Advanced Eye Care & Surgery
Patient Demographics

☐ Mr. ☐ Ms. ☐ Mrs. ☐ Miss ☐ Dr. ☐ Master

Patient First Name: ________________________________ M.I. _____

Patient Last Name: ______________________________________

Nickname: ____

Address: ____

City: ______________________ State: ____________ Zip: _________

Primary Phone: (__________) ______________________ ☐ Home ☐ Work ☐ Mobile

Secondary Phone: (__________) ______________________ ☐ Home ☐ Work ☐ Mobile

Email: ____

Communication Preferences: ☐ Email ☐ Mail ☐ Phone

☐ Use email for recalls
☐ Use email for promotions
☐ Use txt message for appointment notifications
☐ Use txt message for order notifications
☐ Do not send mail offers

Date of Birth: ______ / ______ / ______ Gender: ☐ Female ☐ Male

SSN: ________ - ______ - ________

Occupation:

☐ Agriculture/Farmer
☐ Analyst
☐ Arts / Entertainment
☐ Attorney
☐ Child / Student
☐ Computer Field
☐ Data Entry
☐ Engineer
☐ Fashion Designer
☐ Fire Fighter
☐ Food Service/Hospitality
☐ Homemaker
☐ Human Resources – CEO/Pres/CFO
☐ Industrial/Auto Worker
☐ IT
☐ Law Enforcement
☐ Mechanic
☐ Medical/Health Services
☐ Military
☐ Ministry
☐ Nursing
☐ Outdoor – Recreational
☐ Outdoor Worker
☐ Pilot
☐ Plumber/Carpenter
☐ Prof/Office Worker
☐ Retail
☐ Retired
☐ Sales
☐ Science/Research
☐ Security
☐ Software Engineer
☐ Student
☐ Teacher
☐ Wine Industry
☐ Other: ___________________

Employment Status:

☐ Employed ☐ Not Employed ☐ Retired ☐ Self Employed
☐ Student ☐ On Active Military Duty

Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Widow

Race:

☐ Decline to Specify
☐ Asian
☐ White
☐ American Indian or Alaska Native
☐ Black or Afican American
☐ Native Hawaiian or Other Pacific Islander

Ethnicity:

☐ Declined to Specify
☐ Not Hispanic or Latino
☐ Hispanic or Latino

Language:

☐ Declined to Specify
☐ Spanish; Castilian
☐ English
☐ Abkhazian

Referred By:

☐ Advertising
☐ Corporate
☐ Customer
☐ Direct Mailer
☐ Doctor
☐ Dr/Emp
☐ Drive By
☐ Employee
☐ Family Member
☐ Google+
☐ Health Fair
☐ Insurance
☐ Intro Mailer
☐ Monitor
☐ Newspaper
☐ Non Referral
☐ Outside Doctor
☐ Radio
☐ Recall Letter
☐ Store
☐ Walk-In
☐ Website
☐ Yellow Pages
☐ Yelp
☐ ZocDoc

I authorize Advanced Eye Care & Surgery to release medical information to the party listed below:

Name: ____

Relationship: ______________________________

Name: ____

Relationship: ______________________________

Policy Holder for Insurance OR
Responsible Party if Patient is a Minor

(Must be completed by guardian if patient is under age 18)

☐ Mr. ☐ Ms. ☐ Mrs. ☐ Miss ☐ Dr. ☐ Master

First Name: __________________________________ M.I. _________

Last Name: ____

Nickname: ____

Address: ____

City: ______________________ State: ____________ Zip: _________

Primary Phone: (__________) ______________________ ☐ Home ☐ Work ☐ Mobile

Email: ____

Date of Birth: ______ / ______ / ______ Gender: ☐ Female ☐ Male

SSN: ________ - ______ - ________

Are you interested in wearing Contacts? ❑ Yes ❑ No   Is this your first time wearing contacts? ❑ Yes ❑ No

Do you have any diseases or disorders? ❑ Yes ❑ No
If yes, please list ____________________

Are you currently taking any medication (including eye medications)? ❑ Yes ❑ No
If yes, please list all ____________________

Have you had any previous eye surgery or injury? ❑ Yes ❑ No
If yes, please explain ____________________

Have you had any other surgery? ❑ Yes ❑ No
If yes, please explain ____________________

Are you aware of any allergies to medications? ❑ Yes ❑ No
If yes, please list ____________________

Do you have a family history of any eye disease or blindness? ❑ Yes ❑ No
If yes, please explain ____________________

Do you have any of the following conditions?

Heart Disease? ❑ Yes ❑ No
High Blood Pressure? ❑ Yes ❑ No
Diabetes? ❑ Yes ❑ No
Cancer? ❑ Yes ❑ No
GI / Stomach Disorder? ❑ Yes ❑ No
Kidney Disease? ❑ Yes ❑ No
Frequent Headaches or Dizziness? ❑ Yes ❑ No
Blood or Lymphatic Disorders? ❑ Yes ❑ No
AIDS / HIV? ❑ Yes ❑ No
Dermatologic (skin) Conditions? ❑ Yes ❑ No
Musculoskeletal Disorders or Arthritis? ❑ Yes ❑ No
Neurological Disorders or Injury? ❑ Yes ❑ No
Psychiatric Disorders? ❑ Yes ❑ No
Respiratory (lung) Disorder? ❑ Yes ❑ No

(Please fill out for patients 13 years of age or older)

Do you smoke? ❑ Yes ❑ No ❑ Former Smoker If yes: Number of packs per day _______

Do you drink alcohol? ❑ Yes ❑ No If yes: ❑ Social (1-2 drinks or less per week) ❑ 1-2 drinks per day or more

Do you have any of these symptoms on a regular basis?

☐ Itchy Eyes ☐ Red Eyes ☐ Swollen Eyes
☐ Watery Eyes ☐ Burning Eyes ☐ Tired Eyes

On average, how many hours per day do you spend working on a computer? ______ Hours per Day

Do you ever have any problems seeing at night (glare from headlights when driving, etc) ☐ Yes ☐ No

Are you interested in Laser Vision Correction? ☐ Yes ☐ No ☐ Might consider in the future

Do you have trouble keeping your eyes open? ☐ Yes ☐ No   Do your eyelids feel heavy? ☐ Yes ☐ No

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed a copy of Advanced Eye Care & Surgery's Notice of Privacy Practices which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document upon request.

______________________________   ________________
PRINT Patient **OR** Guardian Name if Patient is a Minor   Date

X______________________________   ________________
Signature of Patient **OR** Guardian if Patient is a Minor   Date

I hereby authorize the Doctor to release any information required to process this insurance claim. I also authorize my insurance benefits be paid directly to the Doctor, and I understand I am financially responsible for non-covered services. I have read the Financial and Contact Lens Exam Policies. I understand and agree to these policies. I agree to allow Advanced Eye Care & Surgery to charge my credit card or debit card in the event that all or a portion of my insurance claim is denied for services rendered or materials dispensed and/or in the event that my check is returned for insufficient funds. I understand that an additional fee of $35.00 will be charged for all returned checks. If my account is sent to Collection, I agree to reimburse the fees of any collection agency, which may be based on a percentage at a maximum of $9.40 plus 30% of the principal balance, and all costs and expenses, including reasonable attorneys' fees, incurred in such collection efforts.

X______________________________   ________________
Signature of Patient **OR** Guardian if Patient is a Minor   Date

ADVANCED EYE CARE & SURGERY FINANCIAL POLICY

The following is a statement of our Financial Policy, which we require that you read and sign prior to any treatment: Full payment for service(s) is due at the time of service(s). We accept cash, checks, Visa, MasterCard, and Discover. *We also offer Care Credit as our extended payment option. Ask our staff for details.*

Traditional Insurance: **Benefits quoted by your insurance company are not a guarantee of payment.** As a courtesy, we will be happy to file your insurance claim and accept assignment of insurance benefits. Our staff will be happy to assist you in determining your insurance coverage. In case of non-payment by your insurance company, we must have a valid credit or debit card number and expiration date on file. Non-payment by your insurance company may be due to insurance deductibles that have not been met or for services not covered. You should receive an Explanation of Benefits (EOB) from your insurance company when a claim is filed. In cases where your claim is denied or partially paid by your insurance company, your credit or debit card will be charged for unpaid allowable amounts. A receipt will be mailed to you along with an additional copy of the EOB. Our office is not a party to any dispute of non-payment between you and your insurance company. Your insurance policy is an agreement between you and your insurance company.

APTC Members: The Affordable Care Act includes a provision that allows health insurance marketplace enrollees who receive the Advance Premium Tax Credit (APTC) a three-month grace period to pay their premium – provided they have already paid at least one month's premium in full. It is important to note that not all members who purchase coverage on the health insurance marketplace will receive the APTC. For members that do receive this benefit, when in the 2nd or 3rd month grace period, patient and or guardian will be responsible for entire Usual & Customary fees upfront. No Exceptions.

PPO: Regarding insurance plans, it is your responsibility to be sure we are a participating (in network) provider on your vision plan or your medical insurance plan. All co-pays and deductibles are due at time of service.

Usual and Customary Fees: Our practice is committed to providing the best treatment for our patients. You are responsible for payment regardless of your insurance company's determination of usual and customary rates.

Minor Patients: A legal guardian must accompany minors at their initial visit and by an adult at all subsequent visits. The legal guardian is responsible for full payment of services at the time of treatment. Should the recommended plan of treatment change, approval is required by the legal guardian. If the legal guardian is not present at subsequent visits, he or she must be available by phone in the event of an emergency to approve any changes in treatment, or for any reason that may arise. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized. The legal guardian is required to notify our office of any changes in the minor's medical history prior to treatment.

Divorce Decrees: This office is NOT a party to your divorce decree. The legal guardian who accompanies the minor at the initial visit is responsible for payment.

If you would like our office to file a claim with your medical insurance company, please be prepared to provide a credit card as a secondary form of payment in case your claim is denied or you have not met your deductible.

CANCELLATION POLICY

For families or groups of five or more appointments we will require a Credit Card on file. Patients who fail to show, reschedule or cancel within 24hrs of their appointment will be charged $50 per scheduled appointment. This cancellation fee cannot be billed to your insurance company.

CONTACT LENS EXAM POLICY AND FEES

A Comprehensive Eye Examination includes a thorough eye health assessment for conditions such as glaucoma, cataracts, macular degeneration, diabetic or hypertensive retinopathy, neurological disorders affecting the visual system, binocular vision problems, accommodative disorders, ocular allergies, dry eyes, and a prescription for spectacles. **Measurements for contact lenses and evaluation of current contact lenses are additional services and are not included as part of a Comprehensive Eye Exam.** The initial procedures in determining a Contact Lens prescription include measurements to arrive at optimum refractive correction and the elimination of concerns for concurrent ocular and systemic disease. Our goal is to prescribe contact lenses made of a physiologically adequate material that will have minimal mechanical impact on the corneal surface while providing the required optical correction. Such a process, while both somewhat labor-and time-intensive, allows both the patient and doctor to gain a better perspective in the anticipated performance of the contact lenses prescribed.

Spherical Soft Contacts $95
Multifocal Contacts $190-$220
Keratoconus Contacts $250-$2200
Soft Contacts for Astigmatism $115
Monovision Contacts $170-$190
Scleral Contacts $1400-$2200
Rigid Spherical Contacts $125-$320
Hybrid Contacts $190-$275

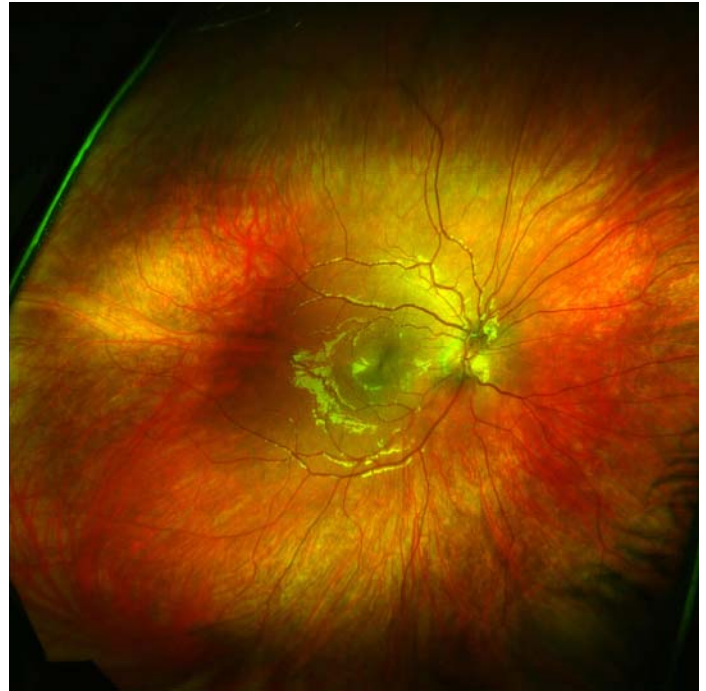
The contact lens exam fee is charged for all contact lens wearers and is dependent upon the type of contact lens prescribed. The fee includes additional measurements taken to determine the most appropriate lens design for your eyes and prescription, evaluation of contact lens fit with the biomicroscope, initial pair of trial contact lenses when appropriate, cleaning kit with solution and new contact lens case, and additional follow-up visits as needed to finalize the contact lens prescription. For first-time contact lens wearers, an additional fee of $25 will be charged for proper training on insertion, removal, and care of contact lenses.

Your doctor may require a follow-up visit 1-2 weeks after your comprehensive examination and dispense of trial lenses. There is no additional charge for your contact lens follow-up visit for 60 days following your contact lens exam. We strongly recommend that your follow up visit be no later than 30 days following your eye exam. If your doctor is requiring a contact lens follow-up visit, your final contact lens prescription cannot be released until after the follow-up visit is complete and the contact lens fit has been assessed.

Contact lenses are medical devices and can cause serious and permanent loss of vision. Always follow your doctor's instructions for proper care and wear of your lenses. Should your eyes become red or irritated while wearing contact lenses, remove the contact lenses and contact our office immediately.

Optomap - *An Alternative To Dilation*

In order to properly examine the health of your eyes, your doctor needs to view the retina, optic nerve, and blood vessels in the back of your eye. The doctor can now take an ultra-wide view of the back of your eye with a laser scanning technology called an "Optomap." The lasers capture a remarkable view of different layers in the back of the eye (retina and choroid) in about ¼ of second! This previously unavailable technology is useful to diagnose eye conditions, as well as other health conditions, at an early stage when many conditions can be better treated. The doctors at Advanced Eye Care & Surgery highly recommend all patients (children and adults) have an Optomap performed on an annual basis as part of a comprehensive eye exam.



The Optomap is the only instrument in the world that allows an ultra-wide view of the back of your eye without pupil dilation.

Advantages of Optomap vs. Conventional Eye Exams

1. **Pupil dilation is usually not necessary- no light sensitivity and blurred vision following your exam!**

2. **Saves time- no waiting for dilating drops to take effect.**

3. **Permanent photographic record of your retina for future comparison.**

Dilation of the Pupils

Dilation of the pupils is a diagnostic procedure that allows an assessment of the internal health of the eyes. Dilation involves placing drops in your eyes that will enlarge the pupil size. This allows the doctor to examine the retina (back of the eye) and optic nerve thoroughly and detect problems or disease.

When your eyes are dilated you may notice certain changes. Your eyes may be more sensitive to light and your vision may be blurred. Do not operate any heavy machinery. If your pupils are dilated, you need to be aware of the following:

1. Care needs to be taken in driving back to work or home. If traveling a long distance you may wish to reschedule the dilation.
2. Focusing at close distances will be impaired approximately 4-6 hours.
3. Sunshades will be provided if you do not have a pair.

If your eyes become red or painful, if you develop a headache or become nauseous after pupil dilation, please call us immediately. This procedure will not be performed on a patient without their informed consent. The doctor will be happy to discuss any questions you may have.