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

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 copays and coinsurances cannot be finalized until payment by your insurance. Copay, 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 EyeMed) 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.

***(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

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

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:
_____
_

Initial ALL, that you have read and understand this information whether it regards to you personally or not.

Initial

_____ 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.

Initial

_____ 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.

Initial

_____ 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. 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. Pupillary distance measurement can be obtained for a service fee of $25.

Initial

_____ We do not refund professional fees. Payment, copay, or coinsurance is expected at time of service. Most medical insurances do not cover Refraction. There is a $35 charge for the refraction at time of service.

Initial

_____ Medical information, prescriptions, charts, etc. will not be released if there is a balance on file for you or a family member until the balance is paid in full. Full payment for outstanding balances due before other office visits or procedures can be performed. Services will not be provided if there is an outstanding balance for patients or their family members. Insufficient check funds are subject to $25.00 service charge.

Initial

_____ 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. Effective September 1 2018.

Initial

_____ If I am a contact lens patient, I give verbal authorization and authorize Austin Vision Care, P.A. to store my credit card information as part of my records to be used to pay over the phone if necessary.

_____	_____	_____
Signature of Patient or Legal Guardian	Relationship	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)**