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: _____

REGISTRATION

1. PATIENT INFORMATION

First Name | Last Name | You prefer to be called

Address | City | State, Zipcode | Social Security Number

Phone Number | Email Address | Birthdate: mm/dd/yyyy

Occupation | Employer | Gender | Marital Status

Race | Age | Emergency Contact Name | Contact Relationship to Patient | Contact Phone Number

2. PARENT/GUARDIAN INFORMATION [IF UNDER 18]

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

3. VISION INSURANCE INFORMATION

Company | 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 | ID # | Group #/ Policy #

Policy Holder's Name | Relationship to Patient | Policy Holder's Date of Birth | Policy Holder's SSN

5. HISTORY

A. How did you hear about our practice? _____

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

Cataract, Crossed Eye, Dry Eye, Flashes of Light, Floaters, Foreign Body, Glaucoma,

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

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

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

_____

_____

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POLICIES

INSURANCE: At Premier Eye Associates, we happily submit claims to your insurance company. We do our best to estimate your insurance coverage and out of pocket costs, but please remember that it is just an estimate. Ultimately, you are responsible for any outstanding balances. Payment of your insurance deductible, co-payment, and/or coinsurance is due and collected on the date of service.

CANCELLATION FEE: We require 24 hours' notice if you are not able to keep an appointment. We reserve the right to charge a $50 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 authorize Premier Eye Associates to perform any necessary services that I may need during diagnosis and treatment with my informed consent.

PROFESSIONAL SERVICES: Fees associated with professional services are non-refundable.

GLASSES

REFUNDS: Prescription glasses 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, we will not be held liable for any damages to the frame.

WARRANTY: Patients have option to purchase a one-year Eyewear Protection Plan at the time of their glasses purchase.

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.
- 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 LENSES

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

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information),or alternative means of communication to ensure privacy.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law or national security activities.

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (Such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information, and postage if you want the copies mailed to you.

Amendment: You have the right to request that we amend your health information.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services. A Privacy/Contact Officer has been designated for this office. The Privacy Officer can be contacted by simply contacting the office and asking to speak to the Office Manager who serves as the Privacy Officer.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Signature: _____ Date: _____