Welcome to Our Office

Thank you for choosing us for your eye care needs. Our goal is to provide comprehensive eye care and high quality eye wear in an environment of superior service, value and friendliness

Name_____ **Date of Birth**_____

We will be happy to file a claim for your visit to your insurance company. Please list your vision and medical insurance:

Routine vision insurance (for ex: Eyemed, Davis Vision, VSP) is used for general exams to update your eyeglass RX.

Routine Vision Insurance _____ Copay _____ Eligibility _____

Routine Vision Insurance _____ Copay _____ Eligibility _____

Medical insurance (for ex: Independent Health, BC & BS, Univera and Medicare) is used for complete exams or medical visits if there is a medical diagnosis (for ex: diabetes, cataracts, glaucoma, macular degeneration, flashes & floaters, allergies dry eye, pink eye etc.).

Medical Insurance (primary) _____ Copay _____ High Deductible_____

Medical Insurance (secondary)_____ Copay _____ High Deductible_____

Office Policy

All professional fees and material fees are payable at the time of service: For orders to be placed a 50% deposit is required.

Consent to Financial Responsibility
We agree to accept direct assignment from insurance company if allowable. Your signature on this form shall suffice for all insurance forms on a continuing basis. You are still responsible for all non covered services such as deductibles, copays or co-insurance. You are also responsible for providing correct and updated insurance information and referrals for services if required by your insurance company.

Our office staff will assist in anyway possible but you are responsible for understanding your insurance benefits, providing sufficient billing information and determining if services are covered under your plan. If services are not covered the patient is always primarily liable for all charges.

Office Payment Policies
Insurance copays, coinsurance and deductibles must be paid at the time of service. Failure to do so may result in a $10 billing surcharge. Balances over 120 days old may be subject to interest at an annual rate of 24% (2% per month).

Communication Opt-In
By providing contact information, you agree to accept communication from our office via mail, telephone, email, cell phone or text message as long as you are an active patient. You will be considered an active patient for a period of 4 years from your last contact with this office. Consent is not a condition of being accepted as a patient and if you don't want to be contacted by certain means of communication you can decline to provide that contact information.

Consent to the Release of Medical Information
The release of medical information is authorized to any entity that may be liable for your coverage to assist in the reimbursement of benefits that the patient is entitled to and to other health care provides that may be providing assistance for your care and treatment

Acknowledgement of the Receipt of Notice of Privacy Practice
I acknowledge that I have received a copy of the office's Notice of Privacy Practice and/or it is posted and readily available for me to read

Additional tests that may be performed today:

Dilated Fundus exam – eye drops dilate the pupils allowing a more complete view of the retina (inside of eye). There is usually no additional charge when done at an initial visit. These drops take a half an hour to work and may affect your vision for a couple of hours after the exam.

Optomap Retinal Exam and iWellness Exam – Optomap is a wide field image of the back of the eye that captures over 80% of the retina in one panoramic image. An iWellnessExam images below the surface of the retina to detect problems that cannot be seen by just looking inside the eye. These help to detect early signs of retinal disease more effectively than a traditional eye exam. If this is done as part of a routine exam the cost is $35.

Contact Lens Evaluation and Prescription Determination

If you are a new contact lens wearer or you need/want to switch lens types a fitting is required. This includes trial lenses, the evaluation of the lenses on your cornea and follow-up appointments. The fee for this service starts at $60.

If you are an established patient who currently wears contact lenses and you just need to renew your prescription, additional monitoring above and beyond a standard eye exam is necessary. This includes monitoring your eyes for adverse effects from contact lens wear and making sure that you are in the most up to date lens material. The fee for this service is $40.

_____ I do not have a known medical diagnosis and would like a routine eye exam

_____ I have a known medical diagnosis and would like a medical eye exam. A refraction is not covered in a medical eye exam and is the patient's responsibility. In some cases (Eyemed and VSP) routine vision insurance can coordinate with your medical insurance to pay for the refraction.

_____

_____ I would like to have a dilated fundus exam

_____ I understand the importance of a **dilated fundus exam,** although it is recommended by my doctor, I wish to decline it.

_____

_____ I would like to have an Optomap Retinal and iWellness exam, I understand the cost is $35.

_____ I understand the importance of an **Optomap Retinal and iWellness exam**, although it is recommended by my doctor, I wish to decline it.

_____

_____ I would like to have a contact lens exam, I understand there may be an additional fee.

I consent to the above:

Patient Name	**Patient Signature**	**Date**
_____	_____	_____
Witness	**Signature**	**Date**
_____	_____	_____