PREMIER EYE
ASSOCIATES

Medical Insurance Verification

Occasionally, medical conditions can be found during a routine eye examination. Having your medical insurance on file allows us to deliver the best possible health care and prescribe helpful medications, while reducing or eliminating your out of pocket cost. In order to best serve you, please select your medical insurance from the list below.

	I do not have medical insurance.

	Aetna
	Blue Cross Blue Shield
	Cigna
	Health Net
	Humana/Tricare
	Medicaid
	Medicare
	United Health Care
	Viva Medicare
	Other:

Signature: _____

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REGISTRATION

1. PATIENT INFORMATION

First Name _____ Last Name _____ You prefer to be called _____ Gender _____

Race _____ Birthdate: mm/dd/yyyy _____ Age _____ Marital Status _____

Social Security Number _____ Address _____ City _____ State, Zipcode _____/_____

Email Address _____ Phone Number _____ Employer _____ Occupation _____

2. PARENT/GUARDIAN INFORMATION [IF UNDER 18]

Name _____ Relationship to patient _____ Phone Number _____ Social Security Number _____

3. VISION INSURANCE INFORMATION

Company _____ Address, City, State, Zip _____ Phone Number _____

ID # _____ Group #/ Policy # _____ Policy Holder's Name _____

Relationship to Patient _____ Policy Holder's Date of Birth _____ Policy Holder's SSN _____

4. HEALTH INSURANCE INFORMATION [BILLED FOR MEDICAL EYE CONDITIONS]

Company _____ Address, City, State, Zip _____ Phone Number _____

ID # _____ Group #/ Policy # _____ Policy Holder's Name _____

Relationship to Patient _____ Policy Holder's Date of Birth _____ Policy Holder's SSN _____

5. EMERGENCY CONTACT

Name _____ Relationship to Patient _____ Phone Number _____

6. HISTORY

A. How did you hear about our practice? _____

B. **Occupation**: _____ **Employer**: _____

C. **Do you or have you experienced any of the following conditions? Circle all that apply.**

Cataract, Crossed Eye, Diabetic, Dry Eye, Flashes of Light, Floaters, Foreign Body, Glaucoma, Headaches, Itchy Eyes, Macular Degeneration, Retinal Detachment

C. Have you had any ocular surgeries? If yes, please explain. _____

D. When and where was your last eye exam? _____

Any family history of:	**Who?**
Y N Blindness	_____
Y N Crossed/Lazy	_____
Y N Glaucoma	_____
Y N Macular Degeneration	_____
Y N Retinal Detachment	_____

Any family history of:	**Who?**
Y N Cancer	_____
Y N Heart Problems	_____
Y N Diabetes	_____
Y N High Cholesterol	_____
Y N Hypertension	_____
Y N Thyroid Problems	_____

Y N Do you smoke?
Y N Do you drink alcohol?
Y N Do you use recreational drugs?

A. Do you have Diabetes? _____ If yes, Type I or II?_____ How many years?_____ Last BS Results_____ Last HBA1C Test Results_____

B. Please list any surgeries with dates: _____

C. What is the name of your Primary Care Physician and their office? _____

D. Are your currently pregnant or nursing? Yes / No / NA

E. Do you have any allergies? Yes / No

If yes, please list: _____

F. Do you currently or have you had any of the following diseases or medical conditions?

Y N Abnormal Bleeding	Y N Herpes / Fever Blisters
Y N Alcohol / Drug Abuse	Y N High Blood Pressure
Y N Anemia	Y N HIV+ / AIDS
Y N Arthritis	Y N Hospitalized for any reason
Y N Artificial bones / Joints/ Valves	Y N Kidney Problems
Y N Asthma	Y N Liver Disease
Y N Blood Transfusion	Y N Low Blood Pressure
Y N Cancer/ Chemotherapy	Y N Lupus
Y N Colitis	Y N Mitral Valve Prolapse
Y N Congenital Heart Defect	Y N Osteoporosis / Paget's Disease
Y N Diabetes	Y N Pacemaker
Y N Difficulty Breathing	Y N Psychiatric Treatment
Y N Emphysema	Y N Radiation Treatment
Y N Epilepsy	Y N Rheumatic / Scarlet Fever
Y N Fainting Spells	Y N Seizures
Y N Frequent Headaches	Y N Sexually Transmitted Disease
Y N Glaucoma	Y N Shingles
Y N Hay Fever	Y N Sickle Cell Disease / Traits
Y N Heart Attack	Y N Sinus Problems
Y N Heart Murmur	Y N Stroke
Y N Heart Surgery	Y N Thyroid Problems
Y N Hemophilia	Y N Tuberculosis (TB)
Y N Hepatitis	Y N Ulcers

G. Do you have any medical conditions not listed above? _____

H. Please list any medications or supplements you are taking:_____

_____

_____

7. ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I. _____ acknowledge that I have received a copy of this Notice.

Please Print Name

X_____

Signature Date

PREMIER EYE
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We are pleased to welcome you as a patient. Our mission is to deliver the best and most comprehensive eye care available. The purpose of this policy is to empower you by giving you a clear understanding of your financial responsibilities regarding any and all shared costs, co-pay amounts, deductibles, and any balance not paid by your insurance.

As a courtesy to you, we will happily submit your insurance claim. We do our best to estimate your insurance coverage, but please remember that it is just an estimate. Ultimately, you are responsible for any unpaid balances. Payment of your insurance deductible, co-payment, and/or coinsurance is due and collected on the date of service.

We are happy to offer these choices so that you can select a payment option that best fits your needs.

- **Cash**
  - includes money orders and personal check and is due at time of service.
- **Insurance**
  - We will bill your insurance as a courtesy to you, but you are responsible for any insurance deductible, co-pay, and/or coinsurance on day of service.
- **Credit**
  - Visa, Master Card, American Express, and Discover, and CareCredit

Cancellation Fee: We require 24 hours' notice if you are not able to keep an appointment. We reserve the right to charge a $25 cancellation fee to patients who miss appointments or reschedule within 24 hours of their appointment.

Communication: I consent to allow office staff to call, text, or email me.

Consent for Treatment: I also authorize Premier Eye Associates to perform any necessary services that I may need during diagnosis and treatment with my informed consent.

Professional Services: Professional fees (examination, refraction, contact lens fitting/ evaluation, or any other services) are not refundable.

Glasses Policy

Refunds: Prescription lenses/contacts are custom made specifically for you and therefore cannot be returned for a refund.

Cancelling an Order: Prescription lenses must be cancelled by close of business on the same day in order to receive an 100% refund.

Use of Personal Frame: If you choose to use your own frame, a $10 fee will be applied. We will not be held responsible if the lab were to break or damage the frame.

Frame Warranty: Defective frames can be reworked within 30 days of the dispense date**.** At your request, we can refit and restyle a new frame of equal of lesser value within 30 days of original dispense date at the return of the original eyewear.

Lens Warranty: Lenses are warranted one time against manufacturer's defects during the first 6 months from the date of purchase. The lenses will only be remade in the original prescription and cut and edged for the original frame.

Remakes: All remakes must be requested within 30 days of the dispense date.

- Prescriptions written by Premier Eye Associates
  - Glasses are eligible for 2 free remakes. If you wish to have further remakes, a $50 fee will be charged for each additional remake. If, after the 2nd remake, you are not satisfied, you have the option to terminate the doctor/patient relationship and receive a 50% refund.
- Prescriptions not written by Premier Eye Associates
  - Your glasses are eligible for 1 free remake. If you wish to have further remakes, a $50 fee will be charged for each additional remake.

Contact Lens Policy

CONTACT LENS TRAINING: NEW WEARERS

New wearers will be provided with insertion, removal and contact lens care training. We ask that you do not take your lenses home until you feel comfortable putting them in and removing them. If you are unable to perform these tasks at your initial visit, more training sessions can be scheduled until you feel competent and comfortable inserting and removing your lenses.

CONTACT LENS FEE POLICY

The contact lens fee is determined by the type of lenses prescribed. The contact lens fee includes the contact lens fitting, fit related follow-up visits up to 30 days. After 30 days a new fitting fee will be charged. Visit not related to adjusting your fit and medical visits must be paid for out of pocket or by using your medical insurance.

REFUNDS AND EXCHANGES

There will be no refunds or exchanges on professional services, custom lenses, opened/damaged/marked/expired boxes of lenses, or colored lenses because of dissatisfaction with the color. Exchanges can only be made for the same brand, if originally purchased at Premier Eye Associates.

CONTACT LENS INSTRUCTIONS

Contact lenses are safely used by many people, but always carry a risk of causing and infection, injury, allergy, or other adverse effect. Please follow these instructions to safely wear your contacts and reduce the risk of possible adverse effects.

- Always wash your hands with soap and water, then rinse and dry them with a lint-free towel.
- Always make sure contact lenses are right side out before insertion. The edges should "roll up" at the lens profile. If the edges are flared slightly the contact may be inside out.
- Wear lenses for 4 hours on the first day and increase wear by 2 hours each day until a maximum of 12-14 hours of wear
- After removing contacts, clean properly and place in contact lens case, using new solution every day. Lenses should be stored at least 6 hours for complete disinfection. Manufacturers guidelines for each specific solution should be followed for best hygiene and safety as different solutions have different instructions.
- Patients using peroxide base solutions must wait at least 6 hours before inserting lenses back into their eyes.
- Do not allow soft lenses to come in contact with water or saliva. Use only the recommended soft contact lens solution.
- Rub and rinse contact lenses with solution before soaking them overnight. Use new solution nightly. While wearing lenses, rinse the case with solution and allow to air dry.
- Replace your contact lenses according to their replacement schedule. Do not extend past your replacement schedule.
- Replace your case at least every three months to decrease risk of contamination and infection.
- If you keep the lenses in the case for an extended period of time, re-disinfect them with fresh solution before wearing. Throw them away if it has been longer than the prescribed replacement time.
- DO NOT SLEEP IN CONTACT LENSES. Although there are contact lenses that permit sleeping while wearing, sleeping in lenses still increases the risk of infection, which could result in permanent vision loss.

ABNORMAL SYMPTOMS

If at any time you experience persistent pain, burning, excessive tearing, redness that does not clear up, hazy vision, discharge, swelling, or abnormal sensitivity to light, you should immediately remove your lenses and call our office.

CLEANING SOLUTIONS

The contact lens cleaning and storing solution we recommend is Bausch and Lomb Biotrue Multi-Purpose Contact Lens Solution.

AKNOWLEDGEMENT

I have read, understand, and agree to the previously stated policies of Premier Eye Associates.

_____ _____

Patient Signature (Guardian if under 18) Date