Welcome to Acuity Eyecare

Name____ Birthdate:____/_____/_____ Date: __________
Age:_______ Last 4 digits of Social Security#: __________ (this is sometimes needed to look up and file your insurance)
Address:____ City: ____________ Zip: ____________
Email:____ Phone (home / cell) (_______)__________________
How would you like us to contact you? ◯ Text ◯ Email ◯ Call ◯ Other: ________________________________
How did you hear about us? ◯ Web Search ◯ Print Ad ◯ Facebook ◯ Insurance ◯ Referral ◯ Other: ________

Reason for today's visit *(fees vary according to level of service)*

MEDICAL EYE EXAMINATION – Any services to diagnose, monitor, or treat a ***medical*** problem – defined as anything that cannot be corrected by glasses or contacts (such as dry eyes, allergies, red eyes, cataracts, glaucoma, diabetes, vision loss, etc.) – must be filed with MEDICAL insurance.

EXTERIOR

◯ Dryness ◯ Burning
◯ Watering ◯ Itching
◯ Eyelid issues ◯ Redness
◯ Foreign Body ◯ Infection
◯ Gritty ◯ Pain/Soreness
◯ Other:_________________

INTERIOR

◯ Glaucoma ◯ Cataracts
◯ Macular degeneration
◯ Diabetic retinopathy
◯ Retinal disease/detachment
◯ Spot or freckle
◯ Other: _______________

VISION DISTURBANCE

◯ Night vision issues ◯ Double vision
◯ Eye fatigue ◯ Flashes/Floaters
◯ Dizziness ◯ Glare/Light Sensitivity

GENERAL HEALTH

◯ Diabetes/Pre-diabetes/High blood sugar
◯ High-risk medication(Plaquenil/Tamoxifen)
◯ Autoimmune Disease

WELLNESS EXAMINATION, GLASSES OR CONTACT LENS FITTING – Typically filed with your VISION plan

A wellness visit includes: review of history, medications, risk factors, screening tests and a complete physical exam. A wellness visit **DOES NOT apply if there are pre-existing eye conditions such as dry eyes, cataracts, glaucoma, or diabetes/pre-diabetes or if you need to discuss certain problems or symptoms with the doctor.**

◯ Blurred distance vision ◯ Blurred near vision ◯ New glasses ◯ New contact lenses

Retinal Imaging Protocol (Part of Our Standard Exam)

Good vision is dependent on good eye health. It is our standard of care to evaluate the health of the retina each year to screen for eye health problems. This test allows the doctor to evaluate the back of the eye without dilation (in most cases) and to track changes in your eye health over the years.

Retinal Imaging Fee: $ 38

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Initial Here

Please ask us if you have questions about this process or are unable to have this test done at this time.

Contact Lens and Glasses History

What is your occupation? ________________________________ What are your hobbies? ____________________________
Any specific vision requirements for your job? ____
How old are your current glasses? ____________________ Wearing schedule: ☐ Part-time ☐ Full time ☐ Other: __________
Do you wear contacts? Yes / No What type of contacts do you wear? (circle one) Soft Soft Toric Rigid Gas Permeable
Brand of contact lens: ____Brand of cleaning solution: ____________________
Contact lens prescription: Right eye____________________________ Left eye ___________________________
Wearing schedule: ☐ Overnight wear ☐ Every day ☐ A few days a week ☐ A few days a month ☐ Special occasions only
How frequently do you replace your contacts? ☐ Daily ☐ Bi-weekly ☐ Monthly ☐ Longer than I should….
Do you want to keep your current brand or are you interested in changing? ☐ Stay ☐ Change ☐ Doctor's choice

Personal Medical History

How long ago was your last eye exam?: ________________________ When was your last medical exam?: ______________________

Please note if you currently have (or if you have ever had) any problems in the following areas:

CARDIOVASCULAR	**Yes**	**No**	**Medication/Treatment**
High blood pressure	O	O	________________
High cholesterol	O	O	________________
Heart Problems/Vascular Disease	O	O	________________
CONSTITUTION			
Sudden weight gain/loss	O	O	________________
ENDOCRINE			
Diabetes	O	O	________________
Thyroid	O	O	________________
GASTROINTESTINAL:			
Diarrhea/Constipation	O	O	________________
GENITOURINARY (kidneys)	O	O	________________
EAR/NOSE/THROAT			________________
Seasonal allergies	O	O	________________
Decreased hearing	O	O	________________
HEMATOLOGIC/LYMPHATIC			________________
Bruising/Bleeding	O	O	________________
Anemia	O	O	________________
INTEGUMENTARY: (Acne/rosacea)	O	O	________________
MUSCULOSKELETAL			________________
Muscle/Joint pain	O	O	________________
Joint swelling	O	O	________________
NEUROLOGIC			________________
Headaches/Migraines	O	O	________________
Seizures/Strokes	O	O	________________
PSYCHIATRIC (anxiety/depression)	O	O	________________
RESPIRATORY (breathing)			________________
Cough	O	O	________________
Shortness of breath	O	O	________________
OTHER CONDITIONS (Please explain):			
CANCER TYPE & TREATMENT:			

Medications & Social History

Do you have any allergies to medications? ☐ Yes ☐ No If yes, please list: ____

Do you take any medications?: ☐ Yes ☐ No If yes, please list (including hormones, oral contraceptives, and non-prescription medications):____

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Are you pregnant or nursing? YES / NO Do you use tobacco products? YES / NO Do you drink alcohol? YES / NO

Do you use illegal drugs? YES / NO Have you been infected with (circle if yes): Gonorrhea HIV Hepatitis Syphilis

Family Medical History

Please note any family history (parents, grandparents, siblings, and/or children for any of the following conditions:

Disease/Condition	**Relationship**	**Disease/Condition**	**Relationship**
Cataract	____________________	Diabetes	____________________
Glaucoma	____________________	Cancer	____________________
Crossed Eyes/Lazy Eye	____________________	Heart Disease	____________________
Macular Degeneration	____________________	Thyroid Disease	____________________
Retinal Detachment/Disease	____________________	Other	____________________

Office Policies

Please read and initial ALL sections & sign at the bottom indicating that you acknowledge our office policies

Medical and Wellness Exams

A. Wellness exams screen for eye health problems and provide a glasses or contact lens prescription. Wellness exams do not apply if there are pre-existing eye conditions or medical problems affecting the eye.

B. Medical exams diagnose, monitor, or treat a ***medical*** problem - defined as anything that cannot be corrected by glasses or contacts (for example: dry eyes, allergies, red eyes, spot in the eye, cataracts, glaucoma, diabetes, vision loss, etc).

C. If we will be filing your insurance for your visit, be aware that insurance companies have strict policies regarding our ability to provide care. To accept and bill the insurance plan for our services, our billing policies must comply with insurance requirements. **Vision plans** only cover ***wellness*** exams, any services providing ***medical*** care must be filed with your **medical insurance.** We keep records of your vision and medical insurance cards on file in case we need it for billing the insurance correctly and avoid unnecessary expenses for our patients. *Please ask us if you have questions about the difference between a medical or wellness exam.*

D. If you will NOT be using insurance for your visit, fees for your visit will vary according to the level of service provided. We offer full transparency with our pricing to provide a quote before your exam based on your eye health needs.

Initial Here: ________

Financial Responsibility

Our staff is committed to provide the best quality of service possible. Before each exam, we confirm your eligibility for services with your insurance provider and will inform you of any known copays, deductibles and non-covered services due at the time of service.

A. If your insurance denies all or part of the claim, you are responsible for the uncovered amount. We can only apply coverage that your insurance company tells us you have at the time of service. Returned checks have a $45 service charge and may be sent to a collection agency if not paid. Late fees may apply.

B. Professional fees, such as exam fees or contact lens evaluation fees, are due at the time of service and represent payments for services that were rendered (even if not successful) and are not refundable. If there is difficulty adjusting to the new prescription or contact lenses, or additional prescriptions are desired, you have 60 days from the time of the exam to be re-evaluated without additional fees.

C. If you will need to order contacts within the next 12 months, we encourage you to update your contact lens prescription at the time of your exam. You may return for a separate contact lens evaluation within 60 days of your exam. After 60 days, a new exam will be needed to identify any vision changes before updating a contact lens prescription.

Initial Here: ________

Purchases of Eyewear or Contact Lenses

A. Eyewear & spectacle lenses: These are custom-made for you and as a result, are non-refundable. A 15% restocking fee will be due if a frame change is desired within 30 days of purchase. A frame will be returned to stock without refund if not picked up within 90 days of manufacturing. All other returns are considered on a case-by-case basis.

B. Contact lenses: Unopened boxes of contact lenses may be returned or exchanged within 90 days of purchase. Orders must be picked up within 90 days of purchase, otherwise we reserve the right to return them to the manufacturer and charge a restocking fee.

C. Acuity Eyecare will not be responsible for any eyewear, lenses or contact lens substitutions purchased from other retailers including, but not limited to, other offices, online platforms, or other retailers.

Initial Here: ________

Release of Information & Acknowledgement of Notice of Privacy Practices: (located on the back of your clipboard)

We protect your personal information and cannot release it without your express permission:

A. I authorize the release of all medical information needed for Acuity Eyecare to process my insurance claim(s). I authorize Acuity Eyecare to release health information about my health, or give my glasses or contact lenses to the following person(s):

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A. I acknowledge that I was given an opportunity to review the Notice of Privacy Practices for Acuity Eyecare which explains how my medical information will be used and disclosed. I have also been told who I can contact if I have any questions or complaints. I understand I may request a copy of the Notice to keep for my records.

B. I authorize Acuity Eyecare to contact me by the phone, text, or email I have provided.

Initial Here: ________

Name: ______________________________ Signature: ______________________________

Date: ________________ *Name of Guardian (if patient is a minor):* ______________________________