elite eyecare

LET US HELP YOU SEE THE WORLD

Name: _____	Address: _____	Email: _____
DOB: _____	_____	Phone Number: _____
SSN: _____	City: _____	Occupation: _____
Last Eye Exam (Month & Year): _____	State: _____ Zip: _____	Today's Date: _____

Do you wear glasses?
Y N

Do you wear contacts?
Y N

Are you allergic to medications?
Y N
List: _____

Are you pregnant?
Y N

Do you see flashes of light/ floaters? **Y N**

Do you have frequent headaches? **Y N**

Do you drink alcohol or/and smoke? **Y N**

_____

Do you have?

- o None
- o Cancer
- o Diabetes
- o Hypertension (High BP)
- o Heart Disease
- o Thyroid

Other_____

Have you ever had?

- o None
- o Amblyopia
- o Cataracts
- o Cataract Surgery
- o Diabetic Retinopathy
- o Dry Eyes
- o Glaucoma
- o Eye Injury
- o Macular Degeneration
- o Lasik/PRK
- o Retinal Disease

Has anyone in your family suffered from:

None	F	M	Bro	Sis	Son	Daughter
Diabetes						
Thyroid						
Cancer						
Hypertension						

Has any in your family ever had?

None	F	M	Bro	Sis	Son	Daughter
Cataract						
Glaucoma						
Degeneration						

Are you taking any medications?

Medication List:

_____

_____

_____

If you have a list, please allow us to scan it into your chart.

How did you hear about us?

_____

FRONT AND BACK

Name: _____ **DOB:**_____ **Date:**_____

Attention:

Retinal Photography: A medical camera that takes a high-resolution picture inside the eye. This procedure is quicker, easier, and much more comfortable than all other types of retinal viewing. Normally, this an $80 procedure. Our charge is only ***$39.***

As part of our commitment to provide you with the most comprehensive eye care, we offer advanced high-definition imaging and retinal photos which allows doctor to gain an earlier indication of any sight threatening conditions that may be developing in your eyes. Many eye problems without warning and progress without symptoms. In the early stages, you may not even notice a change in your vision, but sight threatening conditions such as macular degeneration, glaucoma, and diabetic retinopathy can be detected with a thorough examination of retina. The Wellness Screening Tests are fast, simple procedures that will help the doctor detect common eye diseases in the earliest stages. Doctors strongly encourages all patients to undergo this valuable test as part of your annual eye examination, and particularly and individuals with the following:

- ***Spots, floaters, or flashes***
- ***High Blood Pressure***
- ***Diabetes***
- ***Eye Pain / Headaches***
- ***History of head or eye trauma***
- ***Family history of glaucoma / macular degeneration***

I understand that I will pay $39 for this procedure.

***I want this test done*. Yes_____ No_____**

If no: I accept the risk for refusing this test. Initial: _____

ANY GLASSES OR CONTACT RECHECKS ***OVER 90 DAYS*** FROM THE DATE OF THE EXAM WILL BE **$40, RECHECKS OVER 6 MONTHS** WILL REQUIRE **NEW EXAM FEES**. THERE WILL BE AN ADDITIONAL CHARGE IF ANYTHING OTHER THAN A ROUTINE REFRACTION IS NEEDED. **Initial:** _____	I ACCEPT FINANCIAL RESPONSIBILITY FOR **ANY BAD CHECKS** THAT I ASSIGN AND AGREE TO PAY A **$25** FEE PLUS ALL COURT COSTS AND ANY LEGAL FEE INCURRED IN COLLECTIONS. I ALSO AGREE TO PAY ANY CLAIMS NOT PAID BY MY INSURANCE. **Initial**: _____	Patients using insurance or discounts: If you are doing a contact lens exam, please be aware most insurance does NOT cover the fitting and dispensing fee. This must be done every year to obtain a new contact lens prescription. **Initial:** _____	Patient HIPPA Consent: I hereby acknowledge that I have read my rights under Elite Eyecare's Notice of Privacy Practices, Wavier for Contacts & Glasses, and Office Policies. **Available upon request.** **Initial:** _____

Print: _____ Signature: _____ Date: _____

FRONT AND BACK

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Patient HIPPA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected heath information to carry out:

- Treatment (including direct and indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. I understand that you reserve the right to change the terms of the notice from time to time and I may contact you any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are nit required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with these restrictions.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date: _____

Printed Patient Name: _____

Signature: _____

Relationship to Patient: _____

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EYEWEAR POLICY

It is our goal at Elite Eyecare to provide you with the best quality products to ensure maximum vision, comfort, and style. It is also our goal to ensure our customers are completely satisfied with their eyewear purchases and would recommend family and friends to our office because of our quality products and service. The following is an overview of our policies in the unlikely event you have a problem with an eyewear product you purchase from us.

Eyewear Purchase Policy

- · When you place an order for prescription lenses the lens manufacturer starts creating them immediately, therefore we cannot cancel an eyewear order. If you are not 100% confident in your eyewear selection, we would be happy to hold your order for up to one week.
- · Your prescription lenses are custom cut and ground to fit into your frame perfectly. We are unable to take lenses from one frame and put them into another frame without compromising your safety and quality of the eyewear.
- · If you feel you are not seeing properly with your eyeglasses, our doctors will happily review your prescription and recheck your vision within 90 days of purchase at no charge. If it has been more than 90 days since your original exam date, a refraction fee of $40 will be charged.
- · If your prescription has changed within the first 90 days, we will gladly remake your lenses at no charge.
- · If you require a second remake, you will be responsible for 50% of the cost of the lens.
- · Any changes to your prescription after this 90-day period will incur a new charge.
- · For progressive lens wearers: If you cannot adapt to your progressive addition lenses our office will make new lenses in any other design you wish at no charge within 90 days of dispensing. Your original lenses are a custom order product, which must be discarded; therefore, no refunds will be given if there is a difference in cost.
    - o If an error was made when measuring your progressive lenses, we will remake them at no cost within the first 90 days after purchase.
- · Most frames have a one-year warranty against breakage. If your frame breaks it will be repaired or replaced one year from the date of purchase. Frame warranties do not cover breakage caused by improper care or abuse. Our staff will use their discretion to determine if a frame qualifies for warranty coverage.
- · Your prescription lenses have a one-year warranty against manufacturer defects. This warranty does not include minute scratches or those from routine wear. Our staff will use their discretion to determine if lenses qualify for warranty coverage. Please see our office staff if you have questions about this coverage.
- · If you are unhappy with your eyewear purchase within the first 30 days of purchase, we will accept returns with a 35% restocking fee.
- · We accept outside prescriptions. However, once the lab makes your eyeglasses and for any reason you are not satisfied with the outcome of your vision you must pay a $40 refraction for us to troubleshoot your prescription. Orders must be paid in full before ordering.
- · ALL EYEWEAR MATERIALS MUST BE PAID IN FULL BEFORE GLASSES ARE DISPENSED.
- .If you use your own frame the lab nor office is responsible for breakage.

Please ask for more information if you have questions regarding any of these policies.
I have read and understand Elite Eyecare's Eyewear Policy.

_____ _____ _____

Signature/Print Name Date DOB

FRONT AND BACK

CONTACT LENS POLICY

- · By law, your contact lens prescription expires every year. Please keep this in mind when scheduling appointments and ordering contact lenses. If your contact lens prescription expires, we will not be able to order boxes of contact lenses for you.
- · A contact lens evaluation fee will be added to your standard eye exam fee which covers additional procedures required for contact lens wearers including:
    - o Keratometry which measure and monitors the shape and curvature of the eye which can be affected by contact lens wear.
    - o microscopic examination of the contact lens and ocular surface to ensure the lens fit is proper and that no adverse effects from the contact lens is present on the eye
    - o Refraction and over-refraction when necessary. This measurement is needed to obtain the correct contact lens prescription, which is often different than an eyeglass prescription.
    - o Training or review on correct contact lens insertion and removal techniques, training or review on proper wearing schedule and lens care protocol as well as prescribing an appropriate lens care system.
    - o for new fittings or re-fittings the fee also includes diagnostics lenses which will be given to you to assess the fit, comfort and vision of the contact lens prior to your purchase.
    - o The fitting fee includes ninety (90) days of follow-up care.
- · If additional evaluation is needed beyond the included 90 days of follow-up, then a second contact lens evaluation fee will be charged
- · All contact lens fees are due at the time of service. Contact lens evaluation fees are not refundable even if a patient decides not to order contact lenses or the contact lens prescription is not finalized.
- · Contact lens materials must be paid for in full before they are dispensed.
- · Opened boxes of contact lenses are non-returnable. Unopened and unmarked boxes are not returnable but can be exchanged for other products for up to one year from the time of purchase.
- · By signing you acknowledge the receipt of your contact lens RX and gave us permission to send a digital copy upon request

Please ask for more information if you have questions regarding any of these policies.
I have read and understand Elite Eyecare's Contact Lens Policy.

_____	_____	_____
Signature/Print Name	Date	DOB

FRONT AND BACK