

The Optomap (digital image of the retina) will be done annually for EVERY patient UNLESS a waiver is signed.

Dr. Tate-Brasseaux Recommends the Optomap as her preferred method of looking in the back of the eye for the Following Reasons:

Dr. Tate-Brasseaux is concerned about retinal diseases such as macular degeneration, glaucoma, retinal detachments, malignant melanomas and diabetic retinopathy; all which can lead to partial loss of vision or blindness. Additionally, systemic diseases such as diabetes and high blood pressure can be detected with a retinal examination. Eye exams with retinal evaluations can help you safeguard both your eyesight and general health.

Optomap Retinal Imaging Provides:

- The ability to show you your retinal images today, during your exam.
- An In-Depth 3D view of your retinal layers (where diseases can start). It is able to detect 40% more retinal conditions than traditional dilation
- A permanent record for your medical records, which gives your doctor a comparison for diagnosing and tracking retinal eye disease annually.

Optomap Retinal Imaging is:

- Fast, easy, and comfortable.
- Patient Friendly.
- Eliminates the need to be dilated, in most cases.

The fee is only \$25.00 (it is usually not covered by insurance)

However, you have the option to decline this procedure. If you decide not to have this procedure done a dilation of your eyes may be recommended to view the retina to our satisfaction. If you have any questions or concerns, please don't hesitate to ask any of our staff.

VISIONS SOURCE

Jennifer Tate-Brasseaux O.D., L.L.C.

Family Eye Care

138 Lazaro Blvd, suite B

Opelousas, LA 70570

(337) 407-2888 phone

(337) 407-2999 fax

[www.http://visionsource-tatebrasseaux.com](http://visionsource-tatebrasseaux.com)

Mr. Miss Mrs. Ms.

Male Female

First Name MI Last Name Preferred Name

Street Address City State Zip Code

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Social Security Number Date of Birth Primary phone Alternate Phone

Email address Person Responsible for Account Emergency Contact/Phone

PATIENT DEMOGRAPHICS

Height: _____ ft _____ cm Weight: _____ lbs

Race: African American/Black Asian Caucasian/White Hispanic Indian Native American
 Other Race: _____ Refuse to specify

Current Occupation: _____ Employer _____

Who were you referred by? _____

REFERRING PHYSICIAN

Referring Physician/Clinic Name Address Phone

PRIMARY CARE PHYSICIAN

Physician name/Clinic Name Address Phone

HEALTH HISTORY

What is the main reason for today's examination? _____

When was your last eye exam? _____ Eye Doctor/Clinic Name _____

When was your last Health Exam with your Primary Care Physician? _____

Past Illnesses or Injuries? _____

Past Surgeries: _____

Medication/Food/Environmental Allergies: _____

Current Medications: (please specify names, dosages, and frequency of all prescription and Over-the-Counter medications)

- | | | |
|----|----|----|
| 1) | 4) | 7) |
| 2) | 5) | 8) |
| 3) | 6) | 9) |

SPECTACLE LENS HISTORY

Type of Glasses:

- Full time Part Time Computer
 Distance Reading

CONTACT LENS WEAR YES NO

TYPE/BRAND: _____

REPLACEMENT SCHEDULE: _____

PERSONAL HEALTH HISTORY

	YES	NO
Fever		
Weight Loss		
Ear, Nose, Throat		
Cardiovascular (high blood pressure, etc.)		
Respiratory (asthma, COPD, emphysema)		
Gastrointestinal		
Kidney		
Muscle, Bones, Joints		
Skin		
Neurological		
Anxiety/Depression		
Thyroid/Diabetes		
Blood/Lymph		
Allergic		
Pregnant		
Nursing		
Smoking/Tobacco Use		
Chewing Tobacco Use		
Previous/Former Tobacco Use		
Alcohol Use		
Illegal Drug Use		

PERSONAL EYE HISTORY

	YES	NO
Glaucoma		
Cataract		
Macular Degeneration		
Retinal Detachment		
Color Blindness		
Headaches		
Glare Sensitivity		
Tired Eyes		
Amblyopia (Lazy Eye)		
Burning		
Dryness		
Tearing/Watering		
Eye Pain		
Foreign Body Sensation		
Itching		
Discharge		
Drooping Eyelid		
Redness		
Strabismus (turned eye)		
Blurred Distance Vision		
Blurred Near Vision		
Distorted Vision		
Double Vision		
Floaters/Spots		
Loss of Vision		

FAMILY HISTORY

	YES	NO
Amblyopia (Lazy Eye)		
Blindness		
Cataracts		
Color Blindness		
Glaucoma		
Macular Degeneration		
Retinal Detachment		
Strabismus (turned eye)		
Arthritis		
Diabetes		
Cancer		
Heart Disease		
High Blood Pressure		
Lupus		
Stroke		
Thyroid Disease		
Other:		

Jennifer Tate-Brasseaux, O.D., L.L.C.

Notice of Refraction Fee

Dear Patient:

Refraction is the process of determining the need for/power of your corrective lenses (spectacles or contact lenses). Most private insurances will not cover the cost of this service. Our office charges you a fee of **\$ 15.00** for routine refraction for eyeglasses and/or contacts.

Acknowledgement:

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. My co-payment is separate from and not included in the refraction fee.

CONTACT LENS PATIENTS

Fitting/evaluation of contact lenses is a separate charge from the refraction fee. This fee will be collected on the date of service.

Contact lens fees:

\$20.00 yearly contact lens evaluation

\$25.00 minor contact lens fitting/changes

\$55.00 straight forward contact lens fitting

\$75.00 advanced contact lens fitting

Patient Name (Printed): _____

Patient Signature: _____

Date: _____

**Acknowledgement of Receipt of Notice of Privacy Practices
Jennifer Tate-Brasseaux, O.D. L.L.C.**

Patient Name: _____

I acknowledge that I have received the *Notice of Privacy Practices* from Jennifer Tate-Brasseaux, O.D.

Signature Date

Insurance/Billing Policy

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company, **not** Jennifer Tate-Brasseaux, O.D., L.L.C.

Please provide both your vision plan information as well as your **major medical insurance information**. We are recognized as physicians specializing in the eyes, so we may be able to submit your visit (if there is a medical reason) to your medical insurance for you.

If your insurance company has not reimbursed our office in full within 60 days, you will be responsible for the balance and your insurance company will then reimburse you directly. Additionally, Dr. Tate-Brasseaux O.D., L.L.C. reserves the right to charge an administrative fee for any delinquent accounts submitted to collection services. There will be a service charge on all returned checks.

Patient Acknowledgement of Billing Policy

It is my responsibility (as the patient) to provide Jennifer Tate-Brasseaux, O.D., L.L.C. office with all of my insurance information prior to my office visit.

It is my understanding that I am responsible to obtain any and all referrals that my insurance company requires for services performed by my doctor.

Signature Date

If signing as a personal representative of the patient, describe relationship to the patient.

Relationship to Patient

ABOUT YOUR INSURANCE

THERE ARE TWO TYPES OF INSURANCE THAT WILL HELP PAY FOR YOUR EYE CARE SERVICES. YOU MAY HAVE BOTH AND DR. TATE-BRASSEAU ACCEPTS INSURANCE IN BOTH CATEGORIES.

- 1) VISION PLANS (SUCH AS VSP)
- 2) MEDICAL INSURANCE (SUCH AS: HUMANA, BLUE CROSS, CIGNA, MEDICARE , ETC.)

VISION PLANS ONLY COVER *ROUTINE, VISION WELLNESS* EXAMS, ALONG WITH EYEGASSES AND CONTACT LENSES

MEDICAL INSURANCE MUST BE USED FOR MEDICAL EYE CARE. THIS IS IF YOU ARE BEING TREATED FOR, OR COMPLAINING OF , MEDICAL PROBLEMS (SUCH AS: OCULAR IRRITATION, EYE INFECTION, EMERGENCY EYE CARE, HEADACHES, DIABETES, CATARACTS, GLAUCOMA, MACULAR DEGENERATION, AND MANY OTHER CONDITIONS)

IT IS THE PATIENT'S RESPONSIBILITY TO KNOW WHAT THEIR INSURANCE BENEFITS ARE. IF YOU HAVE QUESTIONS ABOUT YOUR INSURANCE COVERAGE, PLEASE CONTACT YOUR INSURANCE COMPANY.