New Patient Information

Name: ____________________________________ Sex: M F Date of Birth: _____/_____/_____

Patient Soc. Sec. #: __ __ __ - __ __ - __ __ __ __ Marital Status: ○ Single ○ Married ○ Other

Street Address: ____________________________ City: _____________ State: ________ Zip: _____________

○ I receive mail here

Name of Guarantor/Parent if under 18: ______________________________________

Home Phone: ___________________ Work Phone: ___________________ Cell Phone: _________________________

Employment Status: ○ Employed FT ○ Employed PT ○ Not Employed ○ Retired ○ Student FT ○ Student PT

Preferred method of contact: ○ Home Phone ○ Work Phone ○ Cell Phone ○ Email ○ Text ○ Postal Mail

Email: ________________________________

Employer: ________________________ Occupation: ___________________________

Emergency Contact Name & Phone #: ______________________________________

○ Ok to discuss medical information with this person

How Did You Choose Our Office? ○ Referred by: ____

Primary Medical Insurance

Policy Holder (PH) Information (complete only if you are not the primary policy holder)

Carrier (circle): Medicare Medicaid Aetna Anthem BC/BS Cigna Prominence HHP Other

____

ID#: ____ Group #: ____

Name of PH: _______________________ Date of Birth of PH: _________ Soc. Sec. # of PH: __ __ __ - __ __ - __ __ __ __

○ PH address different then patient

Secondary Medical Insurance

Carrier (circle): Medicare Medicaid Aetna Anthem BC/BS Cigna Prominence HHP Other

____

ID#: ____ Group #: ____

Name of PH: _______________________ Date of Birth of PH: _________ Soc. Sec. # of PH: __ __ __ - __ __ - __ __ __ __

○ PH address different then patient

Vision Plan Information

Carrier (circle): VSP EyeMed Davis Other ____

ID#: ____

Name of PH: ________________________ Date of Birth of PH: _________ Soc. Sec. # of PH: __ __ __ - __ __ - __ __ __ __

○ PH address different then patient

By signing below you attest the information listed above is true and that you have read and understand the financial policies of this office listed on both sides of this form. If you are using insurance and they deny any part of your claim you agree to pay any outstanding balance. Please provide your insurance card(s) and a valid form of picture identification with this form at check in.

Patient Signature (**OR** parent/guardian if under 18): _____________________________________ Date: ________________

Financial Responsibility Statement/Acknowledgement of Office Policies

Financial Policy

Payment is expected at the time service is rendered and before orders are placed. A $25.00 service fee will be assessed for failure to pay your requested copay at the time of service. A returned check will incur a fee of $25. Any unpaid balances exceeding 30 days post notice of balance owed may be turned over to a collections agency, which will result in an additional fee equal to 35% of the balance owed plus an administrative fee of $25. A cancellation fee (amount varies based on total time scheduled) may be assessed for any appointment missed without at least 24 hours prior notice. By signing you agree to be held liable for all expenses, costs and reasonable court, attorney and collection agency fees for any delinquent balance.

Prescription Recheck Policy

We will recheck your glasses prescription one time at no cost within 60 days of the date on which the prescription in question was determined. This policy does not apply for planned rechecks as determined by the doctor for issues such as expected adaption or amblyopia. For glasses not purchased through our office an inspection fee for confirming the parameters of a prescription pair of glasses will apply. After 60 days, a fee will be incurred for any recheck. Rechecks will not be performed after 6 months from original exam date and a new exam will be necessary.

Eyewear Policies

This office will remake prescription glasses once within 60 days of pickup at no charge to the patient in cases of prescription change. Progressive lens non-adapts will be remade into lined bifocals or trifocals at no additional charge. Any remakes required beyond the initial remake will result in fees for the lenses and any treatments charged at 50% of our usual and customary fees.

Frames purchased from our office have a 2 year manufacturer defect warranty and does not cover acts of abuse. Lenses with a scratch treatment have either a 1 or 2 year warranty, depending on type of scratch treatment purchased, which covers wear and tear scratches but not acts of abuse. Neither of our warranties for frames or lenses cover loss or theft. If you used insurance to purchase your glasses your warranty changes from our standard office warranty to your insurance company's warranty.

If you wish to be reframed, you may do so once for a $50 administrative fee for frames of equal or lesser value. You may select a frame with a higher value and pay only the difference in frame cost and the administrative fee. Reframing will count towards your one time remake option. A $50 administrative fee will be charged for same day cancellations of eyewear orders submitted to the processing lab. A restocking fee of 35% of usual customary charges for custom orders cancelled before completion of the product will be assessed. As eyewear is a custom made medical product, no refunds are available.

Contact Lens Policies

Contact lens services are a separate service from your eye exam. Should you wish to obtain a prescription for contact lenses, either a separate fitting or an evaluation of your current contact lens parameters is required to ensure the health of your eye. Contact lenses come in two forms, custom made and mass produced. Mass produced lenses may be returned for store credit if the boxes are unopened and in saleable condition (i.e. no markings). A restocking fee of 35% of usual customary charges for custom orders cancelled before completion of the product will be assessed. As custom made contact lenses are designed specifically for your eye no refunds are available.

To our patients with vision/medical benefits:

Medical insurance and vision plans are very different in their terms of service and their coverage. We are unable to determine which, if any, can be billed until after the examination is completed and the diagnosis for your primary complaint has been determined. It is your responsibility to know your coverage and co-pay amounts. Please be aware, unless your insurance plan has specific benefits for contact lens fittings, you will be expected to pay that amount along with your co-pay and any other non-covered services. Any out of pocket expenses collected from you at the time of service are ***estimates*** only, your insurance will determine your final out of pocket costs.

We will do our best to inform you of non-coverage prior to performing a service or ordering materials. In the event that your insurance company determines that you are not eligible at the time of service, or makes a determination that you are eligible for a reduced level of coverage, by signing this statement you are confirming your understanding that you are financially responsible for any and all charges incurred by you and not paid by your third-party plan. Be aware that any pre-authorizations received by our office are not a guarantee of payment from your insurance company. After we receive your plan's response, all remaining balances will be due within 30 days. If we do not receive a response from your insurance company within 90 days we will bill you for the balance due in full. Due to the timely filing restrictions imposed by many insurance companies, failure to supply us with the correct insurance information may result in payment in full being owed by you.

By signing below, you attest that this information was provided to you and that you understand your financial obligations.

Patient Signature (or Guardian, if under 18): ____ **Date:** _________________

Guardian Name, if under 18 (Please Print): ____

Patient Name: ______________________________________

Have you ever had any of the following eye problems? If yes, is it current (within the last month)?

Condition	No	Yes	Current?	Condition	No	Yes	Current?
Glaucoma	○	○	○	Eye Turn/Crossed Eye	○	○	○
Macular Degeneration	○	○	○	Double Vision	○	○	○
Cataracts	○	○	○	Lazy Eye/Amblyopia	○	○	○
Retinal Tear/Detachment	○	○	○	Glare	○	○	○
Eye Injury	○	○	○	Flashes	○	○	○
Dryness/Burning	○	○	○	Floaters	○	○	○
Chronic Redness	○	○	○	Eye Surgery	○	○	○
Itching/Allergies	○	○	○	Complete Blindness	○	○	○
Chronic Watering	○	○	○	Prosthetic Eye	○	○	○

If you answered yes to any of the above, please let us know which eye is affected and any other details you feel might be helpful for us to know: ______________________________________

____

Please list all eye drops or ointments currently used: ______________________________________

____

For Glasses Wearers: How old are your glasses? _________ What do you wear them for? ○ Distance ○ Near ○ Everything

What do you like about your glasses? ____________________ What do you not like about your glasses? ____________________

Did you bring your prescription sunglasses? ○ Yes ○ No Did you bring your prescription computer glasses? ○ Yes ○ No

Did you bring your prescription safety eyewear? ○ Yes ○ No Are you interested in new glasses today? ○ Yes ○ No

For Contact Lens Wearers: Are you wearing them now? ○ Yes ○ No Are you happy with your current contacts? ○ Yes ○ No

How is the comfort of your contacts? ____________________ How is your vision with your contacts? ____________________

Average wear time/day? _________ (Hours) How often do you wear them? ____________________

How often do you replace them? ____________________ How often do you sleep in your lenses? ____________________

How old is your present pair? ______________ Brand? ______________ What solution do you use? ______________

Routine eye exams do not include professional services for contact lens evaluations. Any fees are the responsibility of the patient. We are not able to use your materials benefits to pay for this service with most insurances.

Have you ever had any of the following medical problems? If yes, is it current (within the last month)?

Condition	No	Yes	Current?	Condition	No	Yes	Current?
Seasonal/Environmental Allergy	○	○	○	Rosacea	○	○	○
Medication Allergy (List Below)	○	○	○	Multiple Sclerosis	○	○	○
High Cholesterol/Triglycerides	○	○	○	ADD/ADHD	○	○	○
High Blood Pressure	○	○	○	Depression	○	○	○
Stroke	○	○	○	Anxiety	○	○	○
Hyperthyroid (Overactive)	○	○	○	Autism	○	○	○
Hypothyroid (Underactive)	○	○	○	Dementia	○	○	○
Diabetes (Insulin Dependent, 1)	○	○	○	Asthma	○	○	○
Diabetes (Non-Insulin Dependent (2)	○	○	○	COPD	○	○	○
Herpes Simplex (Oral/Genital)	○	○	○	Migraine Headaches	○	○	○
Herpes Zoster (Pox/Shingles)	○	○	○	Arthritis	○	○	○
HIV/Aids	○	○	○	Sjogren's Disease	○	○	○
Lyme Disease	○	○	○	Autoimmune Disorder	○	○	○

Other medical conditions or details you feel might be helpful for us to know: ____

____

Please list all medications/birth control/vitamins/supplements currently used: ____

____

____

Family History: Do you have any blood relatives with any the following:

Ocular Condition	No	Yes	Relation	Medical Condition	No	Yes	Relation
Glaucoma	○	○		High Blood Pressure	○	○	
Eye Turn/Crossed Eye	○	○		Diabetes	○	○	
Macular Degeneration	○	○		Thyroid	○	○	
Ocular Cancer	○	○		Autoimmune Disorder	○	○	
Retinal Tear/Detachment	○	○		Cancer	○	○	

Review of Symptoms: Have you had any of the following? If yes, is it current (within the last month)?

Symptom	No	Yes	Current?	Symptom	No	Yes	Current?
Allergy				**Hematologic/Lymphatic**			
Itching	○	○	○	Bruise Easy	○	○	○
Sneezing	○	○	○	Slow Clotting	○	○	○
Hives	○	○	○	Swollen Nodes	○	○	○
Cardiovascular				**Integumentary (Skin)**			
Chest Pain	○	○	○	Rash	○	○	○
Racing heartbeat	○	○	○	Sores	○	○	○
Constitutional				**Musculoskeletal**			
Unplanned Weight Loss	○	○	○	Stiffness	○	○	○
Unplanned Weight Gain	○	○	○	Cramps	○	○	○
Loss of Appetite	○	○	○	Back pain	○	○	○
Fatigue	○	○	○	**Neurological**			
Endocrine				Headaches	○	○	○
Frequent Urination	○	○	○	Memory Problems	○	○	○
Excessive Thirst	○	○	○	Muscle weakness	○	○	○
Gastrointestinal				Vertigo	○	○	○
Stomach Pain	○	○	○	**Psychiatric**			
Stomach Upset	○	○	○	Anxious	○	○	○
Jaundice	○	○	○	Depressed	○	○	○
Genitourinary				Paranoid	○	○	○
Trouble Urinating	○	○	○	**Respiratory**			
Burning on Urination	○	○	○	Trouble Breathing	○	○	○
Ear/Nose/Throat				Shortness of Breath	○	○	○
Sinus pressure	○	○	○	Wheezing	○	○	○
Cough	○	○	○	If you have symptoms not listed above please list here:			
Dry Mouth	○	○	○				
Hearing Loss	○	○	○				
Trouble Swallowing	○	○	○				

For Women: Are You Pregnant? ○ Yes ○ No If Yes, How Many Months? ________ Are you breast feeding? ○ Yes ○ No

Social History:

Do you use tobacco? ○ Yes ○ No Type used: ○ Cigarettes/Cigars ○ Chewing tobacco For how long ? __________

Did you ever use tobacco? ○ Yes ○ No If you've quit, how long ago? ____________________

Do you drink? ◌ Yes ◌ No Type used: ◌ Beer ◌ Wine ◌ Liquor For how long? ______________________

Do you use any recreational drugs? ◌ Yes ◌ No What type(s): ______________________ For how long? ______________

Smoking is a known risk factor in the development of macular degeneration, cataracts, dry eye and many other ocular conditions. It is our recommendation that you take action to cease smoking to limit your risk of eye disease.

The Centers for Medicare and Medicaid Services (CMS) requests **ALL PATIENTS** provide the following information about race, ethnicity and preferred language. These classifications were determined by CMS. If you have questions please ask the staff.

Ethnicity: ◌ Not Hispanic or Latino ◌ Hispanic/Latino **Preferred Language:** ◌ English ◌ Spanish ◌ Other ____________

Race: ◌ American Indian/Alaskan Native ◌ Asian ◌ Black/African American ◌ Hawaiian/Other Pacific Islander
◌ Caucasian
◌ Other_____________________________

By signing below you attest the information provided on this form is accurate and true.

Patient Signature (Guardian if under 18): ____ **Date:** ________________

Guardian Name (if under 18, Please Print):____

ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that Visionary Eye Center make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

- ☐ I have read, or have had explained to me, Visionary Eye Center’s Notice of Privacy Practices prior to any services offered at Visionary Eye Center and agree to continue my care with Visionary Eye Center under said terms.
- ☐ I declined to read Visionary Eye Center’s Notice of Privacy Practices, but wish to continue my care with Visionary Eye Center under the terms of Visionary Eye Center’s Privacy Policies.
- ☐ I have read, or have had explained to me, Visionary Eye Center’s Notice of Privacy Practices prior to any services offered at Visionary Eye Center and do not wish to continue my care with Visionary Eye Center under said terms.

____
Patient Name, printed

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

________________________________ ________________
Patient Signature Date

If you are signing as a personal representative of the patient, please indicate your relationship

____ ______________________
Representative   Relationship to Patient   Date