Mobile Vision Care
5900 South Lake Forest Drive
Suite 300
McKinney, TX 75070-2238
Phone: 214-363-5991 Fax: 866-573-0828
www.mobilevisioncare.com

Request for In-Facility Eye Care

Patient Name:_____ Facility Name: _____

This facility is committed to our residents having the highest level of function possible. This includes full visual function for activities of daily living - watching TV, reading, social participation such as bingo and religious services.

It includes management of eye disease related to diabetes, cataracts, glaucoma, macular degeneration. It also includes screening for complications associated with the use of high risk medications such as potiga, seroquel and plaquenil. The doctors of Mobile Vision Care provide dilated eye exams, refractions and ongoing care.

Please make a selection, print name and sign below.

❑ I request to have Mobile Vision Care, Inc. to provide medically necessary comprehensive eye exam and testing.
Please schedule at the next available opening*.

❑ I request to have Mobile Vision Care, Inc provide medically necessary comprehensive eye exam and testing. I am applying for Medicaid.
Please schedule after medicaid is active***

Consent:
As the patient, responsible party (R.P) or designated facility staff member, I request and authorize Kevin Munson, O.D., d.b.a. Mobile Vision Care, Inc. associated optometrists and staff to examine, treat and provide follow up care to the person named above. This consent includes use of pharmaceuticals for examination of the eye and photography of the eye. I acknowledge and consent to the presence of observers such as health care professionals, students, family members, other patients and their family members. I request claims for services provided to be forwarded on my behalf to applicable healthcare payors including medicare, medicaid and supplemental insurance. Patient or R.P. agree to be billed personally for any co-pay, deductible or denied charge including refraction($36). I acknowledge that this form is executed by a patient of adult age, a responsible party including but not limited to a parent, court appointed guardian and by a legally competent individual.

Signature:_____ Date:_____

Print Name:_____

Attn: Facility Personnel – This form must be faxed or mailed to Mobile Vision Care, Inc. for patient to be scheduled. Fax to 866-573-0828

*Completion of this form is not a guarantee that service will be provided.
**We do not accept assignment for all plans.