# *Texas Vision Care*

To help us better assist you today, please provide us with the following updated information.

Name_____ Contact Number_____ Date_____

**Below, list any concerns or changes in your medical history. Include new medications and any new diagnosis of Glaucoma, Diabetes, High Cholesterol, or Hypertension.**

_____
_____
_____

## Visual Field Test:

A computerized instrument now enables us to check for areas of loss of sight in the central (straight ahead) and peripheral (side view) areas. **It can detect early signs of glaucoma, retinal problems, neurological diseases, macular disorders and headache related illnesses.**
We strongly recommend our patients receive this test in addition to their comprehensive visual analysis. The fee for the test is $45.00.

**Would you like to receive this test?**

- ❑ Yes
- ❑ No

## HIPPA

I hereby acknowledge that I have reviewed the HIPPA Notice of Privacy Practices document of Drs. Mark A. Hanley and Kelly A. Slifer.

Signature: _____

Date: _____

## INSURANCE ASSIGNMENT AND RELEASE

I certify that I, and/or my dependant(s), have insurance coverage through
_____and assign directly to **_Dr. Mark A. Hanley/Dr. Kelly A. Slifer_**
Name of Insurance Company Doctor or Provider

All insurance benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
NAME OF PATIENT

X_____ _____
***Signature*** of patient OR guardian/representative of patient Date