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Welcome to our Office!

The mission of Austin Village Eyecare is to contribute to a lifetime of healthy vision, providing each patient with the highest quality vision care and consequent quality of life. Everything we do shall communicate this. The information and questions below will remain confidential, and are critical to the evaluation of your vision and health. Therefore it is very important that every question be answered in detail. Thank you.

Patient Information

TODAY'S DATE: _____

NAME: _____ DATE OF BIRTH: _____ AGE: _____ SEX: M F

ADDRESS: _____ SS#: _____
 (Street) (City) (State) (Zip)

EMAIL: _____ HOME PHONE: _____ | Work: _____
 | Cell: _____

NAME/ADDRESS OF PRIMARY CARE PHYSICIAN: _____ DATE OF LAST EXAM: _____

NAME/ADDRESS OF LAST EYE EXAM: _____ DATE OF LAST EXAM: _____

EMPLOYER/SCHOOL: _____ OCCUPATION: _____

NAME OF SPOUSE/PARENT (Please Circle): _____ | Work: _____
 | Cell: _____

INSURANCE HOLDER (Please circle): SELF / SPOUSE

VISION INSURANCE: _____ MEDICAL INSURANCE: _____ FLEX SPENDING YES NO

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE Name of Friend/Relative: _____

- Insurance Listing Yellow Pages Another Doctor's Office recommendation
- Saw Sign/Building Flyer Web Page: Which website?
- Newspaper Ad Coupon Mailer Other _____

WHAT ARE THE MAIN REASONS FOR TODAY'S APPOINTMENT? (PLEASE CHECK ONE OR MORE)

- Contact lens discomfort Eye Pain or Soreness Frequent eyestrain Red eyes
- Distance blurred vision Eye Watering or Tearing Frequent headaches Seeing flashes of light
- Double vision Eyelids matted shut Mucous Discharge eyes Sudden loss of vision
- Dry/Burning eyes Floating spots in vision Near blurred vision Unusual Light Sensitivity
- Eye Itching or Allergies Foreign matter in eyes One eye turns in or out Other _____

ALLERGIES TO MEDICATIONS? NONE YES: Please List: _____

CURRENT MEDICATIONS: NONE YES: _____

Including prescription, over the counter, natural herbs, vitamins, and birth control. Use space below if needed.

DO YOU USE: *TOBACCO PRODUCTS? YES NO QUIT *DRINK ALCOHOL? YES NO *USE DRUGS? YES NO

IF YES, TYPE/AMOUNT/HOW LONG: _____

CHECK ANY MEDICAL CONDITIONS THAT APPLY TO YOU

- Diabetes
- High Blood Pressure
- High Cholesterol
- Heart Disease
- Vascular Disease/Stroke
- Seizures
- Lung Disease/Asthma
- Headaches/Migraines

() NONE :

- Cancer
- Thyroid Disease
- Arthritis
- Weight Loss/Gain

- Skin Eczema/Rash
- Kidney/Bladder
- Psychiatric
- Autoimmune

CHECK ANY EYE CONDITIONS THAT APPLY TO YOU

- Glaucoma
- Cataracts
- Macular Degeneration
- Dry Eyes/Allergies

() NONE :

- Turned Eyes
- Eye Injury

- Eye Surgery
- Other _____

CHECK CONDITIONS THAT ARE PRESENT IN OTHER FAMILY MEMBERS AND INDICATE WHO () NONE :

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Glaucoma _____ | <input type="checkbox"/> Retinal Detachment _____ | <input type="checkbox"/> Blindness _____ | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> Cataracts _____ | <input type="checkbox"/> Turned/Crossed Eyes _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Heart Disease _____ |
| <input type="checkbox"/> Macular Degeneration _____ | <input type="checkbox"/> Lazy Eye _____ | <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Thyroid Disease _____ |

CONTACT LENS HISTORY

- I do not wear contact lenses
- I am interested in wearing contact lenses or would like to know more about them
- I currently wear contact lenses; If so, what type: _____ Solution: _____ Sleep in your lenses? YES NO
- I am not satisfied with the vision and comfort of my contact lenses

How often do you replace your contacts? DAILY 2-WEEKS MONTHLY QUARTERLY YEARLY

Canon/ReSeevit Retinal Photography: This advanced technology which often becomes an alternative to dilating the pupil is highly recommended and used by the doctors to detect early signs of retinal disorders, including but not limited to: glaucoma, cancer, diabetic retinopathy, high blood pressure, macular degeneration, and retinal detachment. It is fast, painless, and comfortable. It is particularly helpful when you return for your annual exam as it provides a permanent record of your retinal condition, and each subsequent year the digital images can be viewed side by side to discover subtle changes and monitor your continuing eye health. However, new technologies are often not covered by insurance plans, and there may be a \$32 fee associated with the testing.

- YES: I understand the importance of having an Canon/ReSeevit Retinal Photography, and I grant permission.
- NOT SURE: I am interested in the Canon/ReSeevit , but I would like more information before deciding to proceed.

Receipt of Notice of Privacy Policies & Consent Form

I acknowledge that I have received the Notice of Privacy Practices from Austin Village Eye Care. 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 authorize the same to assignment of benefits from my insurance company. I also understand that the premises are under video surveillance, and that these recordings will be kept strictly confidential. Austin Village Eye Care may use them in any way deemed necessary, including use by law enforcement and in a court of law.

Please be advised if you are using insurance coverage for today’s visit, this is a contract between you and your insurance company, not Austin Village Eye Care. If your insurance company has not reimbursed our office in full within 90 days, you may be billed and your insurance company will then pay you directly. If by mistake your insurance company sends the payment check to us, we will of course sign over and forward the check directly to you. Please sign below acknowledging that you understand:

Name: _____

Signature: _____ Date _____

AUSTIN VILLAGE EYE CARE FINANCIAL POLICY

The doctors and staff at Austin Village Eyecare are pleased that you have chosen us for your Eyecare needs. Please review our financial policy and acknowledge it with your signature below.

1. Payment for professional services (eye examinations, specialty testing, office visits) is due the day services are provided. Payment for eyeglasses and contact lenses is due in full the day materials are ordered. For your convenience, we accept cash, checks, debit cards, Visa, Mastercard and Discover.
2. We are providers for a wide array of insurance plans and are happy to file those claims on your behalf. Payments for co-pays, deductibles, and items known not to be covered by your insurance is expected at the time of your visit. You are also ultimately responsible for all charges for which your insurance company denies payment when we receive your *Explanation of Benefits* statement from them.
We ask patients with insurance for which we are not providers to make payment in full when services are rendered. If applicable, an itemized statement that can be submitted to your insurance company for reimbursement will be given to you at the time of your visit.
3. **Both Established and New contact lens wearers are subject to an Evaluation/Fitting fee. This fee varies by the complexity of the individuals prescription and is separate from the exam co-pays. This is a global fee that covers multiple visits until the prescription is finalized and is due at each annual eye exam. These fees are due at the date of service.**
4. For those with Flex Spending accounts, payment in full for services rendered and materials ordered is expected. An itemized statement that can be submitted to your insurance company for reimbursement will be given to you at the time of your visit.
5. If payment from insurance company has not been received in 60 days, you will be responsible for paying your account balance in full.
6. Finance charges at the rate of 1.5%/month (18%APR) will accrue on all outstanding balances.
7. In some families, the question of who is responsible for a child's bill is uncertain. Since we are not party to any separation agreement or court order, this is strictly a matter between parents. We must insist, therefore, that the parent who requests evaluation and treatment for the child will be responsible for all fees incurred.
8. A service charge of \$30.00 will be applicable for all checks returned for any reason, including insufficient funds and stop payments.
9. If our office legal action to collect any unpaid charges, you will be billed the cost of attorney fees, courts costs and collection fees in addition to any unpaid balances.

** If you have any questions, please free to discuss them with us.
We are always willing to work with you in any way possible. **

I acknowledge that I am responsible to pay for all charges associated with the services and materials provided by Austin Village Eyecare. I understand that if I fail to make any payments, my account may be turned over to a collection agency

Patient Signature _____ Date _____