ENVISION FAMILY EYECARE

1. Patient Information

Check title below: Date _____

Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Rev. ☐ Professor ☐ Sister

Patient Name: _____

Address: _____

_____

CITY STATE ZIP

Sex: ☐ M ☐ F Age: _____ Birth date: _____

Social Security: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed

Occupation: _____ Employer: _____

How did you hear about our practice? Social Media
Friend/Relative Other: _____
Who may we thank for referring you to our practice?

2. Insurance Information

Vision Insurance

Who is responsible for this account? _____

Relationship to patient: _____

Insurance Company: _____

Insurance ID#: _____ Group #: _____

Subscriber birth date: _____

Subscriber SSN: _____

Medical Insurance

Subscriber Name: _____

Relationship to patient: _____

Insurance Company: _____

Insurance ID#: _____ Group #: _____

Subscriber birth date: _____

Subscriber SSN: _____

3. Phone Numbers / Email / Emergency Contact Information

Home phone _____ Work _____ Cell phone _____

Email address _____

Preferred method of contact Cell phone Home phone Work phone Email

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home phone _____ Work _____ Cell phone _____

I, _____ (patient name)

hereby authorize Envision Family Eyecare to release my information to me via:

(Check all that apply)

1. Call/Text
2. Email
3. Fax

Print Patient Name: _____

Patient Signature (or Parent of Minor/Legal Guardian): _____

Date: _____

Reviewed: ___ / ___ / ___ Initial: _____
Reviewed: ___ / ___ / ___ Initial: _____

ENVISION FAMILY EYECARE

THANK YOU *for choosing Envision Family Eyecare for your eye care needs. We appreciate your trust in us and we look forward to providing you with quality and affordable eye care. Our financial policy is intended to facilitate excellent service to you while minimizing our administration costs. Please read, sign, and date this agreement.*

1. PATIENT PAYMENTS

Full payment is due **at the time of service.** We accept cash, credit card, debit card, and CareCredit. In cases of financial hardship, are prior to receiving services, you may apply for the CareCredit healthcare credit card and establish an account to make monthly payments. To apply for CareCredit, call (800) 677-0718.

2. **INSURANCE COVERAGE**

We make no claim to know what services your insurance covers. While we make a good faith attempt to verify coverage, we are not able to guarantee that the information given to us by your insurance is correct. It is your responsibility to supply us with the correct insurance information at the time of your visit. **If your insurance plan requires a referral from a primary care physician and you do not present one, you will be financially responsible for payment of these services.** We encourage you to refer to your benefits manual if you have any questions about covered services. Be aware that some or all of the services provided may not be covered by your insurance. You will be responsible for payment of all non-covered services at the time they are rendered.

3. **INSURANCE PAYMENTS**

As your vision care provider, our relationship is with you, our patient, not with your insurance company. We require certain co-payments, deductibles or prepayment amounts depending on the type of insurance and insurance carrier. **Be assured our office works diligently to obtain payment from your insurance company.** However, if we file your insurance, and the claim has not been paid for any reason within 90 days, we require that you pay the balance using one of the approved payment methods. In the event that your insurance pays us after that time, you will be reimbursed.

4. **THIRD PARTY PAYORS**

Our office does not bill third party payors such as PIP (Personal Injury Protection), worker's compensation carriers or attorneys.

5. **MISSED / LATE CANCELLED APPOINTMENTS**

Please give us at least 24 working hour's notification if you cannot keep an appointment. This courtesy will allow others to be seen. If you fail to notify us, you will be billed a $25.00 fee. We realize that emergencies arise; however, habitual late cancels or no-shows may cause our relationship to be terminated.

6. **PRODUCT RETURNS**

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 contacts are customized and fabricated specifically for each individual patient. Opened boxes of contacts are non-refundable. Within 30 days, returned unopened boxes of contact lenses are subject to a restocking fee of 20%, provided the product is returned to the office without damages. Prescription glasses are non-refundable, unless approved by management and will result in a 20% restocking fee. After 30 days, no refund, exchange, or return can be made on the materials purchased at Envision Family EyeCare. All materials not picked up within 90 days become property of Envision Family EyeCare. After an insurance claim has been filed there will be no reimbursement on an insurance benefit.

7. **WARRANTY PROCESSING FEES**

Warranty on frames and lenses are subject to a shipping fee, which is not covered in the manufacturing warranty.

8. **CONTACT LENS EVALUATION**

If you are a contact lens wearer, the doctor needs to evaluate the comfort, fitting characteristics, and vision obtained with a particular contact lens. A separate contact lens evaluation is required to determine the contact lens prescription. Contact lens evaluation fees are due at the time of service.

9. 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 health care.

We welcome the opportunity to discuss any aspect of this agreement. Please let us know if you have any questions, comments, or concerns. We thank you for your support and look forward to serving you.

I have read, understand, and agree to abide by the terms stipulated above.

Patient Signature (or Parent of minor/Legal Guardian): _____

Print Patient Name: _____Date_____

Reviewed: ___ / ___ / ___ Initial: _____
Reviewed: ___ / ___ / ___ Initial: _____

ENVISION FAMILY EYECARE

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: _____

For Patient Use Only:
Reviewed: ___ / ___ / ___ Initial: _____
Reviewed: ___ / ___ / ___ Initial: _____

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*

Reviewed: ___ / ___ / ___ Initial: _____
Reviewed: ___ / ___ / ___ Initial: _____