ENVISION
FAMILY EYECARE

Welcome to Envision Family EyeCare. We are excited to have you as a patient. Please take the time to complete the information below, making sure to read each question carefully.

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone (Home): _____ (Cell): _____ (Work): _____

Social Security: _____ - _____ - _____ Email: _____

Occupation: _____ Employer: _____

How did you hear about Envision? _____

RESPONSIBLE PARTY INFORMATION (If Different From Above)

Name: _____ DOB: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone (Home): _____ (Cell): _____ (Work): _____

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VISION INSURANCE INFORMATION

Insurance Company: _____
Member ID Number: _____ Group Number: _____
Primary Insured: _____ Relationship to Patient: _____
Insured SSN: _____ - _____ - _____ Insured DOB: _____

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MEDICAL INSURANCE INFORMATION

Insurance Company: _____
Member ID Number: _____ Group Number: _____
Primary Insured: _____ Relationship to Patient: _____
Insured SSN: _____ - _____ - _____ Insured DOB: _____

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SECONDARY INSURANCE INFORMATION (If Applicable)

Insurance Company: _____
Member ID Number: _____ Group Number: _____
Primary Insured: _____ Relationship to Patient: _____
Insured SSN: _____ - _____ - _____ Insured DOB: _____

Financial Policy Statement

Welcome to Envision Family EyeCare. We are pleased to have you as a patient and we are committed to providing you the best eye care possible. In order to assist you in receiving your insurance benefits, we ask that you review and sign this Financial Policy Statement.

Required Information
We require all patients to complete patient information and medical history forms, sign the HIPPA acknowledgement form, and provide complete insurance information prior to all services provided. We can bill your insurance plan(s) only if we are provided with complete information. At times, a signed and dated claim form may be required. If you are unable to provide us with your entire insurance information at the time of your visit, any charges for your services and/or materials will be your responsibility. Upon proof of insurance, our staff will be happy to assist you in filing a claim after the date of service if necessary.

Patient Responsibility
All co-pays or co-insurance are to be collected when services are rendered. If a claim is denied in full or in part by your insurance plan, you will be responsible for any charges not covered. If you are currently covered by a plan not accessible by Envision, you will be responsible for the charges for any services and/or materials at the time they are rendered. Some insurances allow members to submit for reimbursement if the member is seen at an out of network facility and pays an out of pocket expense. Our staff will be pleased to provide you with a detailed receipt and any information to assist in that process.

Refund / Return Policies
No refund can be made on clinical procedures or services, including comprehensive eye examination, refraction, contact lens fitting, and/or medical visits. Refunds for optical products, which include frames, lenses, and unopened boxes of contacts, may be made within 30 days of receiving the product, providing the product is returned to the office without damages at that time. Opened boxes of contacts are non-refundable. Returned unopened boxes of contact lenses and glasses are subject to a restocking fee of 20%, based on the original retail invoice. After 30 days, no refund, exchange, or return can be made on the materials purchased at Envision. After an insurance claim has been filed there will be no reimbursement on a insurance benefit.

Payment Options
If you need assistance in payment, or are interested in payment plans, our staff can provide you with information on Care Credit, a line of credit designed specifically for medical expenses. You may be eligible for up to six months no interest for any services or materials purchased at Envision. Please see a staff member for details, or visit www.CareCredit.com for more information.

Privacy Practices
Envision Family EyeCare is concerned about the privacy of our patient's health care information. Your protected health information will be used only to provide you the best care possible, which may include submitting to insurance companies. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your rights to privacy. Please review the details on the attached page to learn more about how Envision Family EyeCare may use your protected health information.

Authorization to Release Information
By signing below, you authorize Envision Family EyeCare to release any medical or incidental information that may be necessary for medical benefit or in processing applications for financial benefit. This includes, but is not limited to, your insurance company, rehabilitation services, social security administration, and Workers Compensation.

Consent for Treatment
By signing below, you authorize Envision Family EyeCare to administer diagnostic and medical procedures, including dilation of the eyes, as may be necessary for proper heath care.

Assistance
We make it our responsibility to ensure full understanding of insurance benefits and charges. Our office staff is available to assist you with any special concerns or questions. Please contact us at (803) 996-2020.

I hereby agree that I understand and acknowledge my patient responsibilities written under the policy and by signing below I agree to comply with all terms stated above.

X _____ Date _____
Signature of patient or responsible party

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Patient Medical History:

Have you ever been or are you currently being treated for any of the following medical conditions? Please include medications taken or treatment currently used for any conditions.

Condition	Yes	No	Medications/Treatment
Diabetes (indicate type)			
High Blood Pressure			
High Cholesterol			
Asthma			
Arthritis			
Sleep Apnea			

Patient Ocular History:

Have you been diagnosed with any of the following eye conditions? Please include medications taken or treatment currently used for any conditions.

Condition	Yes	No	Medications/Treatment
Cataracts			
Glaucoma			
Macular Degeneration			
Retinal Detachment			
Lazy or Crossed Eyes			

Last Complete Eye Exam: _____ By: _____
Last Routine Physical: _____ By: _____

Do you wear contact lenses? _____ Yes _____ No If yes, brand: _____ Comfortable? _____ Yes _____ No
How old is your current pair of glasses? _____ How old is your current pair of prescription sunglasses? _____

Please list any other medications you are currently taking. Include vitamins, supplements, over the counter and home remedies:_____
_____

Please list any allergies (medications or environmental): _____
Other medical history _____

Family Ocular History:

Have any of your relatives been diagnosed with any of the following eye conditions? If yes, please indicate relationship to you (please indicate maternal/paternal)

Condition	Yes	No	Relationship
Glaucoma			
Macular Degeneration			
Retinal Detachment			
Lazy or Crossed Eyes			

I have reviewed the above information, and verify that it is correct, to the best of my knowledge.
X _____ Date: _____
Signature of Patient/Guardian

For Office Use Only
Reviewed: ___ / ___ / ___ OD: _____ Reviewed: ___ / ___ / ___ OD: _____
Reviewed: ___ / ___ / ___ OD: _____ Reviewed: ___ / ___ / ___ OD: _____

ENVISION FAMILY EYECARE

Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of this Notice.

Patient Name:_____ Date of Birth:_____

I acknowledge that I have received and had the opportunity to review the Notice of Privacy Practices on the date below on behalf of Envision Family EyeCare.

I understand that the Notice describes the uses and disclosures of my protected health information by Dr. Reynolds and Staff and informs me of my rights with respects to my protected health information.

_____ _____

Patient's Signature or that of Legal Representative *Printed Name of Patient or that of Legal Representative*

_____ _____

Today's Date *If Legal Representative, Indicate Relationship*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

The patient refused to sign
Due to an emergency situation it was not possible to obtain an acknowledgement
Communications barriers prohibited obtaining the acknowledgement
Other (please specify): _____
_____

_____ _____

Employee Name *Today's Date*