Today's Date:________________

Patient Information Questionnaire

Patient Name: ____ **Name Preferred**: ____________
LAST FIRST MI

Mailing Address: ____
STREET CITY STATE ZIP

Home Phone#: ____________________ **Work Phone#**: ______________________________

Cell Phone#: _____________________ Email **Address***: ____________________________

Date of Birth: __________________ **Social Security #**________________________

Marital Status (circle): Single Married Widowed Domestic Partner

Employer: ____________________________ (**circle**): FT PT FT Student PT Student Retired

Occupation: ______________________________________ **Sex (circle):** M F

Emergency Contact: _________________________________ **Phone#**: ____________________

How did you first hear about us?

(Circle) Sign Insurance Directory Flyer Postcard Radio Friend/Family, who? ____________

Insurance – Policy Holder (if different from patient):

Full Name: ____

Employer: ____

Date of Birth: __________________________ Social Security #_________________________

*Email address may be used for communication with you along with occasional office news and promotions

Patient Eye History

Reason for your visit today: ______________________

____

____

- ❑ Blurry at distance
- ❑ Blurry at near
- ❑ Floaters
- ❑ Flashes of Light
- ❑ Dryness
- ❑ Redness

Previous Eye Doctor: ____________________________

Date of Last Eye Exam: __________________________

Any special vision needs?
- ❑ Interested in trying Contact Lenses
- ❑ Interested in learning more about Lasik
- ❑ Need work related glasses – safety, computer, etc.
- ❑ Need recreational glasses – golf, fishing, etc.

*Have **YOU** been diagnosed or have experienced:*

- ❑ Glaucoma
- ❑ Cataracts
- ❑ Lazy Eye/Amblyopia
- ❑ Eye Turn/Strabismus
- ❑ Color Deficiency
- ❑ Loss of Vision
- ❑ Macular Degeneration
- ❑ Dry Eye
- ❑ Iritis/Uveitis
- ❑ Ocular Herpes
- ❑ Retinal Disease_______________________________
- ❑ Corneal Problems_____________________________

Other____

❑ Eye Surgeries: _________________Date__________

____

❑ Eye Injuries: ___________________Date__________

____

Current Eye Drop Prescriptions, over the counter eye drops or vitamins used: _________________________

____

Patient Medical History

Primary Care Physician______________________

Phone Number______________________________

*Have **YOU** ever been diagnosed with or had problems with any of these systems?*

- ❑ Diabetes Type _____ When diagnosed? ___________
- ❑ High Blood Pressure When diagnosed? ____________
- ❑ Cancer What type? ____________________________
- ❑ Migraine Headaches
- ❑ Thyroid
- ❑ Ear/Nose/Throat
- ❑ Gastrointestinal
- ❑ Endocrine (Glands)
- ❑ Skin
- ❑ Cardiovascular
- ❑ Muscle/Bone
- ❑ Blood/Lymphatic
- ❑ Immunological
- ❑ Respiratory
- ❑ Neurological
- ❑ Depression/Psychiatric
- ❑ Cholesterol

Other Issues Not Listed Above___________________

____

Are You Currently…

- ❑ Pregnant
- ❑ Nursing
- ❑ A Smoker

Current Medications: ________________________

____

____

____

Major Surgeries_____________________________

❑Allergy to Medications __________________

Other Allergies______________________________

Family Medical/Eye History

	Who? Which Side?
❑ Heart Disease	__________________
❑ Diabetes	__________________
❑ Cancer (Type)______________	__________________
❑ Blindness	__________________
❑ Cataracts	__________________
❑ Glaucoma	__________________
❑ Corneal Problems	__________________
❑ Lazy/Turned Eye	__________________
❑ Macular Degeneration	__________________
❑ Retinal Disease	__________________

PRECISION EYE CENTER

Acknowledgement of Receipt of Notice of Privacy Practices (HIPPA)

While providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The Notice of Privacy Practices you have been given describes these uses and disclosures in detail.

I acknowledge that I have reviewed the Notice of Privacy Practices for Precision Eye Center and have received a copy upon request.

____

____

Patient Signature (guardian if under 18) Date

About Your Insurance

There are two types of health insurance that will help pay for your eye care services and products. You may have both and our practice accepts both:

1. Vision care plans (such as VSP and EyeMed) 2. Medical Insurance (such as BCBS and Medicare)

- Vision care plans ONLY cover routine vision exams and may cover some materials (such as glasses or contacts). Vision plans only cover a basic screening for eye disease. They do not cover diagnosis, management, or treatment of eye diseases.
- Medical insurance must be used if you have any eye health problem or systemic health problem that has ocular complications. Your doctor will determine if these conditions apply to you, but some are determined by your case history.
- If you have both types of insurance plans it may be necessary for us to bill some services to one plan and other services to the other. We will use coordination of benefits to do this properly and to minimize your out-of-pocket expense.
- We will bill your insurance plan for services if we are a participating provider for that plan. We will try to obtain advanced authorization of your insurance benefits so we can tell you what is covered. If some fees are not paid by your plan, we may bill you for any unpaid deductibles, co- pays or non-covered services as allowed by the insurance contract.

I have read and agree with these policies.

____

____

Patient Signature (guardian if under 18) Date

Insurance Signature on File

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits and I authorize payment of these benefits directly to Precision Eye Center, OD, PLLC, on my behalf, for any services and materials furnished. I authorize any holder, of medical, information about me to release to the Centers for Medicare and Medicaid Services and its agents, any information, needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in item 9 of CMS-1500 Claim form or electronically submitted claim) my signature authorized release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

____ ________________________________

Patient Signature (guardian if under 18)

Date

CONSENT FOR PUPIL DILATION & RETINAL PHOTOGRAPHY

INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to enlarge the pupils of the eye to allow the doctor to obtain a better view of the inside of your eyes. Temporary light sensitivity and loss of the ability to focus at near are common side effects of dilation and usually subside within 3 to 6 hours after instillation of the drops. Distance vision is usually not affected. However, if you have any concerns about driving immediately following this procedure, arrangements can be made to reschedule for a more convenient time. Risks without test: Possibility of not detecting eye disease that could lead to blindness (i.e. glaucoma, retinal tears or disease, etc.). There is no additional fee for dilation.

________I ACCEPT recommendation ______I DECLINE recommendation

INITIAL: _______________________

Precision Eye Care is pleased to offer DIGITAL RETINAL PHOTOGRAPHY as an extension to our comprehensive eye health and vision examinations. This is a quick, painless procedure that uses advanced digital photography to document the important anatomical structures of the back of the eye WITHOUT the use of dilating drops. This instrument provides important diagnostic information for Dr. Ly and the results will be shared with you during your exam. They will become a permanent part of your electronic medical record in our office and form a baseline to track any subtle changes from year to year. **There is an additional fee of $35 for retinal photography**. In certain cases, the photos may be medically necessary and will be filed to insurance.

WE HIGHLY RECOMMEND THIS PROCEDURE FOR ALL OF OUR PATIENTS

________I ACCEPT recommendation ______I DECLINE recommendation

INITIAL: _______________________

Services and Glasses Policy (Updated 09/01/2022)

- **No refunds on professional services (eye exams, medical visits, and contact lens fittings)**.
- Patient is responsible for fees not paid by insurance plan (deductibles, co-pays, or non-covered services). We try to obtain insurance benefits in advance to estimate coverage.
- **Glasses Return and Refund**: We will issue 50% refund of what the patient paid within 30 days of picking up glasses. Glasses are custom made and we have already incurred lab costs.
- **Frame Exchange**: Patient will pay the difference in the frame upgrade and a $25 restocking fee. Limited to one exchange per original order. Must be done within 30 days of pickup.
- **Prescription Recheck**: A complimentary prescription recheck is allowed within 30 days of picking up glasses. $40 refraction fee will apply after the 30 days.
- Glasses and contacts must be picked up within 30 days of notification.
- Medicaid and some insurance companies have their own labs, and we have no control over quality and timing.
- **We do not give out pupillary distances (PD). They are not part of the glasses prescription.**
- **Full payment must be received before orders are placed. No partial payments or deposits**.
- We only accept credit card and cash payment.
- **There is a $40 No Show Fee if you miss your appointment and do not give us a 24-hour notice.**

I have read and agree with these policies.

_______________________________________ ____________________

Patient Signature (guardian if under 18) Date

Contact Lens Policy

- A contact lens fitting fee applies every year to issue or renew a contact lens prescription. This fee covers the service required to properly fit a patient for contact lenses, as well as trial lenses, and necessary follow-up visits within 90 days.
- There will be a $35 training fee for first time contact lens wearers
- **Contact lens prescriptions are valid for one year, according to NC law. Contact lens prescriptions must be finalized within 90 days of fitting. Follow-ups after the 90 days will be subject to an additional fee**.
- Contact lens fitting fees are non-refundable, regardless of whether the patient decides to wear contact lenses or not. Our contact lens fitting fees range from $70 - 600. Insurance coverage and copays may vary.
- Contact Lens fittings must be done within 90 days of exam, or you will need a new exam.
- Contact lens prescriptions will only be released after the fitting is successfully completed (exam, fitting, necessary follow-up visits) and after all fees are paid.
- There is no refund on custom ordered contacts, opened boxes, marked boxes, or color contacts because of dissatisfaction with the color.
- Full payment must be received before orders are placed. No partial payments or deposits.

I have read and agree with these policies.

_______________________________________ ____________________

Patient Signature (guardian if under 18) Date