Thom Dinh, OD, LLC
4415 Ambassador Caffery Parkway, Suite 100
Lafayette, LA 70508
Phone: (337) 984 -7112
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Office Use Only
APPT/WI: _____
GLS CLS OV Other _____
NPT PPT

PATIENT INFORMATION (PLEASE PRINT)

Today's Date:		Preferred Method of Contact: □ Text □ Email □ Call		Sex: □ Male □ Female
Prefix:	Last Name:	First Name:	M.I.:	Suffix:
Address:		City:	State:	Zip:
Date of Birth: (MM/DD/YYYY)	SSN:	Email:		
Telephone Number: □ Home □ Cell □ Work ( )		Secondary Number: □Home □ Cell □ Work ( )		

INSURANCE INFORMATION

Insurance Provider:	Member ID #:	Insurance Type: □Medical □Vision □Supplement	
Primary Insured Name:	Date of Birth:	SSN:	
Address:	City:	State:	Zip:
Relationship to Patient: □ Self □ Spouse □ Child □ Other			

Insurance Provider:	Member ID #:	Insurance Type: □Medical □Vision □Supplement	
Primary Insured Name:	Date of Birth:	SSN:	
Address:	City:	State:	Zip:
Relationship to Patient: □ Self □ Spouse □ Child □ Other			

GUARANTOR INFORMATION (PARENT/GUARDIAN OR PARTY RESPONSIBLE FOR BALANCES)

Name:	Date of Birth:	SSN:	
Address:	City:	State:	Zip:
Telephone Number:	Relationship to Patient:		

COMMUNICATION CONSENT: I give the following emergency contacts listed below permission to discuss my medical condition or history with the provider or staff.

Last Name:	First Name:	Relation:	Phone Number:
Last Name:	First Name:	Relation:	Phone Number:

ACKNOWLEGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ , acknowledge that I have received have been presented with the Thom Dinh, OD, LLC 'Notice of Privacy Practice Policy' and have been offered a copy of such policy to keep for my records. This Notice describes how Thom Dinh, OD, LLC may use and disclose my protected health information, certain restriction on the use and disclosure of my healthcare information and rights I may have regarding my protected health information. **(INITIAL ONE)**

_____ I hereby acknowledge that I have been provided with a copy of the Policy.

_____ I hereby refuse to acknowledge receipt of the policy. I understand that even though I may refuse to sign this acknowledgement, Provider may still provide treatment to me.

Signature of Patient, or Personal Representative: Date:

Thom Dinh, OD, LLC

OFFICE POLICIES

Welcome to Thom Dinh, OD, LLC, and thank you for choosing us for your eye care needs. In an effort to better serve you, we ask that you familiarize yourself with out Office Policy so that your visits will run smoothly and efficiently. We look forward to seeing you.

APPOINTMENTS: We know that our patients' time is valuable and make every effort to stay on schedule. For this reason, you may be asked to reschedule if you are more than 15 minutes late to your scheduled appointment depending on the day's schedule. If we are still taking walk-ins, you will be considered walk-in status at that time and will be seen accordingly.

Please bring your most current pair of glasses and contact lens boxes, containers, or prescriptions. We also request that you bring a current driver's license, or guardian driver's license, and vision/medical insurance cards to each appointment for us to copy for verification purposes in each patient's file for insurances for which we are in network. Please note after three no shows, we will be able to only work you in, as our schedule permits, on the day you call.

PAYMENTS: All examination fees and copayments are due when service is rendered and are **NON-REFUNDABLE.** We accept payment by cash, check (need a valid driver's license), debit card, credit card, and Care Credit.

GLASSES RECHECKS: For any glasses rechecks, there will be a base refraction fee of $25 unless a more thorough medical examination is required.

CONTACT LENS EXAMINATION: Contact lens exam include follow – ups and dispenses required by the doctor as part of the contact lens fitting for 90 days from the initial date of exam. An office visit fee will apply after the **90 DAYS**. Contact lens prescriptions will be released only after all contact lens dispenses and patient is ready to finalize order. A new complete exam is required for contact lens exams where follow – ups and dispenses were not completed within **90 DAYS** OF THE INITIAL DATE OF EXAM. Usual and customary fees will apply unless insurance is applicable. Any open boxes of contacts lens are non-refundable. Any contact lens fitting **within** 90 days of initial exam will be charged fitting fee only, unless eye irritation of red eye, then visit will be deemed an office visit.

PAST DUE ACCOUNTS: Accounts not settled within 30 days will be considered past due. A $30 monthly rebilling fee will be applied until the balance is paid. You will be responsible for the original past due balance along with these additional changes.

COLLECTIONS: Open accounts with no payment activity for 90 days may be automatically placed with our collection agency. If this action becomes necessary, you will be responsible for payment of the original balance plus any billing charges, finance charges, collection fees, and attorney fees and expenses incurred in collecting amounts owed.

VISION AND MEDICAL INSURANCES: For your convenience, we file claims with insurance companies for which we are in network. However, it is the patient's responsibility to be aware of the insurance benefits and address any such issues with the insurance company. Please remember that you may be ultimately responsible for payment if your insurer or health plan does not pay in full.

We accept BOTH vision and medical insurances and which to use is determined by the type of exam. Vision insurances only cover routine eye exams without any medical history, complaints, or diagnosis affecting the eyes. Medical insurances cover exams with ocular symptoms or diagnosis, such as dry eye, itchy eyes, or floaters or if there is a medical history with the potential of affecting the visual system, such as diabetes or persistent headaches. Many medical insurances also cover routine eye exams.

I understand that:

- I am personally responsible for the insurance copayment and any non-covered services including, but not limited to, the contact lens fit and follow-up, non-routine office visits, and optional medical tests.
- Should there be a non-payment from the insurance company for any reason after 30 days of the claim submission, I am personally responsible for the balance of the usual and customary fees less the copayment amount.

I hereby authorize:

- My signature to be used for all insurance claims on my behalf.
- My medical records to be released to all parties related to my insurance.
- Assignment of insurance payment to be issued directly to Thom Dinh, OD, LLC and its Doctors.

I have read, understood, and agree to the terms of the Office Policy and consent to treatment. I understand that I can request a copy of the Office Policy by calling the office at (337) 984 – 7112.

Print: _____ Relationship to patient: _____

Signature: _____ Date: _____