Visionary Eye Center
Patient Information

Name: _____ Sex: M F Date of Birth: _____/_____/_____

Patient Soc. Sec. #: __ __ __ - __ __ - __ __ __ __ Marital Status: ☐Single ☐Married ☐ Other

Street Address: _____ City: _____ State: _____ Zip: _____ ☐ I receive mail here

Name of Guarantor/Parent if under 18: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employment Status: ☐ Employed FT ☐ Employed PT ☐ Not Employed ☐ Retired ☐ Student FT ☐ Student PT

Preferred method of contact**:** ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Email ☐ Text ☐ Postal Mail

Email: _____ Employer: _____ Occupation: _____

Emergency Contact Name & Phone #: _____ ☐ Ok to discuss medical information with this person

How Did You Choose Our Office? ☐ Referred by: _____

☐ Insurance List ☐ Yellow Pages ☐ Newspaper ☐ Website ☐ YouTube ☐ Facebook ☐ Other _____

Insurance Information

It is your responsibility to know the terms and limitation of your policies. Failure to inform us of all of your insurance information may result in a denial of benefits and payment in full being owed by you. Please provide us with all of your insurance information. Your carrier is required to respond to our claim submission within 30 days. If we receive no response from your insurance company we may ask you to contact your insurance company or remit payment yourself and seek reimbursement from your insurance company. ***Medical insurance and vision plans are very different in their terms of service and their coverage. We are unable to determine which, if any, can be billed until after the examination is completed.*** When a medical condition is present (diabetes, high blood pressure, dry eyes, red eyes, allergies, etc.) it is necessary to file the claim with your major medical carrier. Vision plans do not typically cover medical problems, just as medical insurance does not cover routine glasses and contact lens exams. ***We are often unable to bill your vision plan for the glasses/contact lens portion of your exam on the same day we bill your medical insurance for management of your medical eye problem. Our office does not make these rules, they are defined by the insurance carriers themselves.*** We will need copies of your insurance cards and a photo ID

Primary Medical Insurance

Policy Holder (PH) Information (complete only if you are not the primary policy holder)

Carrier (circle): Medicare Medicaid Aetna Anthem BC/BS Cigna Prominence HHP Other _____

ID#: _____ Group #: _____

Name of PH: _____ Date of Birth of PH: _____ Soc. Sec. # of PH: __ __ __ - __ __ - __ __ __ __

Secondary Medical Insurance

Carrier (circle): Medicare Medicaid Aetna Anthem BC/BS Cigna Prominence HHP Other _____

ID#: _____ Group #: _____

Name of PH: _____ Date of Birth of PH: _____ Soc. Sec. # of PH: __ __ __ - __ __ - __ __ __ __

Vision Plan Information

Carrier (circle): VSP EyeMed Davis Other _____

ID#: _____

Name of PH: _____ Date of Birth of PH: _____ Soc. Sec. # of PH: __ __ __ - __ __ - __ __ __ __

By signing below you attest the information listed above is true and that you have read and understand the financial policies of this office listed on both sides of this form. If you are using insurance and they deny any part of your claim you agree to pay any outstanding balance. Please provide your insurance card(s) and a valid form of picture identification with this form at check in.

Patient Signature (**OR** parent/guardian if under 18): _____ Date: _____

Financial Responsibility Statement/Acknowledgement of Office Policies

Financial Policy

Payment is expected at time service is rendered and before orders are placed. By signing you agree to be held liable for all expenses, costs and reasonable court, attorney and collection agency fees for any delinquent balance. Any check returned unpaid will incur a fee of $25 applicable under state law. A collection service fee will be assessed for any unpaid balances after 30 days of initial notice of balance due. A $25.00 service fee will be assessed for failure to pay your copay at the time of service. Our office may assess an administrative fee for completion of any outside paperwork, forms and chart reviews requested by you. A cancellation fee may be assessed for any appointment missed without at least 24 hours prior notice.

To our patients *WITH* vision/medical benefits:

It is your responsibility to know your coverage and co-pay amounts. Please be aware, unless your particular insurance plan has *specific* benefits for contact lens fittings, you will be expected to pay that amount along with your co-pay and any other non-covered services. Any out of pocket expenses collected from you at the time of service are estimates only; your insurance will determine your final out of pocket costs.

In the event that your insurance company determines that you are not eligible at the time of service, or makes a determination that you are eligible for a reduced level of coverage, by signing this statement you hereby agree to be financially responsible for any and all charges incurred by you and not paid by the Plan Sponsor, and any additional collection fees necessary to collect all amounts due. Be aware that any pre-authorizations received by our office are not in any way a guarantee of payment from your insurance company. After we receive your plan sponsor's response any and all remaining balances will be due within 30 days. If we do not receive a response from your insurance company within 90 days we will bill you for the balance due in full. Due to the time limit restrictions imposed by many insurance companies, failure to supply us with the correct insurance information may result in payment in full being owed by you.

Glasses Recheck Policy

This office will recheck any prescription one time at no cost within 90 days of the date on which the prescription was determined. If you were told at the time of the exam that your glasses will need to be altered for varying medical reasons within the 90 day period this recheck policy does not apply and you may be charged a fee. You must be able to furnish the glasses/contacts that you had filled with the aforementioned prescription if not filled through our office. A fee to confirm the parameters of a prescription pair of glasses not purchased in our office or online store may apply. Other restrictions may apply, ask an associate for details. After 90 days a fee will be incurred for any recheck. Rechecks will not be performed after 6 months from original exam date and a new exam will be necessary.

Glasses Remake Policy and Frame and Lens Warranty

This office will remake prescription glasses once within 90 days of pickup at no charge to the patient in cases of prescription change. Any remakes required beyond the initial remake will result in fees for the lenses and any treatments charged at 50% of our usual and customary fees. Frames purchased from our office have a 2 year manufacturer defect warranty and does not cover acts of abuse. Lenses with a scratch treatment have either a 1 or 2 year warranty depending on type of scratch treatment purchased which covers wear and tear scratches but not acts of abuse. Neither of our warranties for frames or lenses cover loss or theft. If you used insurance to purchase your glasses your warranty changes from our standard office warranty to your insurance company's warranty.

Pupillary Distance and Other Glasses Measurements

This office takes pupillary distance and other measurements to properly fit prescription glasses as part of the service provided for eyewear purchased from our office or through our online store. Patients that do not purchase prescription eyewear through our office or online store will be charged a fee for taking these measurements in conjunction with our prescription verification service. Patient's that have purchased glasses from our office in the past may request a copy of their records for a small administrative fee, which will include a copy of their previous order(s) with their pupillary distance highlighted.

Refund Policy

All orders are final when placed. No refunds are given on custom made prescription items. If you are unhappy with your glasses for any reason, please bring them back to us so we may change them to meet your expectations. Any contacts purchased from our office may be returned less a restocking fee within 90 days of receipt as part of our Contact Lens Success Program. Vialed soft lenses and rigid gas permeable (RGP) lenses must physically be returned, even if in pieces, for refund. Contact lens boxes, vialed lenses and RGP's may not be returned after 90 days. Opened boxes may not be returned. Refunds will not be given on services provided.

Privacy Policy, HIPAA and Your Records

This office follows HIPAA guidelines concerning the privacy of your medical information. We will not release any of your information to anyone without your written prior authorization with the exception of other health professionals and your insurance company as outlined in HIPAA if applicable. A copy of the HIPAA guidelines is available upon request. Under Nevada law your records will be maintained a minimum of five years.

Welcome to the Visionary Eye Center
Patient Ocular and Medical History

Patient Name: _____ Date: _____

Have you ever had any of the following eye problems? If yes, is it current (within the last month)?

Condition	No	Yes	Current?	Condition	No	Yes	Current?
Glaucoma	☐	☐	☐	Eye Turn/Crossed Eye	☐	☐	☐
Macular Degeneration	☐	☐	☐	Double Vision	☐	☐	☐
Cataracts	☐	☐	☐	Lazy Eye/Amblyopia	☐	☐	☐
Retinal Tear/Detachment	☐	☐	☐	Glare	☐	☐	☐
Eye Injury	☐	☐	☐	Flashes	☐	☐	☐
Dryness/Burning	☐	☐	☐	Floaters	☐	☐	☐
Chronic Redness	☐	☐	☐	Eye Surgery	☐	☐	☐
Itching/Allergies	☐	☐	☐	Complete Blindness	☐	☐	☐
Chronic Watering	☐	☐	☐	Prosthetic Eye	☐	☐	☐

If you answered yes to any of the above, please let us know which eye is affected and any other details you feel might be helpful for us to know: _____

_____

Please list all eye drops or ointments currently used: _____

_____

For Glasses Wearers: How old are your glasses? _____ What do you wear them for? _____

What do you like about your glasses? _____

What do you not like about your glasses? _____

Did you bring your prescription sunglasses? ☐ Yes ☐ No Did you bring your computer glasses? ☐ Yes ☐ No

For Contact Lens Wearers: Are You Wearing Them Now? ☐ Yes ☐ No How Old is Your Present Pair? _____

What Brand? _____ What Solution? _____ How Often Do You Replace Them? _____

Average Wear Time? _____ (Hours) Do You Sleep In Your Lenses? ☐ Yes ☐ No If Yes, How Often? _____

Are You Happy With Your Current Contacts? ☐ Yes ☐ No

Routine eye exams do not include professional services for contact lens evaluations. Any fees are the responsibility of the patient. We are not able to use your materials benefits to pay for this service with most insurances.

Visual Needs	**No**	**Yes**
Do you get eyestrain or headaches when using a computer?	☐	☐
Are you required to wear safety glasses at work?	☐	☐
Do you participate in shooting sports?	☐	☐
Do you golf?	☐	☐
Do you participate in water sports (i.e. skiing, boating) or fishing?	☐	☐
Do you have problems with glare at night?	☐	☐
Do you have problems with glare during the day?	☐	☐
Do you have problems with your glasses fogging over?	☐	☐
Do you have problems cleaning your glasses?	☐	☐

How many hours a day do you spend on the computer (working, gaming, surfing)? _____

Family History

Do you have any blood relatives with any the following:

Ocular Condition	No	Yes	Relation	Medical Condition	No	Yes	Relation
Glaucoma	☐	☐		Diabetes	☐	☐	
Macular Degeneration	☐	☐		Lupus	☐	☐	
Eye Turn/Crossed Eye	☐	☐		Thyroid	☐	☐	
Ocular Cancer	☐	☐		High Blood Pressure	☐	☐	
Retinal Tear/Detachment	☐	☐		Lung Cancer	☐	☐	

Personal Medical History: Have you had any of the following? If yes, is it current (within the last month)?

Condition	No	Yes	Current?	Condition	No	Yes	Current?
Allergy	☐	☐	☐	**Integumentary (Skin)**	☐	☐	☐
Seasonal/Dust/Pollen	☐	☐	☐	Contact Dermatitis	☐	☐	☐
Medication Allergy	☐	☐	☐	Rosacea	☐	☐	☐
Cardiovascular	☐	☐	☐	Lupus	☐	☐	☐
Elevated Cholesterol	☐	☐	☐	**Musculoskeletal**	☐	☐	☐
High Blood Pressure	☐	☐	☐	Ankylosing Spondylitis	☐	☐	☐
Stroke	☐	☐	☐	Arthritis	☐	☐	☐
Constitutional	☐	☐	☐	Myasthenia Gravis	☐	☐	☐
Excessive/Frequent Urination	☐	☐	☐	Marfan's Syndrome	☐	☐	☐
Excessive Thirst	☐	☐	☐	**Neurological**	☐	☐	☐
Endocrine	☐	☐	☐	Bell's Palsy	☐	☐	☐
Hyperthyroid	☐	☐	☐	Seizures	☐	☐	☐
Hypothyroid	☐	☐	☐	Multiple Sclerosis	☐	☐	☐
Diabetes (Insulin Dependant)	☐	☐	☐	**Psychiatric**	☐	☐	☐
Diabetes (Non-insulin Dependant)	☐	☐	☐	ADD/ADHD	☐	☐	☐
Gastrointestinal	☐	☐	☐	Bipolar	☐	☐	☐
Hepatitis	☐	☐	☐	Depression	☐	☐	☐
Genitourinary	☐	☐	☐	Autism	☐	☐	☐
Bladder/Kidney Disease	☐	☐	☐	Mentally Challenged	☐	☐	☐
Ear/Nose/Throat	☐	☐	☐	Dementia	☐	☐	☐
Hearing Impairment	☐	☐	☐	**Respiratory**	☐	☐	☐
General Headaches	☐	☐	☐	Asthma	☐	☐	☐
Migraine Headaches	☐	☐	☐	COPD	☐	☐	☐
Hematologic/Lymphatic	☐	☐	☐	Emphysema	☐	☐	☐
Temporal Arteritis	☐	☐	☐	If you have a condition not listed above please list here: _____			
Immunological	☐	☐	☐	_____			
HIV/AIDS	☐	☐	☐	_____			
Lyme Disease	☐	☐	☐	_____			
Sjogren's Disease	☐	☐	☐	_____			
Herpes Simplex (Oral/Genital)	☐	☐	☐				
Herpes Zoster (Shingles)	☐	☐	☐				

Please list all of your medications, including birth control and over the counter medications/vitamins: _____
_____
_____
_____
_____

For Women: Are You Pregnant? ☐ Yes ☐ No If Yes, How Many Months? _____ Are you breast feeding? ☐ Yes ☐ No

Social History: Do you smoke? ☐ Yes ☐ No Did You Ever Smoke? ☐ Yes ☐ No If you've quit, how long ago?_____
Do You Drink? ☐ Yes ☐ No If Yes, How Many Drinks/Week? _____ Do You Use Any Recreational Drugs? ☐ Yes ☐ No

The following questions are required by the Centers for Medicare and Medicaid Services (CMS) **FOR ALL PATIENTS** to meet the standards for meaningful use of electronic records. Racial and ethnic classifications were determined by CMS.
If you have questions please ask the staff.

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic/Latino **Preferred Language:** ☐ English ☐ Spanish

Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Hawaiian/Other Pacific Islander ☐ White ☐ Other

By signing below you attest the information provided on this form is accurate and true.

Patient (Guardian if under 18) Signature: _____