

DO YOU USE?

Cigarettes/Tobacco	❑ Yes*	❑ No
Alcohol	❑ Yes*	❑ No

If Yes, How Frequently:

❑ Everyday ❑ Some days ❑ Former Smoker

PLEASE CHECK ALL HOBBIES/SPORTS IN WHICH YOU PARTICIPATE:

❑ Drawing ❑ Painting ❑ Fishing ❑ Boating ❑ Football
❑ Bingo ❑ Skiing ❑ Tennis ❑ Driving ❑ Card Games
❑ Marathons ❑ Shooting ❑ Needlepoint Knitting ❑ Contact Sports
❑ Jogging ❑ Cycling ❑ Hunting ❑ Basketball ❑ Online Shopping
❑ Reading ❑ Crosswords ❑ Computer Games ❑ Non-Contact Sports
❑ Golf ❑ Water Sports ❑ Home Workshop ❑ I do not have a hobby.

❑ Hobby Not Listed: _____

PLEASE LIST ANY OTHER QUESTIONS OR CONCERNS:

_____

_____

_____

_____

_____

_____

_____

_____

Patient Signature: _____ Date: __ __ / __ __ / _____

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HIPPA: ACKNOWLEDGEMENT OF RECIEPT OF PRIVACY PRACTICE

By signing this acknowledgment of Receipt of Notice of Privacy Practice; I acknowledge and agree that I have received a copy and/or read a copy of the Notice of Privacy Practices for review and to keep for my records on the date identified below.
I understand that the office may use and disclose necessary personal health information (for example, my name, address, subscriber identification number, eye exam information and/or type of products provided) to another party to permit the office to perform its administrative duties, provide me with eye care services and products, process vision/medical benefit claims, and communicate with me regarding vision/medical claims and communicate with me regarding vision/medical care services provided by the office (for example, mailings of exam reminders or information for services/products provided by the office).
I can be assured that this office does not sell my personal health information of any kind to a third party for such party's own use. I authorize the office to submit my vision/medical benefits claims to my plan(s) sponsor or health plan(s) to receive reimbursement directly for the vision/medical services/products that I have received from the office.

Patient/Guardian LIFETIME signature *Date*

AUTHORIZATION OF INSURANCE BENEFITS/SIGNATURE ON FILE

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment from my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to the doctor on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage, my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above. I understand I am responsible for the balance of fees not paid by my insurance for any reason.

Patient/Guardian LIFETIME signature *Date*

REFRACTION POLICY: (COVERED BY

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 medical 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 refraction a "vision" service not a "medical" service. Our office fee for refraction is $95.00 and unless your plan automatically covers the refraction charges, this fee is collected at the time of service in addition to any co-payment your plan may require. Should your plan pay us for the refraction, we will reimburse you accordingly. Yes, 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 understand that any co-payment, co-insurance or deductible I may have are separate from and not included in the refraction fee.

Patient/Guardian signature *Date*

DILATED FUNDUS EXAM/EXTENDED OPTHALMOSCOPY (OPTIONAL TESTING)

Dilation provides a more comprehensive ocular health analysis, in which the doctor can get a better view of the inside of your eyes. This allows the doctor to detect early signs and changes of the ocular pathologies. **This is RECOMMENDED for ALL PATIENTS, especially those who are diabetic, hypertensive, highly myopic, and/or history of other related ocular diseases**. The side effects include temporary blurry vision at near and light sensitivity. Some individuals may also experience some blurriness at distance vision. Dilation is covered by most vision insurances**. Dilation is not covered by Groupon or Living Social Vouchers.** If it is not covered by you plan, the fee will be an additional $40 to your eye exam fees.

❑ YES, I want my eyes dilated today ❑ YES, I would like my eyes dilated at a LATER date ❑ NO, I do NOT want my eyes dilated

Patient/Guardian signature *Date*

VISUAL FIELD SCREENING/VISUAL FIELD THRESHOLD TEST (OPTIONAL TESTING)

A visual field analyzer is a computerized instrument which enables our office to provide a more thorough ocular health analysis. Visual field testing can assist us in detecting early signs of glaucoma, retinal problems, neurological diseases such as brain tumors, and/or optic nerve disease), and enable is to better diagnose causes of headaches, migraines, or vertigo. We STRONGLY recommend this additional diagnostic screening as part of your yearly comprehensive eye exam. Our office fee for visual field screening/visual field threshold test is $35.00; this fee will be collected at the time of service in addition to any co-payment your plan may require.
THIS IS NOT COVERED BY YOUR VISION INSURANCE, but can covered through your MEDICAL if there is a medical reason for the doctor to perform a FULL VISUAL THRESHOLD TEST and not SCREENING.

❑ YES, I want to have VFS /VFT ❑ YES, I would like my VFS/VFT at a later date ❑ NO, I do NOT want VFS/VFT

Patient/Guardian signature *Date*

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MEDICAL INSURANCE & VISION INSURANCE INFORMATION

(SKIP IF NOT APPLICABLE)

PRIMARY INSURED'S EMPLOYER:	TELEPHONE#:
	(_ _ _) _ _ _ - _ _ _ _

COMPANY ADDRESS	CITY	STATE	ZIP

MEDICAL INSURANCE COMPANY NAME	ID NUMBER	GROUP NUMBER

PRIMARY INSURED'S LAST NAME:	FIRST NAME:	M. I.:

PRIMARY INSURED'S DATE OF BIRTH:	SOCIAL SECURITY:	RELATIONSHIP TO PATIENT:
_ _ / _ _ / _ _ _ _	_ _ _ - _ _ - _ _ _ _	❑Member ❑Spouse ❑Child

VISION INSURANCE COMPANY NAME	ID NUMBER	GROUP NUMBER

PRIMARY INSURED'S LAST NAME	FIRST NAME	M.I.

PRIMARY INSURED'S DATE OF BIRTH:	SOCIAL SECURITY:	RELATIONSHIP TO PATIENT:
_ _ / _ _ / _ _ _ _	_ _ _ - _ _ - _ _ _ _	❑Member ❑Spouse ❑Child

AUTHORIZATION TO BILL INSURANCE:

I, THE UNDERSIGNED, HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE AND AUTHORIZE PAYMENT DIRECTLY TO THE PROVIDER OF SERVICES, AND I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY THIS AUTHORIZATION.

SIGNATURE:	DATE:
	_ _ / _ _ / _ _ _ _

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DO NOT FILL OUT INFORMATION BELOW THIS LINE
[FOR OFFICE STAFF ONLY]

[OFFICE USE ONLY]

FOR DOCTOR:

- ❑ ROUTINE EYE EXAM
- ❑ COMP. EYE EXAM
- ❑ DILATION
- ❑ RX CHECK
- ❑ CONTACT LENS FITTING
- ❑ CL FOLLOW UP
- ❑ CL REFIT WITHIN 1 YEAR
- ❑ INSERTION AND REMOVAL
- ❑ MEDICAL OFFICE VISIT
- ❑ REFRACTION
- ❑ VISUAL FIELD THRESHOLD
- ❑ VISUAL FIELD SCREENING
- ❑ FUNDUS PHOTOS PLUS
- ❑ FUNDUS PHOTOS
- ❑ EXTENDED OPTHALMOSCOPY
- ❑ EMERGENCY VISIT

FOR STAFF:

- ❑ DILATION REVIEWED
- ❑ C/L RX REVIEWED/ FINALIZED
- ❑ RETURN FOR F/U 1WK
- ❑ RETURN FOR F/U 4 WKS
- ❑ RETURN FOR F/U 12 WKS
- ❑ VISUAL FIELDS REVIEWED
- ❑ RETURN FOR DRY EYE EVAL
- ❑ RETURN FOR ALLERGY EVAL
- ❑ RETURN FOR INFECTION EVAL
- ❑ FUNDUS PHOTOS REVIEWED

Zeinep O. Echetebu O.D., Ph.D.
Therapeutic Optometrist

CONTACT LENS AGREEMENT

It cannot be guaranteed in advance that you will be a successful contact lens wearer. Among the factors that can influence your success are: allergies, dry eyes, certain medications, improper lens cleaning and care, failure to return for progress evaluation (follow –up).
I understand that it is important for me to keep all appointments for progress evaluation, which are meant to assure the proper fit of my contact lenses, good vision, and the good health of my eyes. Knowing this, I agree to keep all my progress evaluation appointments. Follow-up visits within one month of the eye exam are at ***NO CHARGE***. After one month there will be a **$45** fee.

MY FAILURE TO DO SO RELIEVES MY EYE CARE PRACTICIONER OF ANY RESPONSIBILITY.

I understand that contact lenses are a visual medical device and not just a convenience or a cosmetic aid. Improper use, wearing dirty, unsterilized lenses or lenses that have any unremovable deposits/film can cause permanent eye damage. If at any time my contact lens becomes uncomfortable, or my eyes become red, irritated or sensitive to light I will immediately remove the contact lenses and contact my eye doctor at once.

MY FAILURE TO DO SO RELIEVES MY EYE CARE PRACTICIONER OF ANY RESPONSIBILITY.

I realize that my eyes may change gradually over a period of time without my being aware of it, and for that reason the current prescription is good for a maximum of 1 year. After this period, a full eye examination will be required to receive new or replacement lenses.
I have received instruction on the care and cleaning of my contact lenses and full care kit, and I understand that I should not change brands of solutions without first checking with my eye doctor.

I have read and understand the above contact lens agreement.

_____ ___ / ___ / ___
Signature

_____
Name (print, please)

GULFGATE/GULF VISION, PLLC REMAKE/EXCHANGE/WARRANTY/REFUND POLICIES

Prescription Eyewear: Every pair of eyeglasses ordered from GULFGATE/GULF VISION, PLLC is custom made to order. Therefore, GULFGATE/GULF VISION, PLLC cannot refund any products that are not resalable or returnable to the manufacturer. We are happy to service all of our products, and guarantee their quality and workmanship. GULFGATE/GULF VISION, PLLC provides a limited warranty that protects against manufacturing defects in products associated with normal wearing conditions. Accidental breakage, abuse, or loss is not covered by this warranty. Warranties are only in effect for the duration offered by the manufacturer, are non-extendable, and begin at the time of the order. Please consult with a GULFGATE/GULF VISION, PLLC optician to verify these details.

Doctors Changes and Non-Adapts: GULFGATE/GULF VISION, PLLC will honor a one-time RX change made by the Doctor up to 60 days following the original order. Subsequent changes will incur additional charges. In the event that a patient does not adapt to a pair of prescription Progressive eyeglasses within 60 days, GULFGATE/GULF VISION, PLLC will remake the glasses (only one time) into a standard bifocal at no additional charge to the patient. No refund will be given for the price difference in materials.

Contact Lenses: Many disposable contact lenses and planned replacement contact lenses are eligible for a refund or store credit if returned within 45 days from the date of initial order. The boxes must be unopened and in resalable condition. Most RGP and Daily Wear Vial contact lenses have a 45-day to 75-day warranty from the date of order, and are returnable for a refund or store credit. Vials must be returned with the contacts, and all lenses must match the micro barcode imprinted in the lens to be eligible for refund or credit. Any patient found to be fraudulently returning lenses not matching the order will immediately forfeit any and all refunds, and will be barred from future care at GULFGATE/GULF VISION, PLLC. A stocking fee of $9.95 will be charged to the patient for each box returned.

Custom Contacts and Keratoconus Lenses: Even though custom lenses are very expensive, most are not returnable or refundable. If the manufacturer allows any such returns, GULFGATE/GULF VISION, PLLC will convey this information to the patient and will honor the policy. Some manufacturers only offer a 50% credit if the order is changed or cancelled, and any additional cost are the responsibility of the patient.

Contact Lens Follow-Up Exams: It is the responsibility of the patient to keep all contact lens follow-up appointments with their GULFGATE/GULF VISION, PLLC provider. If a patient misses or fails to keep such appointments, GULFGATE/GULF VISION, PLLC cannot extend the return policy, and the patient will incur additional charges. A fee of $45 will be charged to patient if follow up is performed more than 30 days after original contact lens fitting and evaluation.

Warranty Limitations: Please note Warranties are available only as the manufacturer policies permit, so GULFGATE/ULF VISION, PLLC and your GULFGATE/GULF VISION, PLLC provider does not have the ability to make exceptions or changes. A processing fee of $45 for each frame and/or $15 for each spectacle lens will be charged to the patient for each warranty replacement transaction. THERE ARE NO EXCEPTIONS. Frame Replacements are only possible if the patient purchased the Extended-Warranty for the frame.

I have read the GULFGATE/GULF VISION, PLLC REMAKE/EXCHANGE/WARRANTY/REFUND POLICIES explained above. My signature below confirms I agree and understand all GULFGATE/GULF VISION, PLLC policies.

PRINTED NAME: _____

SIGNATURE: _____ **Date:** _____