## PATIENT HISTORY INFORMATION

**PLEASE PRESENT ALL INSURANCE CARDS TO FRONT DESK TO MAKE COPIES FOR YOUR FILE**

How did you hear about our office??

| Last Name | First | Middle | Date: |
|---|---|---|---|
| | | | |

EMAIL TELEPHONE#

EMPLOYER OCCUPATION

PRIMARY CARE PHYSICIAN PHONE #

LAST EYE EXAM DR. WHO EXAMINED YOUR EYES

HOW OLD ARE CURRENT GLASSES HOW LONG WITH CURRENT CONTACTS?

ARE YOU INTERESTED IN CONTACT LENSES TODAY ??

YES **NO**

| Hobbies: | Current Medications: (Please list all or provide a copy) | |
|---|---|---|
| Computers: How many hours per day? | Allergies to Medications? Hayfever?<br>No Yes (which) | Pregnant? No<br>Yes (_____months) |

**Social History ( Required by Most Insurance Companies)**

Do you …. Smoke? Drink? Use recreational drugs?

I request that payment of my insurance benefits , including Medicare, be made payable to The Eye Dr. for any services rendered to me.
I authorize any holder of medical information about me release to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services. I understand I am financially responsible for ALL services, deductibles, and other charges NOT covered by my insurance company in 90 days. INIT _____

### HIPPA LAW

I understand the HIPPA laws as they relate to my privacy and the protection of my personal information by THE EYE DR.
I am entitled to a copy of THE EYE DR. HIPPA NOTICES and will be provided a copy upon request. INIT_____

### Patient Payment Policy

We Accept payment by Cash, Check, VISA, MasterCard, American Express and Discover.
We Appreciate payment IN FULL for all orders. If that is not possible then a minimum 50% deposit is required to place your order
Copayments and fees for services rendered are due the same day services are received. The balance will be due before dispensing.
Orders left over 30 days will be returned to the lab and deposit will be forfeited. NO REFUNDS.
Once orders have been confirmed and submitted to the lab we cannot give a refund.

If you are NOT satisfied with your frames we will gladly exchange them ONCE within 30 days.
*Patients will be responsible for the difference if exchanged frame price is higher and a $20.00 restocking fee.
Lenses covered by insurance may or may not be covered under the exchange

Patients experiencing problems with their glasses or contacts can be re-examined within 30 days of the initial eye exam.
Problems reported after 30 days will incur an office visit fee starting at $55.00 to be re-examined by the doctor.
We CAN NOT guarantee that prescriptions filled at an outside lab will be made to the same specifications required by our doctor.
Patients who choose to have their prescriptions filled by an outside lab will be responsible for a $55.00 refraction fee if the doctor has to recheck glasses manufactured incorrectly at an outside lab.

Contact Lenses can NOT be returned once the boxes are opened, the prescription has been finalized and your fitting completed.
Once contact prescription has been finalized NO MORE TRIAL LENSES WILL GIVEN.

Insurance information must be presented at the time services are rendered in order to gain authorization eligibility.
We are happy to bill your insurance company once we have determined that you are eligible for services.
Please note that insurances that are not paid in 90 days will become the responsibility of the patient.

**Patient Signature:** _____ **Date:** _____

## Retinal Exam – Retinal Exam without drops - NO DILATION

The Retinal photo is used by our optometrists to get a more comprehensive view of the eyes **WITHOUT EYEDROPS**. This will detect possible abnormalities or signs of disease and can provide early diagnosis and treatment. In some instances, a dilated retinal exam is still required in addition to retinal photo if chosen. It is, however, recommended to have both retinal photo AND a dilated retinal exam to ensure the most comprehensive retinal evaluation. If you choose not to have dilation in addition to retinal photo, you do understand that some areas of the eye cannot be evaluated thoroughly and diseases such as some early glaucoma, tumors, retinal holes, and detachments can be missed. **Patient co-payment for the Retinal Photo is $25.00** which is payable today upon receipt of the service. We will inform you if your particular insurance plan covers the retinal photo co-payment. If you choose NOT to have the Retinal photo then you will be dilated to examine your retina.

*****PLEASE NOTE: the dilation eye drops will leave your vision blurry at both near and far distances and you will be sensitive to the light for at least 4-5 hours following the eye drops.**

☐ **YES**. I want the Retinal Photo to make certain I am receiving the most comprehensive retinal evaluation possible. I also understand that the Dr. will advise me if it is important to have my eyes dilated in addition to the Retinal Photo because of their findings and/or if there are areas of the retina not captured by Retinal photo.

☐ **NO.** I choose **NOT** to have the Retinal Photo today. I understand that my pupils **WILL** be dilated today as part of my comprehensive exam and I understand the side effects of the eye drops

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## Contact Lens Patient Agreement

Due to the nature and possible problems associated with the wearing of contact lenses, it is critical that contacts be worn on the schedule prescribed to maintain the health of your eyes. To assure that the patients understand this very important consideration our optometrists have developed this patient agreement form.

☐ I agree to be fitted for contact lenses today and fitting fees ***will start at $85.00***. The fees will vary depending on the type of lenses the doctor knows are best suited for your lifestyle, wearing schedule, activities and hobbies.

☐ Full payment of fees for contact lens services is due at the time of the examination.

☐ Patient is solely responsible for care and maintenance of lenses using (solutions) recommended by us: **OPTIFREE or COMPLETE or BOSTON for RPGs**. Our optometrists DO NOT recommend generic brand solutions for the care and maintenance of contact lenses. Always wash hands before handling lenses. Lenses are to be stored and cleaned immediately upon removing the lenses or dispose of, if at the end of the prescribed replacement period.

☐ **Patient agrees to schedule a follow up to assure proper fit and adaptation to contacts.** Scheduling of follow up will be determined during the fitting examination and an appointment will be schedule for you at that time. If diagnostic (trial) lenses need to be ordered then the appointment may be scheduled upon receiving the trial lenses in our office. Follow-ups for all problems and concerns related to the contacts lenses will be covered for a period of **2 MONTHS**. Medical problems related to the use and abuse of lenses will be treated as a medical office visit for which the patient will be responsible for presenting medical insurance and will be responsible for co-payments related to such visits if covered by the medical insurance plan. Patients agree to return to doctor's office if any problems develop with the eyes or wearing of contact lenses during use period of contacts.

☐ Fees for follow-ups not included in original fitting fee (**after 2 months of the initial fitting**) will start at $50.00. Fees for medical visits related to abuse of lenses or infections from lenses will start at $75.00. If a patient wishes to be fitted into another brand of contact lenses after the original fitting has been completed there will be a refit fee of $50.00.

☐ For health safety and safety reasons contact lenses are **neither returnable NOR** refundable after the prescription has been finalized if boxes have been opened. This is a security measure mandated by the government and the contact lens manufacturers

**Patient Signature: _____** **Date: _____**