

Patient Information

LAST NAME:		ADDRESS:	APT #:	
FIRST NAME:	MIDDLE INITIAL:	CITY:	STATE:	ZIP:
SEX: F / M	DATE OF BIRTH:	AGE:	HOME #:	WORK #:
SOCIAL SECURITY #:		CELLULAR #:		
EMPLOYER:	OCCUPATION:	EMAIL:		
EMPLOYMENT STATUS: <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> RETIRED <input type="checkbox"/> COLLEGE STUDENT				

Responsible Party / Adult accompanying a minor

LAST NAME:		ADDRESS:	APT #:	
FIRST NAME:	MIDDLE INITIAL:	CITY:	STATE:	ZIP:
SOCIAL SECURITY #:		HOME #:	WORK #:	
SEX: F / M	DATE OF BIRTH:	CELLULAR #:		
RELATIONSHIP TO PATIENT:		EMPLOYER:		

Insurance

VISION INSURANCE:		MEDICAL or SECONDARY INSURANCE:			
POLICY HOLDER'S ID #:	GROUP #:	POLICY HOLDER'S ID #:	GROUP #:		
POLICY HOLDER'S SOCIAL SECURITY #:		POLICY HOLDER'S SOCIAL SECURITY #:			
POLICY HOLDER'S NAME:		POLICY HOLDER'S NAME:			
POLICY HOLDER'S DATE OF BIRTH:	RELATIONSHIP TO PATIENT:	POLICY HOLDER'S DATE OF BIRTH:	RELATIONSHIP TO PATIENT:		
POLICY HOLDER'S ADDRESS		POLICY HOLDER'S ADDRESS:			
CITY:	STATE:	ZIP:	CITY:	STATE:	ZIP:
POLICY HOLDER'S PHONE #:		POLICY HOLDER'S PHONE #:			
POLICY HOLDER'S EMPLOYER:		POLICY HOLDER'S EMPLOYER:			
POLICY HOLDER'S MARITAL STATUS: <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DOMESTIC PARTNER		POLICY HOLDER'S MARITAL STATUS: <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DOMESTIC PARTNER			

Contact Lens Policy

Should you decide to have a contact lens exam, additional fees may apply to include lens evaluations and follow up visits within one month.

Medical Office Visit Policy

Any type of medical eye condition may result in an office visit which is not covered by vision insurance. Payment for this service is required at the time of visit.

Practice Policies & Signature on File

I authorize the doctor to release any information including the diagnosis and records of any treatment or examination rendered to me or my child to third party payers and/or practitioners. I will inform this office of any changes in my medical history, insurance coverage, telephone number and/or address as they occur. I herein authorize payment of vision/medical benefits to Dynamic Eye Care LLC when an assigned claim is filed. I authorize the use of this form or a copy (or fax) to be used in place of this original on all my insurance submissions, if needed. An adult accompanying a minor patient (the "responsible party") is responsible for full payment of the minor patient's account. I UNDERSTAND AND ACCEPT THAT I AM FINANCIALLY RESPONSIBLE FOR ALL EXPENSES INCURRED FOR SERVICES PROVIDED REGARDLESS OF MY INSURANCE STATUS.

As a courtesy to our patients, we will bill your insurance company. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Your account with this office is your responsibility whether or not your insurance company pays. In the event that your account becomes past due, your balance will accrue interest at the rate of 1.5% per month (18% per annum). We are preferred providers for most vision insurances, which means we have agreed to accept reduced reimbursement for our professional services. However, despite this fact, some insurers may use a variety of tactics to avoid, delay, or inappropriately pay for our services, in addition to the already reduced ("contracted") fee schedule that we have agreed to. As your advocate, we will make every effort to obtain appropriate payment from your insurance company. However, if your insurance company has not paid your account appropriately, in full within 60 days from the date of service, your account will be due and payable by you, regardless of whether or not your insurance company states otherwise. In the event that you fail to pay in full or make any kind of satisfactory arrangement for payment or otherwise within 60 days of your first bill, (or we are unable to locate/notify you of your account status despite reasonable effort) your balance will be turned over to our collection agency. A \$25 charge will be assessed to all collection accounts, in addition to any collection charges and accrued interest. If your account is referred to our collection agency, interest will continue to accrue at the rate noted herein. In addition, you will be responsible for all collection costs, attorney fees, court costs, service fees, and associated miscellaneous fees and costs.

Your medical records will be kept for 5 years from the last date of service and/or 5 years from the date the patient attains the age of 18 years.

Furthermore, my signature here acknowledges that Dynamic Eye Care LLC has informed me that they have a Notice of Privacy Practices (which describes how medical information about you may be used and disclosed and how you can get access to this information—see green page) as in compliance with HIPAA.

I certify that the given information is correct to the best of my knowledge. MY SIGNATURE BELOW INDICATES THAT I UNDERSTAND AND ACCEPT ALL OFFICE POLICIES LISTED ON THIS PAGE, INCLUDING CONTACT LENS, MEDICAL OFFICE VISIT, AND FINANCIAL POLICIES.

Signature: _____ Date: _____

Have you ever had eye surgery? Yes No If yes, please list _____
 Have you ever had an eye injury? Yes No If yes, please list _____
 Have you ever worn contacts? Yes No If yes, what brand? _____
 Drug Allergies: _____
 Current Medications: _____

REVIEW OF SYSTEMS Do you currently have any problems in the following area? PLEASE CIRCLE ALL THAT APPLY.

ALLERGIC: seasonal allergies, sneezing, itching other: _____	<input type="checkbox"/> No
CARDIOVASCULAR: heart disease, high blood pressure, cholesterol, stroke other: _____	<input type="checkbox"/> No
CONSTITUTIONAL: fever, weight loss/gain, fatigue, trauma other: _____	<input type="checkbox"/> No
ENDOCRINE: diabetes, hyperthyroid, hypothyroid other: _____	<input type="checkbox"/> No
GASTROINTESTINAL: Hepatitis, Crohn's disease, colitis, ulcer, constipation, diarrhea other: _____	<input type="checkbox"/> No
GENITOURINARY: painful/frequent urination, STDs, kidney/bladder problems other: _____	<input type="checkbox"/> No
EARS, NOSE, MOUTH, THROAT: sinus congestion, respiratory infection, earache other: _____	<input type="checkbox"/> No
BLOOD / LYMPH: anemia, leukemia, bleeding problems other: _____	<input type="checkbox"/> No
IMMUNOLOGIC: HIV/AIDS, lupus, arthritis, Sjogren's other: _____	<input type="checkbox"/> No
SKIN: rosacea, eczema, psoriasis, acne other: _____	<input type="checkbox"/> No
MUSCLES, BONES, JOINTS: joint pain, stiffness, swelling, arthritis other: _____	<input type="checkbox"/> No
NEUROLOGICAL: MS, epilepsy, paralysis, seizures, numbness other: _____	<input type="checkbox"/> No
PSYCHIATRIC: depression, panic disorder, schizophrenia other: _____	<input type="checkbox"/> No
RESPIRATORY: asthma, bronchitis, emphysema, shortness of breath other: _____	<input type="checkbox"/> No

EYE HISTORY

Please check any current problems

- Glaucoma
- Cataracts
- Macular degeneration
- Retinal problems
- Flashes / Floaters
- Loss of side vision
- Blurred vision with glasses/contacts
- Distorted vision with glasses/contacts
- Double vision
- Eye turn/strabismus
- Redness
- Mucous discharge
- Dryness
- Sandy / Gritty feeling
- Burning
- Watering / Tearing
- Glare / Light sensitivity
- Itching
- Eye fatigue
- Eye pain / Sore eyes
- Styes
- Chronic infections
- Other: _____

SOCIAL HISTORY Please answer the following questions.

Are you currently pregnant? Yes No Do you consume alcohol? Never Occasionally Frequently
 Are you currently nursing? Yes No Do you smoke? Never Occasionally Frequently Former smoker

FAMILY HISTORY Check if any medical or eye diseases run in your family and note their relationship to you.

Glaucoma _____ Diabetes _____ High blood pressure _____
 Cataracts _____ Retinal disease _____ Other: _____
 Macular degeneration _____ Heart disease _____

Dilated Fundus Exam Informed Consent

Dilating the pupil with eye drops allows the doctor a much better view inside the eye to detect conditions such as glaucoma, cataracts, retinal detachments, macular degeneration, diabetes, and high blood pressure. Without dilation, the doctor has a limited view of the interior of the eye and would not be able to detect any tears, holes, hemorrhages, or abnormalities that occur in the far periphery of the retina. **It is strongly recommended that all patients receive this evaluation. It is especially important for those patients who are over the age of 40, have a history of diabetes, high blood pressure, flashes of light or floaters, high nearsightedness, cataracts, or a family history of glaucoma or retinal problems.** Patients will experience light sensitivity and blurred vision especially at near distances for 4-6 hours. We recommend you have a driver, although in most cases you can drive yourself. Side effects from the drops rarely occur, but if you should experience any eye pain or nausea, please contact this office or an eye care specialist immediately. The doctor will be happy to answer any questions you have.

I certify that the given information is correct to the best of my knowledge.

Patient's Signature: (If patient is a minor, guardian must sign)

 _____ Dilation: YES / NO Date: _____



Patient Name: _____

Date: _____

DRY EYE SURVEY

Do your eyes ever feel or do you experience:

Gritty or sandy sensation?	Never	Slight	Moderate	Severe
Pain or soreness?	Never	Slight	Moderate	Severe
Fluctuating vision?	Never	Slight	Moderate	Severe
Occasional tearing?	Never	Slight	Moderate	Severe
Blurred vision while reading?	Never	Slight	Moderate	Severe
Discomfort in windy conditions?	Never	Slight	Moderate	Severe
Discomfort in air conditioned areas?	Never	Slight	Moderate	Severe

ALLERGY SURVEY

Do you EVER suffer from red eyes, itchy eyes, watery eyes, or swollen eye lids?	Yes	No
Do you EVER use an over-the-counter or prescribed eye drops (i.e. Visine A, Visine AC, Opcon A, etc.) to treat red eyes, itchy eyes, watery eyes, or swollen eye lids?	Yes	No
Do you take any prescribed or over-the-counter medications like Claritin, Allegra, or Zyrtec for your allergies?	Yes	No

LIFESTYLE SURVEY

Have you had LASIK?	Yes	No
Are you interested in having LASIK?	Yes	No

Please list your hobbies and activities: _____



Patient's Last Name: _____ Patient's First Name: _____

EYEWEAR & CONTACT LENS ORDER POLICIES

Eyewear is custom to you. Once lenses are cut or a frame is used they belong to you. Please make your choice wisely as we **CANNOT GRANT REFUNDS**. Unopened/unaltered contact lens boxes MAY be returnable, depending on the make and manufacturer. All custom devices, including custom contact lenses and/or medical devices, are **NON-RETURNABLE** and are **NON-REFUNDABLE**.

CONTACT LENS FEES & POLICIES

Contact lens prescriptions require a contact lens evaluation, which is **in addition** to an eye glass exam. Most contact lens fitting fees range from \$50 to \$150. Specialty and medically necessary fittings range from \$325 to \$1,000. The type of evaluation is based upon your prescription, type of lens, and expertise necessary. The doctor will determine the best contact lenses for you. Your insurance company may not cover the entire cost of the contact lens evaluation, which means the difference will be **your responsibility**.

A contact lens fitting includes one pair of trial lenses and follow up care **within one month** of the exam date. If a follow up visit is necessary, please keep your appointment, as all contact lens prescriptions must be finalized within **one month**, otherwise **additional fees** may apply. Any voluntary changes to contact lens brand or prescription after the prescription has been finalized are also subject to **additional fees**.

INSURANCE/FINANCIAL POLICIES

We are happy to assist you in the filing of your primary insurance claim, although **we are not expected to know your benefits**. If your insurance does not pay the anticipated amount, if you have an unmet deductible, or your insurance pays you directly, **you are ultimately responsible for the balance of your account**. Please note that an insurance card or insurance authorization does NOT guarantee payment or coverage.

Payment at the time of service is required. If eyewear or contact lenses are to be ordered, full payment is required prior to placing the order. **ALL CO-PAYS AND EXAM EXPENSES MUST BE COLLECTED IN FULL**. We accept cash, debit cards, Visa, Mastercard, and Discover. Late fees and interest will accrue on accounts with unpaid balances after 30 days. Accounts left unpaid after 60 days will be considered delinquent and forwarded to a collection agency. Returned checks and all accounts sent to collections will incur a \$25 charge.

BY SIGNING BELOW, I CERTIFY THAT I HAVE READ AND AGREE TO ALL OF THE ABOVE PROVISIONS.

Patient/Guardian Signature

Date