Patient's Name:_____ _____ _____
(last) (first) (middle)

Mailing Address:_____ _____ _____
(street) (city) (state) (zip)

Phone Numbers: Home:_____ **Cell:**_____

Email Address_____

Patient's Social Security #:_____

Birthdate:_____

Patient's Status: Single Married Widowed

Emergency Contact: _____**Emergency Phone:**_____

Responsible Party (if other than above)
Name:_____**Relation to Patient?**_____

Insurance Information: Please allow receptionist to photocopy your insurance card.

Medicare and many private insurance carriers do not cover the refraction (the test to determine the power for eyeglasses and best corrected vision) You are responsible for this charge plus any insurance deductibles and/or copayments.

All payments and co-payments are due on the day of service.

Signature:_____**Date:**_____

Name _____ **Date of Birth** ___/____/____

Primary Physician: _____ **Referring Doctor:** _____

Pharmacy: _____ **Location:** _____

Allergies: ☐ None Known

_____ Reaction Type: _____

_____ Reaction Type: _____

Past Ocular History: _____

_____

Current Eye Medications: ☐ NONE _____

Past Medical History: ☐ No History Of Illness

☐ Heart Problems ☐ Hepatitis A/B/C ☐ Lung Disease ☐ Lupus ☐ Anemia
☐ COPD ☐ High Blood Pressure ☐ Migraine ☐ Arthritis ☐ Stroke
☐ Diabetes ☐ Type I ☐ Type II ☐ High Cholesterol ☐ Eczema ☐ HIV
☐ Psychiatric Disorder ☐ Asthma ☐ Fibromyalgia ☐ Thyroid ☐ Sjrogrens
☐ Multiple Sclerosis ☐ Liver Disease ☐ Cancer _____
☐ Herpes Simplex ☐ Syphillis ☐ Chicken Pox ☐ Monkey Pox ☐ MRSA
☐ Herpes Zoster / Shingles ☐ Meningitis ☐ Toxoplasmosis
☐ Other: _____

General Surgeries: ☐ None

_____

Current Medications: _____

_____

Family History: ☐ NONE

☐ Diabetes ☐ Stroke ☐ Blindness ☐ Glaucoma ☐ Lazy Eye
☐ Retinal Disease ☐ Caner ☐ Heart Disease ☐ TB

Social History:

Smoking: ☐ Current Smoker ☐ Former ☐ Never

Alcohol Use: ☐ Yes ☐ No If yes, how much _____

Drug Use: ☐ Yes ☐ No If yes, how much _____

Patient Signature: _____ **Date:** _____

Official Policy on Standard Insurance and Managed Care Insurers

In order to accommodate the needs and requests of our patients, we have enrolled in numerous managed care insurance programs.
While we are please to be able to provide this service to you, it is extremely difficult for us to keep track of all the individual requirements of each plan. Each plan has different stipulations regarding how often services may be rendered by whom and, even more importantly, where those services may be performed. Even within the same insurance company, the plans differ depending upon what type of contract your employer has negotiated.

Unfortunately, if you do not inform us of any special requirements in your contract and we subsequently order services, such as lab work or hospitalization that are not covered, we or the selected medical facility will have no choice but to bill you directly for those charges. Payment for those charges will be your responsibility.

FINANCIAL AGREEMENT: The undersigned agrees, as patient or agent of the patient is accepting financial responsibility for services rendered and is obligated to pay the account balance in full. If there is verifiable Medical Insurance Coverage or other verifiable financial coverage, a claim will be filed as a convenience to the patient. However, it remains the responsibility of the patient/guarantor to follow up with his/her insurance company if the claim is not paid within 45 days. Pre-certification is the responsibility of the patient/guarantor and should be secured prior to services whenever possible, within policy limitations in case of emergencies. Payment for services not covered by the insurance or third party payor is the responsibility of the patient/guarantor.

1. REMINDER: Payment of co-pays and deductibles are required at the time services are rendered.
2. HMO and PPO participants are responsible for verifying that referred specialists are participating providers for their plan and that a referral, if required, is obtained prior to their appointment by your primary care physician. If a referral is needed for any visit, it is the patient's responsibility to obtain that referral.
3. Tissue reports, special lab tests, and other laboratory procedures may be billed to you from a reference lab.
4. Vision Plans require preauthorizations. Please provide us with your vision plan information so that a preauthorization may be obtained. If a preauthorization is not obtained you will be responsible for all charges at the time of service.

We file insurance claims for the physicians' charges to contracted PPO's and HMO's. A copy of your insurance card and a signed form is required. Any remaining balance after the insurance payment is your responsibility. Follow-up with your insurance carrier for reconsideration of your claim is your responsibility. Our office will gladly assist you in any way that we can.

I have read and understand the office policy stated above and agree to accept responsibility as described.
I authorize the release of any medical or other information necessary to process any insurance claims.

Signed:_____ SS#_____ Date:_____

Contact Lens / Vision Plan Policy

Contact lens prescriptions are written after a complete contact lens evaluation has been performed. Contact lens patients will be charged a contact lens fitting fee, in addition to their comprehensive exam fee. The contact lens fitting fee covers the contact lens evaluation, a pair of trial contact lenses and any necessary contact lens follow-up visits within a 90 day period. The contact lens fee is determined by your prescription needs. If adjustments are needed, or changes to the contact lens prescription are required, they must be requested within 90 days of the original date of exam. If changes are required outside of the 90 day period then an additional fitting fee may be charged. New patients and any contact lens brand change may be required to return for a contact lens follow-up to evaluate the changes. If this appointment is not kept the contact lens prescription will not be final and the contact lens prescription will not be released.

Vision Plans:
Some vision plans will pay the contact lens fitting fee in full. Some vision plans allow the member to deduct the fitting fee from the contact lens materials allowance. Some vision plans require a contact lens fitting copay. Most vision plans require the materials copay and/or contact lens fitting copay be collected on the day of the visit. We will be happy to discuss your vision plan benefits and charges with you.

Contact Lens Policy and Fee Agreement

• I understand that I am responsible for the contact lens fitting fee at the time of my visit. _____

• I understand that it is my responsibility to schedule my contact lens follow-up appointments in a timely manner. I understand that any appointment required outside of 90 days from the initial visit may require an additional office visit fee. _____

• I understand that if I cancel or do not keep my contact lens follow-up appointment my contact lens prescription will not be finalized and will not be released. _____

• I understand that if I am using a vision plan, my vision plan may require a materials copay in order to file the contact lens fitting fee under the contact lens materials allowance. _____

• I understand that I may be charged an additional handling fee for a replacement diagnostic contact lens if I lose or damage my lens(es), do not return to my follow-up with my diagnostic contact lens(es), or if multiple diagnostic lenses are required. This fee ranges from $2.50-$5.00 per lens. This handling fee depends on the contact lens manufacturer. _____

• Our Optometrists will make every effort to fit patients with contact lenses the day of their appointment, however, some prescriptions will be outside the range of contact lenses on hand or require a custom contact lens. These lenses will be ordered and are typically available within 1-4 weeks. I understand that I will still be responsible for the contact lens fitting fee the day of the appointment, even if the contact lenses have to be ordered for me. _____

• I understand that contact lens fitting fees are non-refundable. If I decide I do not like contact lenses and I decide to discontinue wear, fitting fees will not be refunded. _____

• Contact Lens orders: Opened boxes of contact lenses cannot be exchanged. Refunds will not be processed on opened boxes of contact lenses. _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION
NOTICE OF PRIVACY PRACTICES ACKNOWLDEDGES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payments from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy.

The HIPAA privacy act gives patients the right to request a restriction on the uses and disclosures of their protected health information (PIH). The patient is also provided the right to request confidential communications or that a communication PHI made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

You may contact me in the following manner:

Telephone: Home____Work____Cell____Other____Auto Dial____Text ____

Mail Address: ___Fax: ____Email: _____
May we leave a message on your answering machine? Yes_____No____

I hereby give Oculus Eyewear, LLC permission to release any necessary information including examination results, test results and appointment dates and/or times to the following friends or relatives: (please print)
NAME OF INDIVIDUAL PHONE # RELATIONSHIP TO PATIENT

1_____

2_____

3_____

_____ _____
Patient/Guardian Signature Date

_____
Print Name