ENVISION
EYE CARE

WELCOME TO OUR OFFICE

Patient Information

Today's Date _____

Last _____

First _____ MI ___

Street _____

City _____ State _____

Zip Code _____

Home Phone _____

Cell Phone _____

Work Phone _____

E-mail _____

Sex ❑M ❑F Birth Date _____ Age _____

❑Single ❑Married ❑Widowed ❑Minor

Occupation (or Grade) _____

Employer (or School) _____

Spouse (or Parent's) Name _____

Spouse (or Parent's) Work _____

Whom may we thank for recommending you or how did you hear of us?

_____

What is the major purpose of this visit?

_____

List Hobbies/Interests (helps us determine your visual needs)?

_____

Insurance Information

Who is responsible for this account?_____
Relationship to Patient_____

Vision Insurance _____
Subscriber Name_____
Subscriber SSN (last 4 digits)_____
Subscriber Birth Date_____

Primary Medical Insurance_____
Subscriber Name_____
Subscriber SSN (last 4 digits)_____
Subscriber Birth Date_____
Do you participate in a flex spending account?
❑ Yes ❑ No

Notice of Payment Policy

All professional fees, including exam and any additional testing recommended by the doctor, are due and payable the day they are provided. If glasses are included in your fees, 50% is required when ordering and the balance is due at dispensing.

If your fees are covered by a vision or medical plan for which we participate, any applicable deductibles, co-payments, and non-covered services and/or materials are due and payable on the date of your examination.

A Private Pay Plan is available to patients whose examination fees are not covered by a vision plan or who do not have any type of vision coverage. By signing a Private Pay Plan the patient agrees to the terms of the contract which provide a reduction in our usual and customary examination fee. This agreed upon amount, as determined by the contract, is payable at the time of your initial visit.

I understand that any fees incurred are my responsibility, unless otherwise prohibited by law, regardless of any insurance benefits, and said fees are to be paid as stated in the above payment policy. Any collections and/or legal fees are my responsibility.

Payment will be made by: (Please check one)

❑Self(Ask for Financial Agreement/Contract)
❑Insurance as listed above

Patient/Parent or Guardian Signature Date

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History

Name of Family Physician_____
Date of Last Physical Check-up_____

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills)_____

Do you have any allergies to medications? ❑Yes ❑ No

If yes, what medications?_____

Do you smoke? ❑ Yes ❑ No Packs/day_____
Do you use alcohol? ❑ Yes❑ No Drinks/day_____

Are you pregnant? ❑ Yes ❑ No

Have you had any surgeries? ❑ Yes ❑ No
If yes, please list (include eye surgeries)_____

Have you ever been diagnosed or treated for the following health problems? Check only if yes and specify.

Yes		
Allergies	❑	_____
Arthritis	❑	_____
Asthma	❑	_____
Blood/Lymph	❑	_____
Cancer	❑	_____
Cardiovascular	❑	_____
Cholesterol	❑	_____
Diabetes	❑	_____
Digestive	❑	_____
Ears/Nose/Throat (Sinus)	❑	_____
Eczema/Rashes	❑	_____
Genitourinary	❑	_____
High Blood Pressure	❑	_____
Integumentary (Skin)	❑	_____
Kidney	❑	_____
Muscle/Bone	❑	_____
Neurological	❑	_____
Migraines	❑	_____
Psychological (Anxiety)	❑	_____
Respiratory (COPD)	❑	_____
Thyroid	❑	_____

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EYE CARE

Patient Eye History

Date of Last Eye Exam_____
By Whom?_____

Do you wear glasses? ❑ Yes ❑ No
If yes,
❑All the time For: ❑Distance ❑Near ❑Both
or
❑Occasionally For: ❑Distance ❑Near ❑Both

Do you have problems with glare or reflections?
❑ Yes ❑ No

Are you interested in contact lenses? ❑ Yes ❑ No

Have you ever tried contact lenses? ❑ Yes ❑ No

Do you currently wear contact lenses? ❑ Yes ❑ No
What kind?_____
Solutions used_____

Are you satisfied with the vision and comfort of your contact lenses? ❑ Yes ❑ No

Have you ever experienced, been diagnosed or treated for any of the following? Check only if yes.

❑ Blurry Vision
❑ Cataracts
❑ Crossed eye/Eye turn
❑ Eye Infections
❑ Flash of light
❑ Glaucoma
❑ Headaches
❑ Itchiness
❑ Macular Degeneration
❑ Retinal Detachment
❑ Excessive Tearing
❑ Uncomfortable glasses
❑ Other eye disorders_____
❑ Burning
❑ Corneal Abrasions
❑ Double Vision
❑ Eye Injury
❑ Floaters/Spots
❑ Grittiness
❑ Iritis/Uveitis
❑ Lazy Eye
❑ Occasional dryness
❑ Sunlight Sensitivity
❑ Trouble seeing at night

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following? Please indicate relationship (Mother's or Father's side).

Blindness	❑_____
Cataracts	❑_____
Corneal Problems	❑_____
Diabetes	❑_____
Glaucoma	❑_____
Heart Disease	❑_____
Lazy Eye	❑_____
Macular Degeneration	❑_____
Retinal Problems	❑_____

Envision Eye Care
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info@Envision-Eyes.com

ACKNOWLEDGEMENT AND AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION AND ACKNOWLEDGMENT OF RECEIPT OF NOTED PRIVACY ACT

I acknowledge that I have been offered a copy of Envision Eye Care's Notice of Privacy Practices.

I authorize the professional office of **ENVISION EYE CARE** to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description of the information to be released:

2. To whom may the information be released [name(s) or class(es) of recipients]:

Name:_____Relationship to patient:_____

Name:_____Relationship to patient:_____

Name:_____Relationship to patient:_____

3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):

4. Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

For authorizations, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient Name_____Patient/Guardian Signature _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____Print Name_____

Source of Authority _____

Reviewed/Updated_____Date_____

Notice of Payment Policy

All professional fees, including exam and any additional testing recommended by the doctor, are due and payable the day they are provided. If glasses or contact lenses are included in your fees, 50% is required when ordering and the balance is due at dispensing. If glasses and/or contact lenses are not picked up within 90 days of the ordering date, any and all payments collected thus far for said products are non-refundable.

If your fees are covered by a vision or medical plan for which we participate, any applicable deductibles, co-payments, and non-covered services and/or materials are due and payable on the date of your examination.

A Private Pay Plan is available to patients whose examination fees are not covered by a vision plan or who do not have any type of vision coverage. By signing a Private Pay Plan Agreement the patient agrees to the terms of the contract which provide a reduction in our usual and customary examination fee. This agreed upon amount, as determined by the contract, is payable at the time of your initial visit.

Insurance:

You will be expected to present your insurance card with each visit. We bill participating insurance companies as a courtesy to you. It is your responsibility to know your insurance. If the insurance company has not processed or paid a claim within a timely manner, payment of the account may become the responsibility of the guarantor. If you feel that your insurance company unfairly denies your claim, it is your responsibility to pursue the insurance company.

In today's constantly changing insurance environment, it is not possible for Envision Eye Care to accurately predict all possible outcomes of your insurance claim. Please understand that while we do our best, in the end, insurance is a contract between the patient and the insurance company and all fees, if denied, applied to deductible, co-payment or co-insurance, are **your** responsibility.

Referrals/Prior Authorizations:

If you are enrolled in an insurance that requires a prior authorization or written referral for a specialty service, you must notify our office **before** the appointment. Our office will not be held responsible for any service that has been denied due to lack of authorization.

Collections:

Referral to our professional collection service will be made on delinquent accounts when payment and/or payment arrangements have not been made. If your account is referred to a collection agency, you agree to pay all collection costs that are incurred.

I understand that any fees incurred are my responsibility, unless otherwise prohibited by law, regardless of any insurance benefits, and said fees are to be paid as stated in the above payment policy. Any collections and/or legal fees are my responsibility, including returned check fees for non-sufficient funds.

Payment will be made by: (Please check one)

- Self
- Insurance Vision_____ Medical_____

Patient/Parent or Guardian Signature Date