wayne EYECARE
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For Office Use

INSURANCE _____

SCANNED ◯ UPDATED ◯

PATIENT INFORMATION

Date of Exam: _____ Time: _____

Name: _____ D.O.B. _____ Phone: _____

Address: _____ City:_____ State/Zip: _____

E-Mail: _____ Preferred Method of Contact? ◯ phone call ◯ text message ◯ email

Emergency Contact: _____ Emergency Number: _____

How did you hear about us?
_____

OCCULAR HISTORY

Chief complaint for today's visit?:
_____

Do you currently have prescription glasses: **Y / N** How often do you wear them? _____

When was your last vision exam? _____ How old is your prescription? _____

If you are having blurry vision, is this happening with or without glasses / contact lenses? _____

Do you currently wear contact lenses? **Y / N** What brand? _____

How often do you wear them? _____ How old is your prescription? _____

Have you ever been told that you could not wear contact lenses? **Y / N**

CONTACT LENS EVALUATION & ASSESSMENT

In order to receive an updated contact lens prescription, whether you are a new or established contact lens wearer, your routine eye exam must include a **Contact Lens Evaluation**. The Contact Lens Evaluation is a health evaluation, to confirm that the patient is physically fit to wear contact lenses, and that wearing them in the past has not had an adverse effect on the eyes. It also ensures that the brand and prescription that the doctor prescribed is the best option for you. This evaluation determines the following:

- Health Assessment, to check for: corneal and eyelid swelling, dry eye, scarring, irregular blood vessels, etc
- Proper movement of each lens
- Proper size (curvature/diameter) of each lens

This is a separate service from the usual routine eye exam, and therefore the patient is responsible for additional copays. These copays will be determined by your insurance policy. In the event that your plan doesn't cover the evaluation, you will be responsible for this payment on the day of your visit. Contact Lens Evaluations start at **$75** but the actual cost is determined by the complexity of your prescription. New wearers must also receive **Contact Lens Training**, which is meant to educate the patient on the insertion/removal of contact lenses, as well as how to properly clean and take care of them. Evaluation and Training for first-time wearers is $125. Please

discuss any questions about this pricing with the doctor or receptionist *before* services are rendered.

Signed: _____ Date: _____

Your Ocular Symptoms	***Your Medical History***	***Your Medical Family History***
◯Blurred distance vision ◯Blurred near vision ◯Flashes of light ◯Fluctuating vision when blinking ◯Loss of vision ◯Double vision ◯Contact lens discomfort ◯Eye pain ◯Light sensitivity ◯Headaches/migraines ◯Burning eyes ◯Sore/tired eyes ◯Dryness ◯Excessive tearing/watering ◯Itchiness ◯Redness ◯Foreign body sensation ◯Floaters ◯Other _____	◯Seasonal allergies ◯Ear, nose, throat problems ◯Cardiovascular Problems ◯Hypertension (blood pressure) ◯High cholesterol ◯Diabetes Mellitus ◯Thyroid disorder ◯Respiratory problems ◯Gastrointestinal problems ◯Heart disease ◯Kidney or liver problems ◯Muscle disorders ◯Bone or joint problems ◯Skin problems ◯Blood/Lymph disorder ◯Immune problems ◯Neurological disorder ◯Psychiatric disorder ◯Other _____	◯Arthritis ◯Cancer ◯Heart disease ◯Hypertension ◯Diabetes Mellitus ◯Thyroid disorder ◯High cholesterol ◯Kidney/ liver disease ◯Autoimmune disease ***Your Ocular Family History*** ◯Diabetic retinopathy ◯Blindness ◯Glaucoma ◯Macular Degeneration ◯Retinal detachment ◯Cataracts ◯"Crossed Eyes"

Social History and Lifestyle:

Do you smoke? _____ Do you drive? _____

Are you bothered by the glare of lights when you drive? _____

Areas to improve with new glasses

- ❑ Too heavy
- ❑ Sizing issues
- ❑ Frame corrosion
- ❑ Lenses resting on cheeks
- ❑ Tint too dark
- ❑ Computer screen protection needed

Hobbies or Sports

- ❑ Needlework
- ❑ Reading
- ❑ Video Games/Blogging
- ❑ Field Sports
- ❑ Swimming
- ❑ Skiing/snow sports
- ❑ Running/walking
- ❑ Aerobics

Please list current medications: _____

Are you using eye drops? **Y / N** Why? _____

Who is your Primary Care Physician? _____ Phone Number: _____

Any allergies? _____ Are you pregnant? _____

Any history of eye disease, injury, surgery, or prior vision training? **Y / N** If yes, please detail below:

_____

_____

Signed: _____ Date: _____

FINANCIAL POLICY STATEMENT

Welcome to Wayne EyeCare. Thank you for choosing our practice for your routine vision care. We are committed to providing you with the highest quality services available. In order to achieve this goal, we need your understanding of our payment policy. Please read and sign the following policy. If we are contracted with your insurance company, we will accept assignment. Most health insurance contracts do not cover the refraction exam, which is used to determine your eyeglass prescription. In the event that your insurance does not cover the refraction fee, the patient/responsible party will be billed $35.00. All co-pays (for the patient's exam, contact lens fitting, etc.) are due at time of service. Failure to provide necessary referrals or current accurate billing information will result in all charges being billed to the patient/responsible party. Wayne EyeCare is not responsible for honoring insurance coverage presented after the date of service.

I understand that it is my responsibility to understand the policies of my insurance and to pay any deductible amount, coinsurance or copayment at the time of service. I understand that I am responsible for paying any claims denied by my insurance.

Signed: _____ Date: _____

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I agree that my signature authorizes Wayne EyeCare to submit claims regarding benefits for services rendered or to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents.

I hereby authorize my insurance company(ies) to pay and hereby assign directly to Wayne EyeCare all benefits, if any, otherwise payable to me for the services as described on the attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Wayne EyeCare will be credited to my account, in accordance with the above assignment.

Signed: _____ Date: _____

Medical Information Release Form
(HIPAA Release Form)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

At Wayne EyeCare, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lens, or eye medications and faxing them to be filled; referring you to another doctor or clinic for eye care; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). “Health care operations” mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans, defense of legal matters; and business planning.

We routinely use your health information inside our office for these purposes without any special permission. For example, one of our staff will enter your information into our computer. We may also use your information to contact you. For example, we may send annual eye exam recall cards and birthday cards to you. We also will call to remind you about scheduled appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. You have the right to request, in writing that we do not send you any office mailings. You also have the right to ask that we confirm your appointments at whatever telephone number you prefer.

In the case of an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law. If this practice is sold, your information will become the property of the new owner.

Except as described previously, this practice will not use or disclose your health information without your prior written request. You may request in writing that we not use or disclose your health information as previously described. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the described normal uses. You have the right to transfer copies of your health information to another practice or to have your prescriptions sent to another facility. A written request from you must be made, either in person, by fax or by mail before our office will release your health information or prescriptions. You have the right to see and receive a copy of your health information, with a few exceptions. We will need a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies. You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice. If we change the details of this notice, we will notify you of the changes in writing.

I have read and understand the policy described above.

Signed: _____ Date: _____