



Patient Information

Last Name: _____ First Name: _____ MI: _____ Date: ____ / ____ / ____
(If patient is a minor, name of parent/guardian: _____)
DOB: ____ / ____ / ____ Sex: Female Male SSN#: _____ Marital Status: Single Married Divorced Widowed
Address: _____ City: _____ State: _____ Zip: _____
Home: _____ Cell: _____ Email: _____
Employer: _____ Occupation: _____
Primary Language: English Spanish Other: _____
Race: Asian Caucasian Hispanic/Latino American Indian Black/African American Pacific Islander Other: _____
Emergency Contact: _____ Relation: _____ Phone: _____
Who do you authorize to pick up your prescriptions or discuss your health? _____
Whom may we thank for referring you to our office? _____

Vision Insurance

Subscribers Name: _____ Relationship to patient: _____ DOB: ____ / ____ / ____
Insurance Co: _____ Policy #: _____ SSN#: _____

Medical Insurance

Subscribers Name: _____ Relationship to patient: _____ DOB: ____ / ____ / ____
Insurance Co: _____ Policy #: _____ SSN#: _____

Personal Medical & Social History

Your reason(s) for visiting our office today: _____
Do you have any allergies to medications? Yes No *If yes, explain:* _____

Do you take any medications? (please include over the counter & ocular medications) Yes No *If yes, explain:* _____

List all major injuries, surgeries and/or hospitalizations: _____

Are you nursing/pregnant? Yes No Do you wear glasses? Yes No Do you wear currently wear contacts? Yes No
Are you interested in being fit with contact lenses? Yes No

Are you currently experiencing any of the following concerns? If so, please check the applicable box(es):

- Loss of Vision Blurred Vision Distorted Vision/Halos Double Vision Dryness
- Mucous Discharge Redness/Itching Sandy/Gritty Feeling Burning Eyes Tired Eyes/Eye Strain
- Eye Pain/Soreness Styte/Chalazion Excess Tearing/Watering Headaches/Migraines Glare/Light Sensitive
- Foreign Body Sensation Infection of Eye or Lid Flashes/Floater in Vision Seizures Rheumatoid Arthritis

Personal & Family Medical History

Please list yourself, and/or any immediate family members with the following conditions:

OCULAR:	YES	NO	Relationship to you (please indicate self/maternal/paternal)
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blindness/Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
SYSTEMIC:			
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

If you or an immediate family member have a condition that is not listed above, please explain: _____

Do you use tobacco products? YES NO TYPE/AMOUNT: _____

Do you drink alcohol? YES NO TYPE/AMOUNT: _____

Do you use illegal drugs? YES NO TYPE/AMOUNT: _____

Have you ever been exposed to or infected with: Gonorrhea HIV Syphilis Hepatitis (type): _____

Internal Examination

RETINAL SCREENING: Our office requires new patients and established patients that have not returned for 3+ years to receive a retinal screening on their first comprehensive eye exam. This is a non-invasive procedure that uses ultrasound technology to assist the doctor in examining the internal structures of the eyes. This test enhances the doctor's ability to earlier detect certain ocular pathology such as, macular degeneration, glaucoma and diabetic eye disease. This service is a \$39 fee that insurance does not cover but *is included* in the cost for a self-pay exam.

DILATION: A dilated eye exam is strongly encouraged but not mandatory. Eye dilation enables the doctor to thoroughly examine the internal health of your eyes. This enhances the doctor's ability to detect certain pathology that could potentially cause visual impairment/blindness, such as retinal detachment or tumors. Eye dilation will cause blurred near vision and light sensitivity, which could last anywhere from 4-6 hours. We will provide sunshades to you if you opt in for dilation. If you would like to return on another day for dilation, please let the doctor know.

PLEASE INITIAL BELOW WHETEHR OR NOT YOU CONSENT TO DILATION.

_____ **YES**, I give my permission for eye dilation to be performed. My initials signify that I have read & understand the side effects.

_____ **NO**, I do not give my permission for eye dilation to be performed. My initials signify that although I understand the importance of dilation, I do not give my permission to be dilated. I understand that my decision to decline dilation releases Visionary Eye Care from all liability that may arise from this refusal.

EYEWEAR & WARRANTY POLICY

Visionary Eye Care is proud to offer the latest trends in fashion frames and premium lens styles with superior anti-reflective coatings. Any eyewear purchase that includes any Crizal anti-reflective coating is eligible to add our Manufacturer's Warranty Package to their order. This warranty package offers coverage for two (2) lens replacements and one (1) frame replacement within 12 months of the original purchase date and does not cover accidental/intentional damage, loss, or theft. Visionary Eye Care is not responsible if the frame or lens manufacturer refuses to honor the warranty due to their coverage guidelines. Visionary Eye Care will replace your frame with one of equal or lesser value should your frame become discontinued within the warranty period. Once the warranty is processed and the new frame/lenses are dispensed, the original frame/lenses from the order are required to be sent back to the manufacturer and therefore cannot be kept by or given back to the patient. This manufacturer's warranty can be added at the time of your glasses purchase for a lab processing fee of \$40.00. If you opt out of the warranty package at the time of purchase, you have the option to add the package at a later date for a lab processing fee of \$60.00. This package excludes safety/industrial frames/lenses and patient's own frames. It is our policy to remake your lenses once (at no cost to you) if the original prescription is in error or if the patient is non-adapt to a progressive lens. For non-adapt progressive lenses, we will make lenses in any other design (of equal or lesser value; no refunds issued if the replacement lenses are of lesser value) at no charge within 90 days of dispensing. Original lenses are a medical device containing a custom prescription & must be sent back to our lab when the lenses are replaced. You may return to our office at any time should you need adjustments, replacement of screws or nose pieces, or restringing of Nylon frames.

MY SIGNATURE BELOW CONFIRMS THAT I HAVE READ, UNDERTSAND AND AGREE TO THE POLICY OUTLINED ABOVE

Patient Signature: _____ Date: _____
(or signature of parent/guardian if patient is a minor)

FINANCIAL POLICY

We accept cash, debit cards, Care Credit, NC FSA/HSA, Visa, American Express, Mastercard & Discover for your convenience. All frames, prescription lenses and sunglasses are custom orders and are non-refundable and non-returnable. Orders are processed automatically at the time of purchase and cannot be altered in any way or cancelled once the order has been submitted. There are no exceptions, please deliberate your purchase wisely and consider the advice of our trained professionals. We will gladly bill your primary vision & medical insurance carriers, including Medicaid and/or Medicare, with whom we have a contract, as a courtesy to you. If we are not contracted with your insurance company, we will provide you with all of the information needed so that you may submit your statement to them for reimbursement. In order for us to bill your insurance on your behalf, we must be provided with a copy of your current insurance card at the time of service. Every insurance plan is different, we recommend that you contact your insurance company prior to your visit to verify eligibility & plan coverage. Visionary Eye Care cannot accept responsibility for knowing your insurance coverage. Your insurance coverage is a contract between the insured individual(s) and that company, it is your responsibility as the member to know your benefits. We make every effort to verify your vision coverage prior to your visit as a courtesy to you. **The benefits quoted are an estimate only.** Any difference after the claim has been processed will be your responsibility. **You are ultimately responsible for your account, regardless of your insurance coverage.** The estimated fees are due at the time of service. A service charge of 1.50% per month will be added to any unpaid balance after 30 days (equal to 18% APR). After 120 days, the account will be turned over to a third party for collections. The patient will also be responsible for any legal fees that incur due to the balance being sent to collections.

MY SIGNATURE BELOW CONFIRMS THAT I HAVE READ, UNDERTSAND AND AGREE TO THE FINANCIAL POLICY OUTLINED ABOVE

Patient Signature: _____ Date: _____
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RECIPT OF NOTICE OF PRIVACY POLICIES AND HIPPA CONSENT

In the course of providing services to you, we create receive & store health information that identifies you. It is often necessary to use & disclose this health information in order to treat you, to obtain payment for our services & to conduct healthcare operations involving our office. The notice of privacy practices you have been given describes these uses & disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our notice of privacy practices, the use & disclosure of your health information for treatment purposes not only includes care & service provided here, but also disclosure of your health information as may be necessary or appropriate for you to receive follow-up care from another healthcare professional. Similarly, the use & disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payors or insurers for claims review, determination of benefits & payment; (3) our submission of your health information to auditors hired by third-party payers & insurers, and (4) other aspects of payment described in our notice of privacy practices. Our notice of privacy practices will be updated whenever our privacy practices change, you can receive an updated copy at our office at any time. When you sign this consent document, you signify that you have received a copy of our notice of privacy practices & agree that we can & will use and disclose your health information to treat you, to obtain payment for services and to perform healthcare operations. You have the right to ask us to restrict the use or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our notice of privacy practices, we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Please refer to our notice of privacy practices to learn how to ask for a restriction.

MY SIGNATURE BELOW CONFIRMS THAT I HAVE READ, UNDERTSAND AND AGREE TO THE POLICY OUTLINED ABOVE

Patient Signature: _____ Date: _____
(or signature of parent/guardian if patient is a minor)