Established Patient_____Today's Date:_____

Information Changes

Full Legal Name: _____
Address_____City_____Zip Code_____
Phone_____ Email_____
Current Medications: _____ Allergies to Medications:_____
New Medical Diagnosis since last visit _____Medical Doctor_____ Last Visit_____
Are you pregnant or nursing NO YES

Insurance Changes

New Insurance_____ New Insurance Card ID number_____

Reason for this Visit: Check all that apply

Glasses____ Contacts____ Problem (please specify)_____

Dilation is recommended as a yearly standard of care. It allows the doctor to check for glaucoma, cataracts, macular degeneration, and other eye diseases. You eyes will gradually return to normal over the next 2 to 8 hours. No additional charge for dilation. I may return anytime if refused today.

_____**Yes**, I would like to have my eyes dilated.

_____**No**, I decline this procedure. I fully understand the reasons and need for a retinal exam and accept full liability for any consequences of not having this procedure preformed.

---

*Austin Vision Care, P.A. will revise the eyeglass prescription at no change, as long as the glasses and glasses check are made within 30 days of the exam date or it will be considered as a regular office visit and the patient will be charged accordingly. Contact lens follow up exams must be done within the 30-day time period. Any contact lens follow up visit after this period will be considered as a regular office visit and the patient will be charged accordingly. Contact lenses orders will be returned after 30 days if not picked up. We will take back unopened contact lens boxes if they need to be returned or exchanged. There is also a 15% restocking fee for unopened returned boxes.

*Medicare & Humana do not cover Refraction. I agree to pay for any services and materials I order, but which are not covered by my insurance listed. I request that payment of authorized Insurance benefits be made on my behalf to Laura Austin, O.D., for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 on CMS-1500 form, or elsewhere on other approved claim forms or electronic submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. I agree that I am responsible for any deductibles, co-insurance, or other balance not paid by my insurance.

* I authorize Austin Vision Care, P.A. to store my credit card information as part of my records to be used with my approval to pay over the phone if necessary.

***Patient/Beneficiary Signature**_____

***Date**_____

Cancellation Policy/No Show Policy For Appointments

1. Cancellation/ No Show Policy for Appointments

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty dollar ($50) fee; this will not be covered by your insurance company.

2. Scheduled Appointments

We understand that delays can happen however we must try to keep the other patients and doctors on time.

If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.

3. Account balances

We will require that patients with self pay balances do pay their account balances to zero (0) prior to receiving further services by our practice. Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns. Patients with balances over $100 must make payment arrangements prior to future appointments being made.

Signature_____Date_____

***(This lifetime signature on file authorizes acknowledgement of this policy.)**

Items to bring to Exam

- **All** Insurance Cards: Medical & Vision (Benefits cannot be obtained without card and
  you will be cash pay without prior benefits.)

- Photo ID
- Contact boxes, flat packs, or prescription
- Drops: currently using
- Glasses