PATIENT FINANCIAL INFORMATION SHEET

I understand that payment in full is due at the time of service unless other arrangements have been made.

Name: _____ Phone # (H): _____

Social Security Number: _____-_____-_____ (C): _____

Primary Insurance (Vision/Medical): _____ (W): _____

Secondary Insurance (If applicable): _____ DOB: _____

Occupation: _____ Email: _____

Reason for visit: Routine exam for a glasses prescription ☐

Routine exam for a glasses and contact lens prescription ☐

A medical problem ☐ A re-evaluation/ follow-up for a previous visit ☐

Post-operative care ☐ CRT ☐ Vision Therapy ☐ Training ☐

Authorization and Release:

- I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to the third party payers/or other health practitioners.
- I authorize the request of my insurance company to pay directly to the doctor insurance benefits otherwise payable to me.
- I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.
- I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child to: _____

_____ _____

Signature of patient or parent if minor Date

********HIPAA Privacy Practice Acknowledgement********

PLEASE SIGN THE BELOW STATEMENT

I HAVE RECEIVED OR HAVE AVAILABLE ACCESS TO A NOTICE OF PRIVACY PRACTICES. I UNDERSTAND MY RIGHTS AS A PATIENT REGARDING MY PERSONAL HEALTH INFORMATION AND PRIVACY.

Signature:_____ Date:_____

Retinal imaging:

The posterior pole of the retina (back of the eye) contains the optic nerve, central blood vessels and macula. This is the part of the eye that transmits images of your world to the brain for processing. A healthy retina is necessary for clear vision. Retinal imaging allows you and the doctor to examine the retina and these important structures in the most detailed manner available. We recommend retinal imaging for:

1. All new patients (for accurate baseline reference)
2. Patients with but not limited to:
    a. Diabetes
    b. Hypertension
    c. Changes in vision
    d. Headaches
    e. Autoimmune disease
    f. History of cancer

*Cost for retinal imaging is $39.00. This procedure is not covered by routine vision insurance.

I wish to have retinal imaging (initial) _____

I do not wish to have retinal imaging (initial)_____

Concerning dilation of the eyes:

Dilation of the eyes is a procedure in which drops are used to enlarge the pupil, allowing the doctor to see most internal structures of the eye. There is no substitute for dilation, and it is recommended at regular intervals depending on age and condition of the eyes. Dilation is part of the comprehensive eye exam and is performed with no additional fees.

Do we have permission to dilate your eyes should it be necessary today:

Yes (initial)_____

No, I decline dilation and acknowledge that it has been recommended and

Offered today (initial)_____

CONTACT LENS PATIENTS: Release Form

I understand that although my contacts have been proven to be safe and have been used successfully for many years, there is still a risk of damage and/or blindness with the use of contact lenses.

Signed _____ Date _____