WELCOME BACK TO CRYSTAL EYECARE

PATIENT INFORMATION

Reason for today's visit: ☐ Routine Eye Exam ☐ Glasses Purchase ☐ Contacts Purchase **OR** ☐ Medical

If Medical, Specify: Date: / /

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Name: Nickname:

Street Address: City: State: Zip:

Date of Birth: / / Gender: ☐ Male ☐ Female Last 4 SSN:

Home Phone: Cell Phone: Work Phone:

Email: Preferred Phone Contact: ☐ Home ☐ Cell ☐ Work

HEALTH HISTORY

IF DIABETIC:
DATE DIAGNOSED: / / LAST BLOOD SUGAR:_______MG/DL LAST HEMOGOBIN A1C: ______%

PLEASE LIST ALL

Medications	Allergies	Eye Surgeries

INSURANCE INFORMATION

Vision Insurance: ____________________
Subscriber Name: ____________________
Subscriber DOB: ____/____/____
Relationship to Subscriber: ☐ Self ☐ Child ☐ Spouse
Subscriber ID: ____________________

Medical Insurance: ____________________
Subscriber Name: ____________________
Subscriber DOB: ____/____/____
Relationship to Subscriber: ☐ Self ☐ Child ☐ Spouse
Subscriber ID: ____________________

OPTOMAP CONSENT

The doctors at Crystal Eyecare strongly recommend a retinal examination, which allows the doctor to view your internal retinal health. The retina is the light sensitive tissue lining the inside of your eyes.
We are concerned about retinal problems including macular degeneration, glaucoma, retinal holes or detachments, tumors and systemic diseases such as diabetes, stroke and high blood pressure. These conditions can lead to serious health problems including partial loss of vision or blindness, and often develop without warning and progress with no symptoms.
The Optomap provides an annual eye wellness scan of the retina, replacing dilation for most patients. It is fast, easy and comfortable and does NOT require dilating drops.
Because Crystal Eyecare advises ALL of our patients to have an Optomap exam, we will perform the Optomap Retinal Examination as an enhanced service for an additional fee of **$45.00** for both eyes. Note: VSP and Eyemed discount this service to **$39.00**

YES: By signing below I have elected to have the Optomap imaging.

Patient Signature ______________________________ Date __________

NO: By signing below I have elected NOT to have Optomap imaging or dilation performed today against the recommendation of my Doctor.

Patient Signature ______________________________ Date __________

Please read, and sign the following FINANCIAL POLICY. If you have any questions please feel free to ask us.

1) Payment due at time of service:
Payment is due at check-out after services rendered. We accept cash, check, and major credit cards. The patient/guarantor is responsible for all charges, including charges for minors and dependents.

2) Insurance and vision plans:
Insurance (vision & medical) plans are agreements between you and your insurance company. If we participate with your plan, we are happy to submit claims when you provide current, complete plan information. If your plan requires a referral or authorization, please obtain it before your visit. Any eligibility or benefit information we provide is an estimate and not a guarantee of payment. You are responsible for any charges not paid by your plan, including deductibles, co-pays, coinsurance, non-covered services, out-of-network amounts, and denied claims.

3) Contact lenses:
Contact lens evaluations and fittings incur additional fees and are often not covered by insurance or vision plans. Contact lens evaluation fees are due at the time of service.

4) Cancellations and missed appointments:
We understand life happens. Please give at least 24 hours' notice to cancel or reschedule. Appointments missed or canceled with less than 24 hours' notice may be charged a $50 missed appointment fee per appointment. This fee is not billable to insurance and is due before a future appointment is scheduled.

5) Billing, statements, and returned payments:
Returned checks are subject to a $35 returned-payment fee, plus any bank charges we incur. After a returned payment, we may request future payments by cash or card. If a balance remains after insurance processes the claim, it is due when you receive your first statement. If the balance is not paid within 60 days, we may charge a $15 administrative fee for each additional statement we send.

ACKNOWLEDGEMENT

I have read and understand this Financial Policy and agree to be responsible for payment as described above.

Patient/Guarantor Signature: ________________________________ Date: _____________________

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. As required by "HIPAA", we have prepared a "Notice of Privacy Practices Policy". This explains how we are required to maintain the privacy of your health information and how we may use and disclose your health information. A copy of this policy is available to you at your request.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Crystal Eyecare, Notice of Privacy Practices.

Date__________ Patient Name______________________ Signature________________________

The Doctors or staff may discuss my situation or condition with the following individual(s):

Name____________________________________ Relationship________________________

Name____________________________________ Relationship________________________