



Welcome!

We welcome you to our practice and ask that you kindly complete, or correct, all information below.

Patient Name: _____ D.O.B. _____
Last complete eye exam was: _____ Occupation: _____

Patient Medical History:

Have you been diagnosed or do you take medication for the following conditions:

- 1. Diabetes: Yes / No
2. High Blood Pressure: Yes / No
3. High Cholesterol: Yes / No
4. Asthma: Yes / No
5. Arthritis: Yes / No
6. Sleep Apnea: Yes / No

Patient Ocular History:

Have you been diagnosed with the following eye conditions:

- 1. Cataracts: Yes / No
2. Glaucoma: Yes / No
3. Macular Degeneration: Yes / No
4. Retinal Detachment: Yes / No
5. Lazy or Crossed Eyes: Yes / No

Family Ocular History:

Do any of your blood relatives have the following eye conditions:

- 1. Glaucoma: Yes / No
2. Macular Degeneration: Yes / No
3. Retinal Detachment: Yes / No
4. Lazy or Crossed Eyes: Yes / No

Please list all current medications: _____

List any allergies to medication: _____

Patient/Parent's Signature Date

Office Use:
Reviewed: __/__/__
Reviewed: __/__/__
Reviewed: __/__/__
Reviewed: __/__/__
Reviewed: __/__/__
Reviewed: __/__/__
Reviewed: __/__/__

Office Use:
OD__
OD__
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Acknowledgement of Receipt of Privacy Practices:

This practice is concerned about the privacy of our patient’s health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your healthcare services will in no way be conditioned upon your signed acknowledgement. If you decline to provide a signed acknowledgement, we will continue to provide your treatment and will use and disclose your protected health information for treatment, payment and health care operations when necessary.

I acknowledge that I have received the Notice of Privacy Practices for Envision Family Eye Care

Name of Patient

Signature of patient or authorized representative

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Medical Insurance Policy:

As part of our services, we are happy to assist you, the patient, in determining the benefits of your individual policy and in collecting your insurance benefit reimbursement. To avoid any misunderstandings please read the following statements carefully:

1. The legal obligations of your insurance provider are between yourself and your insurer, not between this practice and your insurer.
2. When your insurance provider(s) have settled your plan’s covered items, you will be notified by a monthly statement if there were any unpaid balances. Unpaid balances can include non-covered items or services, co-pays, deductibles, lapses, ineligibility or termination of coverage. Unpaid balances are the sole responsibility of the patient.
3. To keep the cost of records and collections down any patient portion amounts on your order will be due at the time of service.
4. I authorize the use of this form on all insurance submissions as well as authorize the release of information to all my insurance provider(s), and allow the doctor to act as my agent to assist me in obtaining payment from my insurance provider(s).
5. I authorize payment to be made directly to the doctor and permit a copy of this authorization to be used in place of the original.

Signature of patient or authorized representative

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Refund/ Return Policies:

No refund can be made on clinical procedures or services, including comprehensive eye examination, refraction, contact lens fitting, and medical office visits. Refunds for optical products, which include frames, lenses, and unopened boxes of contact lenses, can only be made within 30 days of receiving the product, provided that the product is returned to the office without damage at the time the refund is issued. Opened boxes of contact lenses are non-refundable. After the 30 days period, only 50% of the original payment made by the patient (private-pay or with vision medical insurance) can be issued back to the patient as in-office credit with the return of the product. 90 days after a product is dispensed, no refund, exchange, or return can be made on any goods purchased at this office.

Signature of patient or authorized representative

Patient Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone : (home) : _____ (work) : _____ (cell) : _____

SSN: _____ D.O.B : _____

Email: _____

Responsible Party Information

If different from above:

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Tel: (home) _____ : (work) _____ : (cell) _____

SSN: _____ D.O.B: _____

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Primary Insurance Information

Insurance company: _____

Policy number: _____

Group number: _____

Insured/Member Name: _____

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Secondary Insurance Information

Insurance company: _____

Policy number: _____

Group number: _____

Insured/Member Name: _____

AUTHORIZATION TO RELEASE INFORMATION: I/ WE hereby authorize Envision Family EyeCare to release any medical or incidental information that may be necessary for medical benefit or in processing applications for financial benefit. This includes, but is not limited to, my insurance company, Rehabilitation Services, Social Security Administration and Workers Compensation.

CONSENT FOR TREATMENT: I/WE hereby authorize the practice to administer diagnostic and medical procedures as may be necessary for proper health care, including eye dilation.

OFFICE POLICY ON PAYMENT: I understand that I am responsible for payment on all charges. As a courtesy, my insurance will be billed for me. It is my responsibility to pay deductible, co pay, or any other balance not paid by my insurance company. I authorize insurance benefits to be paid directly to the practice.

Print Name: _____

Signature: _____

Date: _____