DOWNEY EYE CARE

Patient Information

If applicable, Gaurdian Name: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Nickname: _____ Date of Birth: _____/_____/_____

Gender (Circle): Male Female SSN: _____-_____-_____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone #: _____ Alternate Phone #: _____

E-mail Address: _____

Marital Status (Circle): Single Married Divorced Widowed

Employment Status (Circle): Employed Unemployed Disabled Retired Student

How Did You Hear About Our Office? _____

Insurance Information

Vision Plan: _____

Primary **Medical** Insurance

Plan Name: _____

Cardholder's Name: _____

Cardholder's DOB: _____

Cardholder's SSN #: _____

Relationship to Patient: _____

Secondary **Medical** Insurance

Plan Name: _____

Cardholder's Name: _____

Cardholder's DOB: _____

Cardholder's SSN #: _____

Relationship to Patient: _____

I hereby accept full financial responsibility for the cost of the goods and services provided to the patient identified hereinafter (the "Patient") by Downey Eye Care, LLC (the "Provider"). I further understand that although the Provider may, at its discretion, file a claim with the Patient's insurance carrier on behalf of the Patient, I will remain financially responsible for the full cost of the goods and services provided until paid in full. In the event the Provider elects to file such a claim with the Patient's insurance carrier, I will remit to the Provider at the time of service, the full amount of the Patient's co-pay. Should the Patient's insurance carrier deny such claim, I will, immediately upon notice of such denial, remit to the Provider the balance owed for the goods and services provided. Should the Provider be forced to take any action to collect from me any monies owed for goods and services provided to the Patient, I will be responsible for all cost of such collections, including without limitation all reasonable attorney's fees, expenses and costs of court.

_____ _____

Patient Signature Date

Notice of Privacy Practices and Acknowledgement of Receipt

I, the below stated individual, acknowledge that I have received a copy of Downey Eye Care's Notice of Privacy Practice.

_____ _____

Patient Signature Date

Please feel free to take a copy of the "Notice of Privacy Practices", if you choose so.
A copy can also be found on our website.

HIPAA Release / Authorization Form

Keeping our patient's information private is important to us, and by default we will disclose information related to the patient's billing account and medical conditions only to the patient or legal guardian.

Please list any indiviuals who may obtain billing account information and medical information. The listed individuals may also pickup glasses, contacts, and/or prescriptions for the patient.

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Name Relationship

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____

_____

_____

Acknowledgement of Covered Services

Refraction

A refraction is the test performed to determine your spectacle (eyeglass) prescription. A refraction is also needed for a contact lens prescription, although a separate fitting and evaluation is required to finalize a contact lens prescription. If the refraction is declined, then no eyeglasses or contact lens prescription may be ordered unless a current (non-expired) prescription is supplied.

Contact Lens Fitting and Evaluation

A contact lens fitting and evaluation is required to obtain a new contact lens prescription. This exam is separate from a comprehensive eye exam. New contact lens wearers are also required to go through a contact lens training at the time of their fitting.

Medical Insurance Coverage

Medical insurance only covers **medical diagnoses** such as abrasions, glaucoma, diabetes, cataracts, macular degeneration, dry eyes, conjunctivitis, etc. Medical insurance **does not** cover refractions, contact lens fittings and evaluations, eyeglasses, or contact lens supplies.

Vision Insurance Coverage

Vision insurance covers routine eye exams and refractions to determine eyeglass prescriptions. **Some** vision plans cover a contact lens fitting and evaluation (with a copay), but not all plans do. Vision insurance **does not** cover a contact lens training. **Most** vision plans will also have benefits for some materials such as frames, lenses, or contact supplies.

Patient Acknowledgement

I understand that a refraction is a non-covered service under **major medical insurance.** I also understand that my vision insurance plan may or may not cover a contact lens fitting and evaluation. I acknowledge that I must receive a contact lens training if I am a new contact lens wearer. I agree to pay any fees for non-covered services such as refraction, contact lens fitting and evaluation, and contact lens training along with any co-pays and non-covered doctor recommended testing or products at the time of service.

_____ _____

Patient Signature Date

DOWNEY EYE CARE

Office Policies

- Patients are responsible for providing the correct insurance information at the time of checking in.
  - Any fees associated with not providing the correct insurance information will be the patient's responsibility.
- All copays and any non-covered service fees are due at the time of service.
- Any fees that are transferred from the insurance to the patient will be due at the time the patient receives a statement.
- A $25 fee will be placed on the patient's account if they no show to a confirmed appointment.
- At least half down must be paid on glasses **before** the order is placed.
- Orders for eyeglasses and contacts **must** be picked up within 30 days from the date of purchase.
  - After this time, the materials will be returned to the lab and manufacturer.
  - Our office **will not** refund any deposits made on the materials that were not picked up.
- Warranties for glasses are only eligible on broken frame and lenses.
  - If the broken frame is not given to a staff member at the time of pickup, the warranty eyeglasses will not be dispensed.

_____ _____

Patient Signature Date

Patient History Form

Primary Care Physician: _____

Pharmacy: _____

Do you wear glasses? (Circle) Yes No

Do you wear contacts? (Circle) Yes No

What is your smoking status? (Circle) Current Smoker Former Smoker Never Smoked

If current, how many packs per day? _____ How many years have you smoked? _____

Please list any medications or drops you are currently taking.
Include strength and frequency if you are able.

_____

_____

_____

_____

_____

Please list any allergies you have. (Medication, Drops, and Non-medication)

_____

_____

Please list any major surgeries you have had. Also include any eye surgeries.

_____

_____

_____

_____

_____

Patient History Form

Have you been diagnosed with any of the following medical conditions? (Circle)

Diabetes - Type I or Type II	High Cholesterol	Kidney Disease
High Blood Pressure	Heart Disease	Thyroid Disorder

Other: _____

_____

Have you been diagnosed with any of the following ocular conditions? (Circle)

Diabetic Retinopathy	Glaucoma	Retinal Detachment
Macular Degeneration	Cataracts	Dry Eye Syndrome

Other: _____

_____

Family History (Parents, Siblings, Children, Grandparents)

	Relationship To You
Diabetes	_____
High Blood Pressure	_____
High Cholesterol	_____
Heart Disease	_____
Kidney Disease	_____
Thyroid Disorder	_____
Diabetic Retinopathy	_____
Macular Degeneration	_____
Glaucoma	_____
Cataracts	_____
Retinal Detachment	_____

Other: _____

_____