WELCOME

PATIENT INFORMATION

We are pleased to welcome you to our practice.
Please take a few minutes to fill out this form. If you have questions, we will be glad to help you.

Name:_____ Date_____

Birth date:_____ SS#_____ Sex: □ FEMALE □ MALE

Home Phone: _____ Cell Phone: _____ **Text: YES / NO**

STATUS: □ MARRIED □ WIDOWED □ SINGLE □ MINOR □ SEPARATED

Please enter your current **e-mail address** below:

Mailing Address:_____ City, State, Zip_____

Physical Address:_____ City, State, Zip_____

Employer/Student:_____ full-time | part-time Occupation:_____

Employer Address:_____ Phone:_____

Spouse's/Guardian name:_____ Phone:_____

Spouse's/Guardian Employer_____ Phone:_____

Emergency Contact:_____ Phone:_____

ETHNICITY INFORMATION

RACE: ☐ Asian ☐ Caucasian ☐ Hispanic or Latino ☐ American Indian/Alaska Native

☐ Black or African American ☐ Native Hawaiian or Pacific Islander

PRIMARY LANGUAGE SPOKEN

☐ ENGLISH ☐ SPANISH ☐ TAGALOG ☐ OTHER: _____

I permit EYECARE EXCELLENCE to communicate & remind me about my appointments by texting & e-mail.

Communication Preference ☐Phone ☐Email ☐Text

Whom may we thank for referring you to our office? _____

PRIMARY INSURANCE: □ YES □ NO

SUBSCRIBER'S NAME: _____

RELATIONSHIP TO PATIENT: _____

BIRTH DATE: _____/_____/_____

SS#: _____-_____-_____

INSURANCE COMPANY: _____

SECONDARY INSURANCE: □ YES □ NO

SUBSCRIBER'S NAME: _____

RELATIONSHIP TO PATIENT: _____

BIRTH DATE: _____/_____/_____

SS#: _____-_____-_____

INSURANCE COMPANY: _____

ASSIGNMENT AND RELEASE : I authorize Eyecare Excellence associates to act as my agent in applying for insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Eyecare Excellence on my behalf for any services and materials provided. I authorize any holder of my medical information to release such information as needed to determine benefits payable for related services. If I have additional insurance, my signature authorizes release of the above medical information to any insurer or agency I have given, and authorizes my doctor to act as my representative above. If my insurance does not cover any portion of this visit or any materials or portion of materials, I further acknowledge that I am responsible for payment of these services or materials. This authorization will remain in effect until revoked by me in writing.

SIGNATURE OF PATIENT/GUARDIAN: _____ DATE: _____

PRINT NAME OF PATIENT/GUARDIAN: _____ RELATION TO PATIENT: _____

A PHOTO COPY OF THIS AUTHORIZATION SHALL BE VALID AS THE ORIGINAL.

Medicare/ Medicaid:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Shank or Dr. Lewis of Eyecare Excellence for any services furnished to me by my provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers of Medicare and Medicaid Services and their agents any information needed to determine these benefits or benefits for related services.

SIGNATURE OF PATIENT/GUARDIAN: _____ DATE: _____

PRINT NAME OF PATIENT/GUARDIAN: _____ RELATION TO PATIENT: _____

EYEWEAR POLICY

FRAMES: *EYECARE EXCELLENCE CARRIES THE LATEST STYLES AND TRENDS IN FASHION FRAMES. ALL OF OUR FRAMES HAVE A ONE OR TWO YEAR WARRANTY DEPENDING ON THE MANUFACTURER. IF YOUR NEW FRAME BREAKS UNDER NORMAL WEARING CONDITIONS, WE WILL REPAIR OR REPLACE IT, ONE TIME FOR FREE. SHOULD A PRODUCT BECOME DISCONTINUED WITHIN WARRANTY WE WILL REPLACE THE DISCONTINUED FRAME WITH A NEW ONE OF EQUAL OR LESSER VALUE. THIS WARRANTY DOES NOT COVER ACCIDENTAL DAMAGE, SCRATCHES, LOSS OR THEFT.*

LENSES: *LENSES ARE CUSTOM MADE FOR YOU, **THEY ARE NON-REFUNDABLE.** IT IS OUR POLICY TO REMAKE YOUR LENSES (AT NO COST TO YOU) IF THE ORIGINAL PRESCRIPTION IS IN ERROR OR IF THE PATIENT IS NON-ADAPT TO A PROGRESSIVE LENS. FOR NON-ADAPT PROGRESSIVE LENSES WE WILL MAKE NEW LENSES IN ANY OTHER DESIGN THAT YOU WISH AT NO CHARGE, **WITHIN 90 DAYS OF DISPENSING**. ORIGINAL LENSES ARE A CUSTOM PRESCRIPTION ITEM WHICH MUST BE DISCARDED. NO REFUNDS ARE ISSUED IF THE DIFFERENCE IN COST IF THE REMAKE PAIR IS OF LESSER VALUE. OUR LENS TREATMENTS ARE THE HARDEST, MOST DURABLE SURFACE PROTECTION AVAILABLE. HOWEVER, ANY LENS CAN SCRATCH OR BREAK. PLEASE FOLLOW RECOMMENDED PROCEDURES FOR CARE AND CLEANING. REPLACEMENT OF POLYCARBONATE LENSES PURCHASED WITH SCRATCH RESISTANT COATING IS LIMITED TO ONCE IN A 24 MONTH PERIOD. LENS REPLACEMENT MUST BE IN THE ORIGINAL PRESCRIPTION. THIS WARRANTY DOES NOT COVER LOSS, THEFT, OR HAIRLINE SCRATCHES WHICH HAVE NO EFFECT ON VISION.*

YOU MAY RETURN TO OUR OFFICE FOR AS MANY ADJUSTMENTS TO YOUR GLASSES AS NEEDED. THIS SERVICE INCLUDES REPLACEMENT OF SCREWS, LOST OR BROKEN NOSE PADS, AND STRINGING OF NYLOR FRAMES.

FINANCIAL POLICY

The goal of Eyecare Excellence is to provide the best possible eye health and vision care with high quality products. In an effort to minimize the cost to our patients, Eyecare Excellence has established the following financial policy.

We accept cash, checks, debit cards, VISA, Master Card and Care Credit for your convenience. All returned checks are subject to a $25.00 NSF fee and any other applicable bank fees. All prescription eyeglasses are considered to be custom orders and are not refundable. The orders are processed automatically at the time of purchase and cannot be altered in any way or cancelled once the order has been submitted. Please choose your purchase wisely and consider the advice of our trained professionals.

*We will gladly bill your primary vision and medical insurance carriers, with whom we have a contract, as a courtesy to you. If we are not contracted with your insurance company, we will provide you with the information needed so that you may submit your statement to them for reimbursement. In order for us to bill your insurance, we must be provided with a copy of your current insurance card at the time of service. We will not bill your insurance after 30 days from the date of service. Every insurance plan is different, we recommend that you contact your insurance company prior to your visit to verify eligibility and plan coverage. Eyecare Excellence cannot accept responsibility for knowing your insurance coverage. We will make every effort to verify your vision coverage prior to your visit. **The benefits quoted are an estimate only**. Any difference after the claim has been processed will be your responsibility. **You are ultimately responsible for your account regardless of your insurance coverage**. The estimated fees are due at the time of service. Please remember that insurance coverage is typically a defined benefit and is not intended to cover the cost of examinations or optical goods in full.*
A service charge of 1.50% per month will be added to my unpaid balance after 30 days (equal to an 18% APR). After 120 days, the account will be turned over to a third party for collection. The guarantor will also be responsible for any legal fees that may incur.

My signature below confirms I have been informed of and understand the above outlined policies.

Patient's Signature: _____ ***Date:*** _____

Receipt of Notice of Privacy Policies & Consent Form

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.
The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our ***Notice of Privacy Practices***, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our ***Notice of Privacy Practices***. Our ***Notice of Privacy Practices*** will be updated whenever our privacy practices change. You can get an updated copy here at the office.
When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our ***Notice of Privacy Practices***. You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our ***Notice of Privacy Practices***, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our ***Notice of Privacy Practices*** describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices* from EYECARE EXCELLENCE.

Signature _____ ***Date*** _____

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

Relationship to Patient_____ Print Name_____

Source of Authority:_____

MEDICAL HISTORY QUESTIONNAIRE

NAME: _____ BIRTHDATE: _____ Date: _____

Name of Medical Doctor _____ Dr's Phone # _____ Date of last medical exam _____

Pharmacy: □ Safeway □ Wal-Mart □ other: _____

Your reason(s) for visiting our office today: _____

SO WE MAY BETTER SERVE YOUR VISION NEEDS, PLEASE ANSWER THE FOLLOWING QUESTIONS.

OCCUPATION: _____ **Visual demands?** ☐ **Distance** ☐ **Reading** ☐ **Computer** ☐ **Welding** ☐ **Power Tools**

♦**Do you work on a computer? If so, how many hours a day?** _____

♦ **Hobbies and Interests:** _____

OCULAR CONDITIONS- Do you currently have or have you been diagnosed with the following:

Cataracts	☐ Yes	☐ No	Infection of eye or Lid	☐ Yes	☐ No
Crossed eye	☐ Yes	☐ No	Lazy Eye	☐ Yes	☐ No
Drooping Eyelid	☐ Yes	☐ No	Retinal Diseases	☐ Yes	☐ No
Eye Injury	☐ Yes	☐ No	Styes or Chalazion	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No			

MEDICAL HISTORY:

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? □ NO □ YES If yes, explain: _____

_____

LIST ANY CURRENT MEDICATIONS (include over the counter & ocular medications) _____

_____

_____

List all major injuries, surgeries and/or hospitalizations you have had: _____

_____

Nursing/Pregnant: □ **YES** □ **NO**

Do you wear glasses? □ **YES** □ **NO** If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? □ **YES** □ **NO** If yes, how old is your present pair of lenses? _____

Type of contact lenses: □ Rigid □ Soft □ Extended Wear □ Other Are they comfortable? □ YES □ NO

FAMILY HISTORY:

Please note any family history (mother, father, siblings, children, grandparents, living or deceased) for the following conditions:

OCULAR:	YES	NO	RELATIONSHIP TO YOU (**please indicate maternal/paternal**)
BLINDNESS	□	□	_____
CATARACT	□	□	_____
CROSSED EYES	□	□	_____
GLAUCOMA	□	□	_____
MACULAR DEGENERATION	□	□	_____
RETINAL DETACHMENT/DISEASE	□	□	_____
SYSTEMIC:			
ARTHRITIS	□	□	_____
CANCER	□	□	_____
DIABETES	□	□	_____
HEART DISEASE	□	□	_____
HIGH BLOOD PRESSURE	□	□	_____
KIDNEY DISEASE	□	□	_____
LUPUS	□	□	_____
THYROID DISEASE	□	□	_____
OTHER: _____	□	□	_____

CONTINUE ON THE BACK

PERSONAL/SOCIAL HISTORY:

Do you use tobacco products? □ YES □ NO TYPE / AMOUNT: _____
Do you drink alcohol? □ YES □ NO TYPE / AMOUNT: _____
Do you use illegal drugs? □ YES □ NO TYPE / AMOUNT: _____
Have you ever been exposed to or infected with: □ Gonorrhea □ HIV □ Syphilis □ Hepatitis (type): _____

REVIEW OF SYSTEMS (Please mark if you experience any of the following):

CONSTITUTIONAL	YES	NO
Fever, Weight Loss / Gain	□	□
NEUROLOGICAL		
Headaches / Migraines	□	□
Seizures	□	□
EYES		
Loss of Vision	□	□
Blurred Vision	□	□
Distorted Vision / Halos	□	□
Loss of Side Vision	□	□
Double Vision	□	□
Dryness	□	□
Mucous Discharge	□	□
Redness / Itching	□	□
Sandy / Gritty Feeling	□	□
Tired Eyes	□	□
Burning	□	□
Foreign Body Sensation	□	□
Excess Tearing / Watering	□	□
Glare / Sensitivity to Light	□	□
Eye Pain or Soreness	□	□
Chronic Infection of Eye or Lid	□	□
Sties or Chalazion	□	□
Flashes / Floaters in Vision	□	□
ENDOCRINE (Thyroid/Glands / Hormones)	□	□

EARS, NOSE, MOUTH, THROAT	YES	NO
Allergies / Hay Fever	□	□
Sinus Congestion	□	□
Chronic Cough	□	□
RESPIRATORY		
Asthma	□	□
Chronic Bronchitis	□	□
Emphysema	□	□
VASCULAR / CARDIOVASCULAR		
Diabetes	□	□
Heart Pain	□	□
High Cholesterol	□	□
High Blood Pressure	□	□
Vascular Disease	□	□
GASTROINTESTINAL (Constipation / Diarrhea)	□	□
GENITOURINARY (Bladder / kidney)	□	□
BONES / JOINTS / MUSCLES		
Rheumatoid Arthritis	□	□
Muscle Pain	□	□
Joint Pain	□	□
LYMPHATIC / HEMATOLOGIC		
Anemia / Bleeding Problems	□	□
ALLERGIC / IMMUNOLOGIC	□	□
PSYCHIATRIC	□	□
INTEGUMENTARY (Skin)	□	□

If you answered YES to any of the above or have a condition not listed, please explain and list medications:

_____

_____

_____

PATIENT'S SIGNATURE (or parent/legal guardian):_____ **Date:** _____
I certify that I have read and understand the above information to the best of my knowledge.

Doctor's Signature_____ Date_____
Doctor's Signature_____ Date_____
Doctor's Signature_____ Date_____