Jason M. Jost, O.D.   Kristen Worthen, O.D. Seth Baldwin, O.D.

Welcome to Pikes Peak Eye Care! Thank you for choosing us for your eye care needs. We are committed to providing the best and most comprehensive care possible. Please take a moment to complete the following information.

Personal Information:

Patient Name: ____ Today's Date: ______________________

Date of Birth: _______________ Gender____________ Social Security Number ____________________

Phone: Home______________________ Cell:_____________________ Work______________________

Email (for appointment reminders and newsletters): ____

Communication Preference (Check one): Phone_______ Text______ Email_______ Postal Mail________

Street Address: ____ Apt/Lot #__________________

City: _________________________________ State: ________________ Zip Code: ___________________

Employer's Name: ________________________________ Occupation: _____________________________

Preferred Language: ______________________ Race: ________________ Ethnicity: ________________

Parent/Guardian's Name (if under 18): ____

Parent/Guardian's Primary Phone Number: ______________________

Are you a hospice care patient? Yes__________ No__________

Emergency Contact: ____________________________________ Phone: __________________________

Relationship to Patient: _________________________________

COVID-19 Symptom Form

To best protect our staff, patients, and community, please fill out the following form to be reviewed for your appointment today.

Do you have any of the following symptoms?	YES	NO
Cough		
Shortness of Breath		
Fever		
Chills/Shaking		
Fatigued/Run Down		
Headache		
Loss of taste or smell		
Sore Throat		
Muscle Aches/Pains		

Have you been exposed to a COVID-19 positive patient? And if yes, when?

____

____

Is anyone in your family ill? No ________ Yes _______ Please Explain ________________________

____

Would you prefer your tech and doctor wear a mask during your exam today? Yes____ No____

Print Patient Name: ____

Patient Signature(or Parent/Guardian): _____________________________________ Date: ________

Financial and Privacy Policy

It is important to read and understand the policies below. Please let our staff know should you have any questions.

Medical Insurance vs. Vision Plans: An Optometrist specializes in the care of your eyes (like a cardiologist for your heart or an endocrinologist for diabetes) and provides comprehensive, medical eye health exams. However, Optometrists also provide wellness checks for those without any eye disorders. A vision plan is different from your health insurance policy. Health insurance protects you from unexpected costs for eye injury or disease. Vision plans provide a wellness benefit for *healthy* eye exams, which includes prescription eyewear and contact lenses. **Vision plans** cover an eye wellness exam, such as an exam for glasses and contact lenses. Vision plans **do not cover** any part of the eye health exam considered "medical." **Medical insurance** generally only covers eye care in relation to a medical condition. If you need an exam for vision loss, floaters, allergies, infections, cataracts, or diabetes, for example, your medical insurance will be billed for these services. **We will bill your insurance if we are participating providers. All insurance information should be presented at time of service. We make every effort to ensure we are in-network and we have verified your benefits but cannot guarantee payment from your carrier. If some fees are not paid by your plan, we will bill you for any deductibles, co-pays, contact lens fits, or non-covered services.**

Professional Service Policies: While a follow up appointment is in conjunction with an initial visit it is still considered a thorough evaluation of the current condition and will be billed as its own appointment.

Payment: Full payment is due at time of service for both examination and materials. We accept Cash, Check, Visa, Mastercard, Discover, American Express, or Care Credit.

Signature Authorization: I request payment of authorized medical insurance benefits be made either by myself, or on my behalf for any services furnished to me by the staff and doctors affiliated with Pikes Peak Eye Care. I authorize the release of any medical information to the authorized third party necessary to process claims for services rendered.

I understand and agree to the above terms of payment. I understand that if I fail to make my payments, my account may be turned over to a collection agency. I understand and agree to pay reasonable attorney and/or collection fees accrued should my account become delinquent.

Patient Name (Printed) ____ **Date**______________

Patient Signature (or Parent/Guardian)____

Privacy Policy Acknowledgment

HIPAA Privacy Acknowledgment of Notice of Privacy Practices: I acknowledge that all information in my medical records is confidential and will be handled only by the associates of Pikes Peak Eye Care.

Patient Signature (or Parent/Guardian) _______________________________________ **Date** _________

Contact Lens Fitting Acknowledgment Form

At Pikes Peak Eye Care, our mission is to ensure the clearest vision and most comfortable wear experience with the contact lenses you and your doctor choose for you. **It is important to carefully read the contact lens consent form, in full.** By signing and dating at the bottom, you acknowledge that you understand these outlined policies and agree to pay in full for any contact lens related fees.

A contact lens fitting is required ***annually*** to obtain a contact lens prescription, for both new and returning wearers. This is required by federal law.

- Contact Lens Fitting Fees:
  - Level 1: Spherical............................$95.00
  - Level 2: Astigmatism (Toric)...........$130.00
  - Level 3: Multifocal/Monovision......$190.00
  - Extended Wear..............................$150.00
  - Multifocal Toric..............................$250.00
    - **Vision plans may reduce your fitting fees with a discount or copay. Please see our staff for details of your plan.*
  - Specialty fits will be discussed with your doctor on a case-by-case basis. You will be provided with additional informational paperwork in these cases.
  - Additional fees may be incurred for new-to-contact lens patients for training and education.
- Contact Lens Follow-Ups and Re-Fits
  - Contact lens fits are valid for **90 days** after the initial fit. If you are experiencing discomfort or feel your vision is decreased with the contact lenses you were fit into, it is important you return within 90 days of your initial fit for a re-evaluation. Beyond 90 days, a new comprehensive exam and new contact lens fit will be required.
  - If a contact lens fitting is not performed during a comprehensive eye exam, you are able to return within **90 days** of your comprehensive exam to start a contact lens fitting. After 90 days, a new comprehensive exam will be required.

Contact lens fitting fees are non-refundable.

All contact lens fitting fees are due at time of service. All materials must be paid in full before orders will be placed.

Please select one:

I would like a contact lens fitting today: _____ **OR** I would ***NOT*** like a contact lens fitting today: ____

Print Patient Name: ____ Date: _____________

Patient Signature (Parent/Guardian if under 18):______________________________________

Jason Jost, OD | Kristen Worthen, OD | Seth Baldwin, OD

Important Payment Information about Refractions

Most medical insurance plans, including Medicare, do not cover *wellness* eye examinations and they do not consider the refraction part of a medical eye exam. Your doctor believes this test is important to your medical treatment and recommends you have this test annually, although your insurance may not pay for it. When a refraction is performed, your insurance company *may* be able to be billed for this.

A refraction is the process of determining the eye's refractive error or need for corrective lenses. It also provides valuable information to the doctor on how best to treat your needs. However, **it is a non-covered service by Medicare, Medicare supplements, and most insurance companies**. Therefore, it is the responsibility of the patient to pay for the refraction fee at the time of service.

The refraction fee is **$60.00**

I have read the above information and understand that the refraction is often a non-covered service. I accept financial responsibility for the cost of this service should my insurance not pay for it.

Printed Name:_______________________________________ Date:____________

Signature of Patient or Guardian:____

Ocular History (Check all that apply)

Condition	
Glaucoma	
Cataracts	
Macular Degeneration	
Retinal Detachment/Hole/Tear	
Infection of Eye or Lid	
Amblyopia	
Excessive Tearing/Watering	
Discharge	
Foreign Body Sensation	
Sandy/Gritty Feeling	
Strabismus (Lazy Eye)	

Condition	
Eye Pain or Soreness	
Flashes or Floaters	
Diabetic Retinopathy	
Loss of Vision	
Double Vision	
Poor Peripheral Vision	
Headache	
Eye Turn	
Eye Injury/Trauma	
Eye Surgery	
Plaquenil or High Risk Meds	

Medical History (Check all that apply)

Condition	
Heart Disease	
Stroke	
Hypertension	
Elevated Cholesterol	
Diabetes Mellitus Type I	
Diabetes Mellitus Type II	
Thyroid Disorder	
Asthma	
Cancer	
HIV Positive	

Condition	
Chronic Obstruction Pulmonary Disease (COPD)	
Bell's Palsy	
Multiple Sclerosis	
Epilepsy	
Sjogren's Syndrome	
Lupus	
Rheumatoid Arthritis	
Myasthenia Gravis	
Pregnant/Breastfeeding	
Other:	

Family History (Indicate which family member)

Condition	
Heart Disease	
Stroke	
Hypertension	
Elevated Cholesterol	
Diabetes Mellitus Type I	
Diabetes Mellitus Type II	
Thyroid Disorder	
Cancer	

Condition	
Glaucoma	
Macular Degeneration	
Cataracts	
Blindness	
Strabismus	
Retinal Detachment	
Retinitis Pigmentosa	
Other: please specify	

Please list all medications and supplements, including dosage

____

____

____

Please list all allergies (Medications, Seasonal, Other Substances, etc.)

____

Primary Care Physician (PCP)

PCP Name ______________________________ Clinic Name ______________________

Diabetic Patients:

What was your most recent A1C date and results? ___________________________________

Use of Alcohol? (Circle One) No Rarely Moderately Daily

Use of Tobacco? (Circle One) No Yes **If yes, current packs per day?** ________________