

**Full Legal Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

Preferred Name/ Nickname: \_\_\_\_\_

Any history of eye related injuries or surgeries? **NO** **YES** \_\_\_\_\_

Do you have any *drug* allergies? **NO** **YES** \_\_\_\_\_

Do you take any *prescription* medications? **NO** **YES** \_\_\_\_\_

Do you have any special needs or conditions that we should know about? **NO** **YES** \_\_\_\_\_

**Personal Medical History**

Have you had in the past, or do you *currently* have any of the following conditions? Please be specific.

No Yes (Either circle, or list)

<b>General:</b> Fatigue, fever, weight loss/gain, fibromyalgia		
<b>Ear/ Nose/ Throat:</b> Chronic cough, dry mouth, sinus issues, vertigo, ear infection, tonsillitis		
<b>Cardiovascular:</b> Heart disease/failure, high cholesterol, hypertension, sleep apnea		
<b>Respiratory:</b> Asthma, bronchitis, emphysema, COPD		
<b>Genitourinary:</b> hormone dysfunction, PCOS, kidney problems prostate problems, UTI, menopause, prostatic hyperlapsia, STI		
<b>Musculoskeletal:</b> Arthritis, joint pain		
<b>Gastrointestinal:</b> Chrohns, IBS, acid reflux GERD, celiac disease, diverticulitis, colitis		
<b>Skin:</b> Rashes, psoriasis, rosacea, cold sores, acne		
<b>Neurological:</b> Headaches, migraines, epilepsy, seizures, Alzheimers, Parkinson's, dementia, cerebral palsy, MS		
<b>Psychiatric:</b> Anxiety, depression, ADHD, PTSD, OCD, schizophrenia, bipolar disorder, BPD, autism, etc.		
<b>Endocrine:</b> hypo/hyperthyroidism, diabetes- type 1 or 2?		
<b>Blood/Lymph:</b> Anemia, leukemia, HIV, Bleeding disorders		
<b>Immunological:</b> Seasonal allergies, autoimmune disease, etc.		
<b>Cancer:</b> Bowel, prostate, skin, lung, breast, brain		

Do you consume tobacco or nicotine in anyway? (Cigarette, chew, zin, vape, etc.) No Never Yes Former

Do you drink alcohol? No Never Yes Former

**Family History (Mom/ Dad/ Grandparent/ Sibling -blood relative)**

**Eye Conditions**

If yes- who?

- Glaucoma \_\_\_\_\_
- Retinal Detachments \_\_\_\_\_
- Cataracts \_\_\_\_\_
- Crossed/ Lazy Eye(s) \_\_\_\_\_
- Macular Degeneration \_\_\_\_\_
- Blindness \_\_\_\_\_
- Other \_\_\_\_\_

**Systematic Conditions**

If yes- Who?

- Diabetes (Type 1 or 2?) \_\_\_\_\_
- High Blood Pressure \_\_\_\_\_
- High Cholesterol \_\_\_\_\_
- Thyroid Issues \_\_\_\_\_
- Cardiovascular Issues \_\_\_\_\_
- Cancer \_\_\_\_\_
- Other \_\_\_\_\_

**Preferred Pharmacy:** \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_

**Emergency Contact (Name & phone number)** \_\_\_\_\_

# Mid-Valley EYECARE

VISION SOURCE

## Authorization of use and disclosure of protected health information

I authorize Mid-Valley Eyecare, its doctors, and staff to disclose my protected health information (PHI) including medical treatment, diagnosis, and financial information to the following designated individuals or organizations. I understand that I may revoke this authorization at any time in writing, except to the extent that action has already been taken in reliance on it.

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

**Expiration of Authorization:** This authorization expires at the end of each calendar year.

**HIPAA Notice:** I understand the information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations. However, Mid Valley Eyecare will not disclose my information beyond what is necessary for care or payment purposes unless authorized by me.

**Mid-Valley Eyecare** is committed to caring for our patient's complete ocular health. Our patients will receive a **COMPLETE COMPREHENSIVE EXAMINATION**. Our doctors are trained to diagnose and treat most ocular diseases.

**Optomap Screening:** An ultra-wide field retinal imaging that captures **more than 80%** of the back of your eye, allowing for early detection of many eye conditions and other diseases (diabetes, heart disease). **THIS IS AN ALTERNATIVE TO DILATION. We are now offering the Optomap screening at a low rate of \$35.00.**

**Routine Vision Exams** will be billed to a patient's vision plan if you have one. Routine diagnosis is myopia (nearsightedness), hyperopia (farsightedness), astigmatism and presbyopia.

If a **Medical Diagnosis** (cataracts, glaucoma suspect, diabetes, pink eye (conjunctivitis), foreign body, etc) is determined by the doctor, the patient's eye exam is no longer routine, but a **medical exam**. At that time, the doctor may order more imaging of the eye, and this will be billed to your medical insurance. This is the reason we request your medical insurance information to be on file. I have read and understand when my **VISION PLAN** will be billed and when my **MEDICAL PLAN** will be billed.

\_\_\_\_\_  
Initial

I hereby acknowledge receipt of Mid-Valley Eye Care's Notice of Privacy Practices.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(If applicable):

I am a parent/guardian of \_\_\_\_\_. I hereby acknowledge receipt of Mid-Valley Eyecare's Notice of Privacy Practices with respect to the patient.

Relationship to Patient: \_\_\_\_\_

# Mid-Valley EYECARE

VISION SOURCE

## Financial Policy Agreement

**Medicare Insurance Billing:** You are financially responsible for any non-covered services under Medicare guidelines, as well as your 20% co-ins and any amounts applied to your yearly Medicare deductible.

**Health Insurance Billing:** Co-Pay, deductible and coinsurance - If you have a copay, deductible and/or coinsurance that apply, we ask that you pay this on the day of service. We will submit the claim to your insurance company. If payment is not received from your insurance company within 60 days, we will then ask that you contact your insurance carrier to assist us in getting your claim paid.

**Refraction:** The part of the exam that determines your eyeglass or contact lens prescription is called a refraction. Refraction is necessary under certain circumstances to check the effects of certain medical conditions. The Refraction is not covered by Medicare or most other insurance plans, even when your doctor feels that it is necessary for diagnostics purposes. The fee for the refraction is \$39.00. You will be asked to pay the fee for the refraction on the day of your visit.

**Hardware (glasses):** Frames generally come with a 2 year manufacturer's warranty for manufacturer's defects. If your frame breaks under normal wear and tear with no apparent abuse, it will be replaced under the warranty. Lenses purchased with scratch resistant coating are covered for a 2 year scratch resistant warranty, as long as the lens has no apparent abuse, it will be replaced under the warranty.

Progressive lenses are covered under a 90-day non-adaption guarantee. If you are unable to adapt to progressive lenses within 90 days, we will remake your lens into single vision, lined bifocal or lined trifocal lenses at no additional cost to you. No refund can be given for the difference in the price of these lenses.

If you feel that there has been an error in your prescription we will ask you to see the optician in our optical department who will verify that your lenses have been manufactured per the specifications of the written order. After this, you may be scheduled to see a doctor to verify the prescription. If the doctor makes a change to the prescription, that requires that the lenses be remade, the lenses will be remade at no charge. After 60 days, however, you will be charged for the office visits/lens changes.

Your prescription glasses are custom made, and therefore not returnable. No refunds or insurance reversals will be given for any order. If you cancel your order before the lenses are processed, you will receive a 90% refund and a 10% processing fee will be charged.

I hereby authorize that my insurance benefits be paid directly to Mid-Valley Eyecare. I understand that it is my responsibility to pay a deductible amount, coinsurance amount, copayment amount, or any other balance not paid to the physician by my insurance company. It is our policy to collect at the time of service for all services that are not covered by your insurance carrier.

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Patient/ Guarantor Signature

Date