EYES ON THE HEIGHTS
OPTOMETRY

PATIENT INFORMATION

TODAY'S DATE: _____

PATIENT'S FULL LEGAL NAME: _____

PREFERRED NAME: _____ BIRTHDATE: _____

PARENT/GUARDIAN NAME (if applicable): _____

SEX: ☐Male ☐Female ☐Other

PHONE #: _____ EMAIL: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SSN: _____ OCCUPATION: _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

EMERGENCY CONTACT INFORMATION

NAME: _____ PHONE #: _____

RELATIONSHIP TO PATIENT: _____

VISION PLAN INFORMATION

VISION PLAN COMPANY: _____ ID #: _____

ARE YOU THE PRIMARY INSURED? ☐Yes ☐No

If no, NAME OF PRIMARY INSURED: _____

RELATIONSHIP TO PRIMARY: _____ PRIMARY'S BIRTHDATE: _____

PRIMARY'S PHONE #: _____

MEDICAL INSURANCE INFORMATION

INSURANCE COMPANY: _____

ID #: _____ GROUP #: _____

ARE YOU THE POLICY HOLDER? ☐YES ☐NO

If no, NAME OF POLICY HOLDER: _____

POLICY HOLDER'S BIRTHDATE: _____ LAST 4 OF SSN: _____

PATIENT'S RELATIONSHIP TO POLICY HOLDER: _____

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PATIENT INFORMATION

REASON FOR CURRENT VISIT: _____

DATE OF LAST EYE EXAM: _____ EYE DOCTOR/OFFICE: _____

Do you wear glasses? ☐ Yes ☐ No Are they for: ☐ Full time ☐ Reading ☐ Computer ☐ Driving

Do you wear contact lenses? ☐ Yes ☐ No Type of contacts: ☐ Soft ☐ Rigid ☐ Other

Are they comfortable? ☐ Yes ☐ No Brand of contacts: _____

Daily wear time (in hours) _____ How often do you dispose of them? _____

List any eye drops you are currently using: _____

_____

PRIMARY CARE PHYSICIAN/OFFICE NAME: _____

PHONE #: _____ LAST MEDICAL EXAM DATE: _____

_____

LIST ALL CURRENT MEDICATIONS (Rx, OTC, contraceptives, etc.): _____

_____

_____

ALLERGIES TO MEDICATIONS/DRUGS: _____

_____

FAMILY HISTORY: Please review the following conditions and check if applicable to any direct family members, living or deceased (parents, grandparents, siblings, children):

Ocular Condition	No	Yes	Relationship	Medical Condition	No	Yes	Relationship
Cataracts	☐	☐	_____	Diabetes	☐	☐	_____
Glaucoma	☐	☐	_____	High Blood Pressure	☐	☐	_____
Macular Degeneration	☐	☐	_____	Cancer	☐	☐	_____
Retinal Detachment	☐	☐	_____	Thyroid Disease	☐	☐	_____
Crossed Eyes	☐	☐	_____	Heart Attack	☐	☐	_____
Amblyopia	☐	☐	_____	Stroke	☐	☐	_____

If a condition is not included above, please list here: _____

_____

DO YOU USE TOBACCO PRODUCTS? ☐ No, Never smoker ☐ No, Former smoker. Year Quit: _____

☐ Yes, occasional smoker ☐ Yes, everyday smoker. # Cigarettes/Packs per day: _____

NOTICE OF PATIENT PRIVACY RIGHTS, PROTECTION, & RESPONSIBILITIES

MEDICAL NECESSITY

If my insurance determines that medical service(s) and/or material(s) are not covered, I acknowledge that I have been notified and will assume full responsibility for the service(s) and/or material(s) stated below.

COPAYS

I understand that I am responsible to pay all co-payments at the time of service, prior to leaving. Co-payments cannot be waived at any time by Eyes on the Heights.

DEDUCTIBLES

If my insurance determines that I have not met my deductible, I understand that I will be fully responsible for payment in a timely manner, no more than 30 days after I have been notified by insurance and/or provider. Yearly deductibles cannot be waived at any time by Eyes on the Heights.

PROFESSIONAL SERVICES AND MATERIALS

I understand that I am responsible for 100% of all professional fees rendered on the date of service. If I am supplying my own frame, I understand that many plastic and metal products may weaken over time and I will not hold Eyes on the Heights or my insurance carrier responsible for accidental laboratory breakage. If I do not pick up my materials within 60 days from my initial order, my materials will be returned to the laboratory, and my initial deposit will not be refunded. If I am to receive contact lenses by mail, I understand that I am required to pay in full at time of service.

Our Patient Satisfaction Guarantee applies to single vision and progressive lenses. We use only premium single vision optics and premium progressive addition lenses, otherwise known as no line bifocals. Less than one percent of our patients have difficulty adapting to our premium progressive lenses. We will remake a non-adapt progressive lens or single vision lenses one time, in the same frame. If it is still unsatisfactory, we will replace it with a lined bifocal or a single vision lens, in the same frame. While we make every attempt to solve these rare issues, no refunds will be given in a case where a patient does not adapt to a progressive lens or single vision lens.

HIPAA

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), which I have been provided a copy upon request, that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly, obtain payment from third party payers, and conduct normal healthcare operations such as quality assessments and physician certifications.

_____ _____

Patient/Guardian Signature Date

VISION vs. MEDICAL INSURANCE POLICY

Many of our patients have both vision and medical insurance, and we want you to understand the difference between the two. This is important because they differ in what they cover, pay, etc.

Vision coverage is designed to determine a prescription for glasses or contacts and is not equipped to deal with complex medical conditions and/or diseases. Therefore, the fee for this service is usually lower and does not include a detailed retinal exam.

When a medical condition or diagnosis is present (such as glaucoma, diabetes, dry eye or other eye diseases) it is necessary to file with your medical insurance. Any co-pays you have for a medical specialist will then apply. Some components of medical exams may not be covered by your insurance; therefore, you would be responsible for those fees. Medical fees are usually higher than vision fees. **If you do not have medical insurance but require a medical exam, please realize your exam will be out of pocket.**

It is important for you to accurately provide your vision and medical insurance information at least **24 hours prior to your examination,** including any change in information, as we will not be able to file any claims with your insurance at a later date. The benefits quoted by your insurance company may change once the claim has been filed and is not guaranteed.

Our office does not make these rules; they are defined by insurance companies. Often we will not know which type of exam you require until we begin our testing.

By signing below you state that you understand the above and assign all benefits to us. Whether or not you have insurance, please understand that you are responsible for your charges. There will be no refunds for any professional services.

All fees, insurance co-pays, deductibles and contact lens evaluation fees (that insurance may not cover) are due at the completion of your exam.

_____ _____

Patient/Guardian Signature Date