EYEZONE

Demographics

Last Name:	First Name:		Initial:	Date:
Guarantor:				
Address:				
City:	State:			Zip:
Home #:	Work #:			Cell #:
Email:	Communication Preferred:		□ email	□ phone □ mail
Pharmacy of Choice:	Date of Birth:			
□ Male □ Female	Ethnicity:			
Social Security #:	Marital Status:			Race:
Occupation:	Employer if applicable:			
Vision Insurance Co:	Medical Insurance Co:			

Chief Complaint What is the main purpose of your visit today?

Spectacle Rx Status: (Do you wear glasses?)	□ Yes	□ No	If yes, how old is the RX:
For what activities do you wear glasses:			
Contact Rx Status: (Do you wear contacts?)	□ Yes	□ No	If yes, type:

Review of Systems

Allergy: □ Self □ Family:
- ▫ Allergies
- ▫ Drug Hypersensitivities
- ▫ Explain: □ None

Cardiovascular: □ Self □ Family:
- ▫ High Blood Pressure
- ▫ Vascular Disease
- ▫ Heart Pain
- ▫ Cholesterol □ None

Constitutional:
- ▫ Fever
- ▫ Unexpected weight Loss/Gain □ None

Endocrine: □ Self □ Family:
- ▫ Thyroid
- ▫ Diabetes □ None

Gastrointestinal:
- ▫ Diarrhea
- ▫ Constipation □ None

Genitourinary:
- ▫ Prostate
- ▫ Kidney
- ▫ Bladder □ None

Ear Nose and Throat:
- ▫ Allergies/Hay Fever
- ▫ Sinus Congestion
- ▫ Runny Nose
- ▫ Post-Nasal Drip
- ▫ Chronic Cough
- ▫ Dry Throat/Mouth □ None

Hematological/Lymphatic:
- ▫ Anemia
- ▫ Bleeding Problems □ None

Immunological: □ Self □ Family:
- ▫ Sarcoid
- ▫ Lupus
- ▫ HIV
- ▫ Herpes Simplex
- ▫ Herpes Zoster □ None

Integumentary:
- ▫ Skin Problems
- ▫ Explain: □ None

Musculoskeletal: □ Self □ Family:
- ▫ Arthritis
- ▫ Rheumatoid
- ▫ Joint/Muscle Pain □ None

Neurological:
- ▫ Headaches
- ▫ Migraines
- ▫ Seizures □ None

Psychological:
- ▫ Depression
- ▫ Other □ None

Respiratory: □ Self □ Family:
- ▫ Asthma
- ▫ Chronic Bronchitis
- ▫ Emphysema □ None

Cancer: □ Self □ Family:

□ None

Medical History List all Medical Conditions or Hospitalizations ☐ None

Primary Care Provider:

Other Provider:

Medications: List any Medications you use ☐ None

Do you have any allergies to medications? ☐ If Yes, Explain: ☐ None

Surgical History List all major surgeries you have had ☐ None

Ocular History List any of the following you/family have had

Crossed Eyes:
☐ Self ☐ Family_____ ☐ None

Lazy Eye- Amblyopia:
☐ Self ☐ Family_____ ☐ None

Drooping Eyelids:
☐ Self ☐ Family_____ ☐ None

Prominent/Protruding Eyes:
☐ Self ☐ Family_____ ☐ None

Eye Infection/Injury:
☐ Self ☐ Family_____ ☐ None

Cataracts:
☐ Self ☐ Family_____ ☐ None

Glaucoma:
☐ Self ☐ Family_____ ☐ None

Macular Degeneration:
☐ Self ☐ Family_____ ☐ None

Detachment/Retinal Disease:
☐ Self ☐ Family_____ ☐ None

Blindness:
☐ Self ☐ Family_____ ☐ None

Other: _____
_____
☐ Self ☐ Family_____ ☐ None

Ocular Medications List any ocular medications you use ☐ None

Ocular Surgical History List any ocular surgeries you have had ☐ None

☐ Cataract Surgery ☐ Strabismus (Eye Turn) ☐ None

Social History List use of Tobacco, Alcohol, Narcotics & any STD's

Tobacco Use:
- ▫ None
- ▫ Former Smoker Stopped _____ months/years ago
- ▫ Light Smoker (<1 packs)
- ▫ Moderate Smoker (1-2 packs)
- ▫ Heavy Smoker (>2 packs)

Alcohol Use:
- ▫ None
- ▫ Social Use Only
- ▫ 1-2 Drinks Daily
- ▫ Above Average
- ▫ Alcohol Dependence

Narcotics:
- ▫ None
- ▫ Recreational
- ▫ Chemical Dependence

Sexually Transmitted Disease:
- ▫ None
- ▫ Yes
- ▫ HIV Positive

Signature: _____ Date: _____

EyeZone, Inc. is committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

Insurance

Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. We participate in most medical and vision insurance. If you are not insured by a plan we are contracted with, payment in full is expected at each visit. If you are insured by a plan we are contracted with but don't have an up-to-date insurance card, payment in full for each visit is required.

Co-Payments/Co-Insurance

All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments/co-insurance from patients can be considered fraud. Please help us in upholding the law by paying your co-payment/co-insurance at each visit.

Non-covered services

Please be aware that some – or perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by your insurance. You must pay for these services in full at the time of visit.

Proof of insurance

All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance.

Claims submission

We will submit your claims to assist you in getting your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays the claim.

Change in Insurance Coverage

It is the patient's responsibility to notify our office prior to their appointment of any and all changes to their insurance coverage.

Nonpayment

If your account is over 90 days past due, you will receive a letter stating that you have 15 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged as a patient. If this is to occur, you will be notified by mail

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.
Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party Date

I, _____, acknowledge that I have received a copy of EyeZone Nevada's HIPAA Notice of Privacy Practices.

_____ _____

Patient Signature Date

OR

_____

Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

[ ] Parent [ ] Guardian [ ] Power of Attorney [ ] Other: _____

****Please Note: It is your right to refuse to sign this Acknowledgement indicating that we have offered you a copy of our Notice of Privacy Practices.**

OFFICE USE ONLY

I tried to obtain written Acknowledgement by the individual noted above of receipt of our Notice of Privacy Practices, but it could not be obtained because:

_____ An emergency prevented us from obtaining acknowledgement.

_____ A communication barrier prevented us from obtaining acknowledgement.

_____ The individual was unwilling to sign.

_____ Other: (Please specify): _____

_____

GENERAL EYEWEAR POLICIES

ALL SPECTACLE SALES ARE FINAL

EyeZone does not offer refunds for eyewear purchases. All spectacle sales are custom, and therefore, final. If a prescription change is noted within 90 days of the original order, our laboratory will remake the lenses with original lens options (such as anti-reflective coating, tints, etc.). Any difference in the original order price and final price is not refunded. There is no charge for a prescription check within 90 days; however, any recheck after 90 days will be subject to an office visit charge.

If you elect to use your own frame and would like your old lenses returned from the laboratory, staff must be informed at time of order. If you do not inform staff of this request, the existing lenses will be disposed.

DAMAGE

Our frames are warranted for one year from the time of purchase unless otherwise specified. Our frame policy is a manufacturer-defect warranty. This does not cover lost or stolen frames, frames that have been sat or stepped on, or abused in any way. If your frame breaks, we will return all parts to the manufacturer, and the manufacturer will determine if it is a manufacturer's defect. If it is a manufacturer's defect, your frame will be covered at 100%. If the manufacturer determines that it is abuse, you will be responsible for replacing your frame or any broken parts.

If your warranted lenses become scratched from normal wear-and-tear, they will be replaced at no-charge for up to 12 months from the date of purchase. If the lenses are scratched from abuse, you will be responsible for replacing them. Cause of lens scratches will be determined by the laboratory. They manufacture the lenses and are experts in lens defects.

FRAME WAIVER

I am aware that if I am using my own frame, I will not hold the doctors, office staff, laboratory, or any other optical company responsible for damage upon lens insertion or frame adjustment.

CONTACT LENS FITTINGS AND RECHECKS

As with spectacle prescription checks, there is no charge for a prescription check for contact lenses within 90 days of the initial contact lens evaluation. After that point, prescription checks are subject to an office visit charge. In the event that a contact lens evaluation is desired after the comprehensive examination has taken place, there will be a fee for the contact lens evaluation only within 90 days. Beyond 90 days, there will be a fee for both an office visit and contact lens evaluation.

I have read and understand ALL of the above policies.

_____ _____

Signature of Patient (or Guardian) Date