Patient Information Today's Date: _____

Please Make Available a **photo Id/Driver's License** and any **Insurance Cards (vision** and **medical)**

Mr/Mrs/Ms/Miss/Dr: First_____MI___Last_____Nickname_____

Mailing Address:_____

City_____ State_____ Zip_____ Employer/School Name: _____

Primary Phone: _____ Cell/Work Ph: _____Email:_____

Date of Birth: _____ If under 18 y/o, Parent/Guardian Name: _____

Marital Status: Married Single Other Gender: Male Female Height: _____ Weight: ____

Are you a diabetic? _____As a diabetic you need to have a dilated yearly comprehensive eye examination done to check on your retinal health. If you decide not to have your dilated exam today, Dr. Austin will not be able to check our ocular health at this time. **Are you pregnant or nursing?**_____

Primary Care Physician/ Referring Physician:_____ Pharmacy_____

Emergency Contact_____ Phone: _____ Parent/Spouse/Friend/Other

Whom may we thank for you to our office?_____

Phonebook / Website / Walk-In / Insurance / Family/Friend / Coworker / Other

Medical Insurance_____ **Vision Insurance**_____

I authorize the office to release my personal history information (including the picking up of prescriptions, ability to ask medical questions, **insurance questions**, etc.) only to the person listed below.

*This information **may be** released to**:** Name/relationship_____ (Spouse), (Friend), (Parent), (No One), Other

If your deductible is not met we can file your exam with your health insurance in order to help you meet your deductible, however any services received today will need to be paid in full at the time of service. Due to your specific insurance benefits, your co-pays and coinsurances cannot be finalized until payment by your insurance. Co-pay, coinsurance payment is expected at time of service.

There are **two types of insurance** that will help cover your eye exam, products, and other testing. You may have both types, and our practice accepts both: **vision care plans** (such as Superior or Spectera) and **medical insurance plans** (such as BCBS or Medicare).

1. Vision care plans only cover routine vision exams/screenings along with eyeglasses and contact lens benefits. **They do not cover diagnosis, management or treatment of eye diseases such as diabetic retinopathy, cataracts, or dry eye.**
2. Medical insurance must be used if you have any eye health problem or systemic health problem that has ocular complications. The doctor will determine if these conditions apply to you, but some are determined by your case history. In most cases medical insurance **does not** cover contact fits or contact lenses or refractions.
3. Do you have any of these? (please circle) Cataracts/Lens Implants, Dry Eye, Eye Allergies, Macular Degeneration, Amblyopia/Lazy Eye, Diabetes, Glaucoma
4. If you have both types of insurance plans it may be necessary for us to bill part of your services to one plan and the rest of your services to the other. However, we will have to check your insurance benefits for filing policy.
5. We will bill your insurance plan for services if we are a participating provider for that plan. We will try to obtain advanced authorization of your insurance benefits so we can tell you your benefits. If some fees are not paid for by your plan, we must bill you for any unpaid deductibles, co-pays or non-covered services as allowed by the insurance contract.
6. Due to Prior Authorization requirements, I understand this exam will be **CASH PAY** unless all insurance information is presented to Austin Vision Care before my appointment time. Also I understand I can file my own insurance at a later time if I so choose, however, *Austin Vision Care will not be required to file insurance at a later date.*

***(This lifetime signature on file authorizes Insurance payments without you needed to sign a form every time an Insurance form is submitted. You may revoke this at any time by contacting the office or signing a revocation)**

_____ _____ _____

Signature of Patient or Legal Guardian Relationship Date

Other Side →

Printed Name :_____

Check all that may apply:
☐ Wear glasses ☐ Wear Contact Lenses Type (circle): Acuvue Bausch & Lomb Cooper _____
Contact Disposal (circle): 1 day 2 week 1 month 3 month 1 year other
Contact Lens solution (circle): Aquify Biotrue Renu Optifree Complete

Do you have:
☐ Lazy eye/Amblyopia ☐ Drooping eyelid ☐ Glaucoma ☐ Cataract ☐ Eye Injury
☐ Eye Surgery/LASIK ☐ Macular Degeneration ☐ Retinal Disease ☐ Dry Eye ☐ Other_____
☐ Family History of glaucoma ☐ Family History of macular degeneration

Do **YOU** currently have any problems in the following areas: "yes" or "no" or occasionally

	Y	N	Occ.		Y	N	Occ.
Flashes or floaters	☐	☐	☐	Loss of vision	☐	☐	☐
Double vision	☐	☐	☐	Itching of eyes	☐	☐	☐
Sandy or Gritting eyes	☐	☐	☐	Dry eyes	☐	☐	☐
Excess watering	☐	☐	☐	Glare	☐	☐	☐
Light sensitivity	☐	☐	☐	Redness	☐	☐	☐

Your Medical History:

☐ Diabetes ☐ Cancer ☐ COPD/Emphysema
☐ Heart Disease ☐ Radiation ☐ Migraine/Headache
☐ High Cholesterol ☐ Chemotherapy ☐ Allergies
☐ High Blood Pressure ☐ Thyroid Disease ☐ Arthritis

Name of Medical Doctor: _____ Last exam date: _____Specialist:_____Pharmacy_____
List any medications you are currently taking (including over-the-counter medicines, aspirin, **vitamins**, oral contraceptives, and homeopathic remedies):

List any **eye drops** or **eye ointments** you are using:_____
List any **allergies** to medications:_____ Or NO ALLERGIES
List any major injuries, surgeries, and/or hospitalizations you have had within the last 10 years:_____

Are you interested in:

☐ Contact Lenses ☐ Color Contact Lenses ☐ Safety Glasses
☐ Sports eyewear ☐ Computer glasses ☐ Lasik Other:_____

Preferred Communication: Phone Email Mail Preferred Language: English Spanish Other_____

Whom may we thank for referring you to our office?
(Please Circle one) Website Sam's optical Walk-in Insurance Family/Friend Other

Social History: (This information is kept strictly confidential. However you may discuss this portion directly with the doctor if you prefer.)

Do you drive? _____ If yes, are there any visual complications when driving?
_____
Do you use tobacco products? _____ Type/amount: _____
Do you drink alcohol? _____ Type/amount: _____

Any other conditions or questions, please list below:
_____

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

Exams:

My exam's billing will be determined by reason for visit and ultimately diagnosis. I understand that vision insurance (i.e. Superior, Optum Health, etc.) covers only routine/preventative eye examinations for the purposes of vision correction. Medical concerns such as diabetes, cataracts, glaucoma, eye pain, redness, "spots in vision", dry eye, among other problem focused complaints are not addressed during a routine/preventative examination and any visit for those complaints will be considered a medical visit and will be billed through my medical insurance provider. Sign below to acknowledge that you were provided with a copy of your contact lens prescription.

Dilation

Dilation **is recommended**. Dilation allows the doctor to view the complete health of the eye. I fully understand the reasons and need for a retinal exam and accept full liability for any consequences of not having this procedure performed.

Retinal Screening Photos

Retinal Screening photos provide a baseline analysis of the external and internal portions of your eye to allow us to monitor yearly changes in your eye health. Retinal screening photos are $35.

Payments

I authorize that all insurance payments, if any, be made payable to the provider of service. I understand that I am responsible for all charges (co-pays, coinsurances, deductibles, etc.) whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. All charges are due and payable at the time of services unless otherwise specified. I authorize the use of this signature of all insurance submissions. If my insurance is unable to be authorized prior to my appointment, Austin Vision Care will be unable to file my insurance for me. I can obtain a receipt so I can file my insurance for myself. We do not refund professional feels. Most medical insurances do not cover refraction. There is a $40 charge for the refraction at time of service.

Cancellation and/or 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 or if you miss your appointment you will be charged a fifty dollar ($50) fee; this will not be covered by your insurance company.** If you bring a doctor's note/excuse form, we will waive this fee. Without the note or excuse form, we cannot waive this fee.

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 and charge the no show fee.

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.)**

Dr. Laura A Austin
571 W Martin Luther King Blvd, Fayetteville AR 72701
Ph 479-527-0100 Fax 479-527-0102 Email staff@austinvisioncare.com

Frame Warranty

All frames purchased from AVC have a warranty against **manufacturing** defects. This does not include damage from neglect or abuse. We will replace the frame free of charge **one** time within a 12 month period from date of purchase. Defective product **MUST** be returned to AVC prior to dispensing the new frame or you will be responsible for the usual and customary fee.

Lens Warranty

All lenses carry a one year scratch, breakage, or defect warranty from the exam date. We will replace each lens one time at no charge during this period. Defective product **MUST** be returned to AVC prior to dispensing the new lenses or you will be responsible for the usual and customary fee of the lenses.

Policy for Re-Using Your Own Frame

We are happy to make new prescription lenses for your own frame as long as the frame is in good condition and fits your face properly. We pledge to use the utmost care in handling, however, in a small percentage of cases, the frame material may have become worn or brittle to the point that it is no longer able to support a new pair of lenses. Please be aware that older frame styles are often discontinued by the manufacturer and replacement parts are usually not available. This presents a problem if the frame breaks and is unable to be repaired. If your frame breaks during our lens insertion process, we will make new lenses for a comparable frame style you choose. The cost of the replacement frame, less 25%, will be at your expense.

Canceling or Changing an Eyewear Order

Production of most lens orders begins within 24 hours. If you wish to cancel or change an order you may do so within 24 hours of placing the order. Please call the office to change the order. If the cancellation or change is made within the 24 hour processing period, we will refund the full amount of the order. If the request to cancel or change is made after the 24 hour period, we will stop the order at its current status and refund you 50%. We are unable to issue a full refund once the order has been started, as each lens is specifically designed to your prescription in the material of your choice and cannot be reused.

Progressive Lens Non-Adapt Policy

Progressive lenses are highly customized to your prescription and visual needs and cannot be reused. However, we understand that not everyone is able to adapt to progressive lenses. If a patient has worn the progressive lenses for at least 7days, and cannot adapt, we will exchange the progressive lenses for another modality lens type. This offer can be used once within 45 days of purchase. Any additional changes will be charged at 50% of usual and customary fees.

Doctor's Prescription Change Policy

If there is an apparent issue with the prescription, the doctors will gladly see you for a prescription check within forty five (45) days from the date of the original exam. Rechecks beyond 45 days may be subject to usual and customary charges for an office visit. Lenses will be replaced one time at no charge for a prescription that is changed within 45 days from the date of purchase. Subsequent changes will be made at 50% of usual and customary charges.

Transitions Non-Adapt Policy

If you not satisfied with the performance of photochromic (Transitions) lenses, you may exchange them for clear lenses within 45 days of the original order. No refunds. You will be charged 50% of usual and customary fees for any change in Transitions color preference.

Frame Change Policy

We want you to love how you look! If you decide you want to change your frame, you may exchange it for an alternative design within thirty (30) days of the original order. Lenses are cut to fit a specific frame shape so we are unable to reuse your original lenses in a different frame. We can make new lenses at a 40% discount, and you will be responsible for paying the difference on any higher priced frame choice.

Eyewear Orders Not Picked Up after Purchase

We are not able to hold orders over 60 days. This includes, but is not limited to, new orders, and eyewear left for repairs. If after this time you have not called or made arrangements to pick up your order, the order will be discarded. Any insurance benefits used for the order will no longer be available.

Prescriptions

Austin Vision Care, P.A. will revise the eyeglass prescription, at no charge within 30 days of the exam date. Any glasses checks after the 30-day time period will be considered as a regular office visit and the patient will be charged accordingly. Contact lens follow-ups 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. Some insurance companies DO NOT cover contact lens fittings if contact lenses are not purchased in office. Therefore, I agree to pay the fit out of pocket if I decide not to purchase contact lenses from Austin Vision Care.

Contacts

Contact lens orders will be returned after 30 days if not picked up. We will exchange or return unopened contact lens boxes, there is a 15% restocking fee for any returned boxes or orders that were not picked up. Sign below to acknowledge that you were provided with a copy of your contact lens prescription.

Signature_____**Date**_____