Amazing Eyes Family Vision
812 Coshocton Road #3
Mount Vernon, OH 43050-1947
TEL: (740) 326-1190 • FAX: (740) 326-9753
www.amazingeyesvision.com • Amazingeyesvision@gmail.com

WELCOME LETTER

Account No.:	
Printed:	

We welcome you to our practice and ask that you kindly complete or correct all information on this form.

PATIENT INFORMATION

PATIENT NAME:		SEX:	SOCIAL SECURITY NUMBER:
ADDRESS:		DATE OF BIRTH:	MARITAL STATUS:
CITY, STATE & ZIP:		EMAIL:	
HOME PHONE:	WORK PHONE:	MOBILE PHONE:	
EMPLOYER:		OCCUPATION:	
EMPLOYER'S ADDRESS:		PRIMARY CARE PHYSICIAN	
EMPLOYER'S CITY, STATE & ZIP:		PRIMARY CARE PHYSICIAN'S PHONE:	

Do you or your family have any history of the following conditions (check all that apply)?:

Self	Family	
❑	❑	Glaucoma
❑	❑	Cataracts
❑	❑	Diabetes
❑	❑	High Blood Pressure
❑	❑	Macular Degeneration
❑	❑	Heart Problems
❑	❑	Retinal Degeneration
❑	❑	Stroke
❑	❑	Thyroid Condition
❑	❑	Crossed/Lazy Eyes
❑	❑	Asthma/ Allergies
❑	❑	Color Blindness
❑	❑	Arthritis
❑	❑	Tuberculosis
❑	❑	HIV/Hepatitis
❑	❑	Cancer
❑	❑	Neuromuscular
❑	❑	Blindness
❑	❑	Other:

_____

_____

Do you currently have any of the following symptoms (check all that apply)?:

- ❑ Blurry distance vision
- ❑ Poor night vision
- ❑ Eye Strain
- ❑ Blurry Near Vision
- ❑ Trouble Reading
- ❑ Itchy Eyes
- ❑ Discharge
- ❑ Watering
- ❑ Pain in the eye
- ❑ Burning eyes
- ❑ Sandy/dry eyes
- ❑ Red Eyes
- ❑ Glare/reflections
- ❑ Discomfort in sunlight
- ❑ Double vision
- ❑ Floaters or spots in vision
- ❑ Flashes of light
- ❑ Eye injury
- ❑ History of wearing an eye patch
- ❑ History of eye surgery
- ❑ Headaches
- ❑ Dental Abscess

Are you interested in any of the following (check all that apply)?:

- ❑ New spectacles
- ❑ A new prescription
- ❑ Light weight glasses
- ❑ Anti-reflective lens
- ❑ Ortho K
- ❑ Colored contact lens
- ❑ Sunglasses
- ❑ Clip-ons
- ❑ Safety glasses
- ❑ Lasik
- ❑ Contact lenses
- ❑ Dry eye therapy
- ❑ Myopia control

How were you referred to us?

- ❑ Family doctor
- ❑ Yellow Pages
- ❑ Insurance company
- ❑ Another patient
- ❑ _____

MEDICATIONS: **(Attach List)**

ALLERGIES:

SOCIAL HISTORY:

- ❑ Alcohol
- ❑ Drug use
- ❑ Tobacco use
- ❑ Other:

_____

_____

_____

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INSURANCE INFORMATION

Patient Name:	
Account No.:	
Printed:	

GUARANTOR		
GUARANTOR NAME:	GENDER:	SOCIAL SECURITY NUMBER:
ADDRESS:	DATE OF BIRTH:	
CITY, STATE, ZIP:	PATIENT'S RELATIONSHIP TO GUARANTOR:	
HOME PHONE:	WORK PHONE:	

PRIMARY VISION INSURANCE	SECONDARY VISION INSURANCE
COMPANY NAME:	COMPANY NAME:
POLICY ID NO.:	POLICY ID NO.:
POLICY GROUP:	POLICY GROUP:
INSURED PARTY:	

PRIMARY MEDICAL INSURANCE	SECONDARY MEDICAL INSURANCE
COMPANY NAME:	COMPANY NAME:
POLICY ID NO.:	POLICY ID NO.:
POLICY GROUP:	POLICY GROUP:
INSURED PARTY:	INSURED PARTY:

MEDICAL INSURANCE POLICY: As part of our services at this practice we are happy to assist you in determining the benefits of your individual policy and in collecting your reimbursement of insurance benefits for medical services. To avoid any misunderstandings please read the following statements carefully:

1. The legal obligations of your insurance provider are between yourself and your provider, not between this practice and your provider.
2. When your insurance provider (s) has 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's. 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 authorizing the release of information to all my insurance companies as well as allowing the doctor to act as my agent to help me in obtaining payment from my insurance companies.
5. I authorize payment to be made directly to the provider and permit a copy of this authorization to be used in place of the original.

CONSENT FOR TREATMENT: I hereby authorize Amazing Eyes Family Vision to administer diagnostic and medical procedures as may be necessary for proper health care.

***Please circle preferred method of communication: Home Mobile Email Text**

_____
Signature of patient or authorized representative and Date

_____
Authorized representative's name

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HIPAA CONSENT

Patient Name:	
Account No.:	
Printed:	

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Permission to Use and Disclose My Health Information: By signing this form, I give Amazing Eyes Family Vision permission to use and/or disclose my health information to provide treatment, obtain payment, and/or conduct health care operations.

Right to Refuse: I have the right not to sign this consent. If I refuse to sign this consent, Amazing Eyes Family Vision has the right to refuse to treat me. However, treatment required by law –such as emergency care– can be provided to me whether or not I sign this consent.

Right to Review Notice of Privacy Practices: I have been provided with a copy of the Notice of Privacy Practices for Amazing Eyes Family Vision which describes how Amazing Eyes Family Vision may use and disclose my health information. I have the right to review this Notice before signing this consent.

Changes to the Notice of Privacy Practices: Amazing Eyes Family Vision may change the Notice of Privacy Practices as needed. I may obtain a current copy of the Notice of Privacy Practices for Amazing Eyes Family Vision by contacting Amazing Eyes Family Vision.

Right to Request Restrictions on Use/Disclosure: I have the right to request that the usage of my protected health information by Amazing Eyes Family Vision be restricted in how it is used and/or disclosed for the purpose of providing treatment, obtaining payment, and/or conducting health care operations. However, Amazing Eyes Famiy Vision is not required to agree to any restriction that I request. If Amazing Eyes Family Vision does decide to agree to my request, the use and/or disclosure of my health information by Amazing Eyes Family Vision must be restricted as I requested. If I wish to request restrictions I can contact Amazing Eyes Family Vision. Amazing Eyes Family Vision will notify me on whether my restrictions have been accepted or declined.

Right to Withdraw Consent: I have the right to withdraw this consent at any time. I must do so in writing by contacting Amazing Eyes Family Vision at 812 Coshocton Road, Mount Vernon, OH 43050-1947. My withdrawal of this consent will not be effective for uses and/or disclosures that have already been made based on my prior consent. If I withdraw this consent, then Amazing Eyes Family Vision may refuse to provide to me further treatment or follow-up, other than required emergency services.

Effective Period: This consent is good unless and until I withdraw it in writing.

References to "I" or "me": References to "I" or "me" in this Consent include the individual for whom the signing party is authorized to sign. If I am signing this consent on behalf of another person, it is because I am that person's parent, legal guardian, or agent under an active Power of Attorney for Health Care; and I am legally authorized to sign this Consent on behalf of that person.

_____ _____
Signature of patient or authorized representative and Date

_____
Authorized representative's name

FOR OFFICE USE ONLY

Complete this section if this form is not signed and dated by the patient or an authorized representative for the patient.

I have made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices for Amazing Eyes Family Vision but was unable to for the following reason:

❑ Patient refused to sign

❑ Patient is unable to sign

❑ Other _____

_____ _____
Signature of employee Date

_____
Employee's name

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Return Policy for Eyeglasses and Contact Lenses

All sales of prescription and non-prescription eyeglasses and sunglasses are final. If, however, there are any discrepancies between the doctor's prescription and the lenses manufactured by the lab, or between the doctor's prescription and the actual prescription, any adjustments to the prescription lenses are included at no charge within 60 days. All orders require at minimum a 50% deposit. Adjustments for glasses and minor repairs are provided free of charge. **Professional services are non-refundable.**

All name brand eyeglass frames are under manufacturer warranty for any manufacturing defects for up to one year from the date of purchase. This does **not** include accidental damage or breakage that has been incurred to the frames.

Even though the eyeglass frame is under warranty by the manufacturer, the manufacturer does **not** pay for the shipping and handling for the exchange of the defective frames for the new frames. The patient will be responsible for the two-way shipping costs involved, **which is approximately $10.00.** Keep in mind that, as a courtesy to our patients, we do: (1) exchange the frames; (2) physically remount the lenses into the new frames with NO additional fee.

With regard to sales of **non-specialty** soft contact lenses, any unopened and unmarked boxes may be returned for a full refund, or exchanged, within 60 days. All sales of specialty gas permeable (rigid) and hybrid (containing both rigid and soft contact components) contact lenses are **final.** If, however, there are any discrepancies between the doctor's prescription and the actual prescription, any exchanges for the appropriate contact lens prescription will be honored at no charge as long as enough time is given for the lenses to be mailed and physically received by the manufacturer within 60 days.

Policy for Picking up Eyeglasses and Contact Lenses

All eyeglasses and contact lenses that have been prescribed, fitted and purchased by the patient will be kept in the office for a total of **one year** from the date of purchase. If the patient does not pickup his/her eyeglasses or contact lenses within that year, they shall, by default, become the property of **Amazing Eyes Family Vision**, and we will no longer be responsible for those eyeglasses or contact lenses after that one year time period.

I have read, understood, and shall abide by all aspects of the policies explained to me above. It has been made known to me that if any or all parts of the above policies are not fully understood by me, for any reason at all, that proper explanation, or translation, is available and ultimately has been provided to me at the time of signing.

Patient Name	Signature	Date

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We Prefer To Dilate

When indicated, pupillary dilation improves our doctor's ability to examine the internal structures of the eye for signs of disease, which is important for your health and well-being. Normal side effects last three to five hours, and they include sensitivity to bright light and difficulty focusing on near objects. Normally, your distance vision is not affected very much, and it is possible to drive safely after dilation if you currently have fairly up-to-date prescription eyeglasses.

Patient May Refuse

Patients reserve the right to refuse any test or diagnostic procedure recommended. If a patient refuses, however, he or she assumes all of the risk for potentially not detecting, and thereby treating in a timely manner, any serious eye conditions.

Patients May Reschedule

Some patients prefer to reschedule their dilated retinal exam for a different day and time to minimize visual side-effects upon their return to work or school. We will be happy to schedule a second appointment at a later time for this purpose, **privately charging an additional fee of $20.00.** There is absolutely **NO ADDITIONAL CHARGE** if we complete the dilated retinal exam during your initially scheduled comprehensive eye examination.

-OVER-

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DILATION ACCEPTANCE

_____ I agree to dilation today if it is advised or medically necessary.

Patient Name: _____

Patient/Guardian's Signature: _____

Date: _____

DILATION REFUSAL/WAIVER

Please sign ONLY if you are refusing dilation.

I, under my own will and judgement, refuse to have my eyes dilated. As a consequence, I understand that the doctor may not be able to detect cases in which the retina is diseased, physically compromised, or harboring cancerous growths. As such, early detection and diagnosis of certain eye conditions, along with timely and effective treatment, may not be possible. I accept all risk for the possibility of not detecting these eye conditions without pupillary dilation, and I understand that these conditions may result in permanent blindness, or even death.

Patient Name: _____

Patient/Guardian's Signature: _____

Date: _____

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Assignment of Medical Benefits and Appointment Cancellation Policy Form

(1) **Comprehensive Eye Exams** include all services related to the evaluation and treatment of your visual and eye health, including the fitting of eyeglasses and any subsequent adjustments to your eyeglass prescription at no charge within 60 days.

(2) **Treatment of eye diseases,** either upon initial presentation or otherwise following the initial comprehensive eye exam detailed above, is a **separate billable service.** While treatment of eye diseases is **NOT COVERED** by your ***vision insurance,*** your primary health insurance may contribute to these services.

If you have both vision and health insurance plans, it may be necessary for us to bill some services to one plan and some services to the other. We will follow a procedure called ***coordination of benefits*** to do this properly, in order to minimize your out-of-pocket expense as a courtesy to you. It is the patient's responsibility to know your vision coverage at the time of service.

(3) **Contact lens fittings are a separate billable service**, although they may be rendered on the same day as the comprehensive eye exam. A contact lens prescription is only valid for one year. A contact lens fitting may or may not be covered by your vision insurance and usually are NOT covered by your primary health insurance. Any subsequent followups to refine the contact lens prescription are included at no charge for 60 days, unless otherwise stated at the time of the exam.

(4) **Appointment Cancellation Policy:** I am aware that if I have scheduled an appointment, which has been confirmed by e-mail, text, telephone or answering machine message, that I am responsible for a **$25 NOCALL/NO-SHOW FEE** if that appointment is not cancelled within 24 hours of the actual appointment. Exceptions are given in the case of emergencies, such as for medical reasons.

-OVER-

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Assignment of Medical Benefits and Appointment Cancellation Policy Form

I assign all of my medical benefits, including all benefits to which I am entitled through Medicare, private insurances, and any other health plans to **Amazing Eyes Family Vision.** A photocopy of this assignment is to be considered as valid as an original. I authorize said assignee to release all information necessary to secure payment from my insurance company. **I understand, however, that if some fees are not paid by my insurance, I am still responsible and will be billed for them.** All co-payments, deductibles, and charges for non-covered services, as per your insurance contract, are due at the time that they are rendered.

Patient Name: _____

Patient Signature: _____

Date: _____