## WELCOME BACK TO CLIFTON EYE CENTER!

Date: ____________________

Email Address: ______________________________ Contact by email? YES NO

Name: ________________________________ Date of Birth: _________________________

Address: ____________________________________________________________________

City: _______________________ State: _____________ Zip: _________________________

Home Phone: _______________________ Work Phone: _____________________________

Cell Phone: _________________________ Family Doctor: ____________________________

**ALLERGIES** to Medications/Seasonal/Food: ________________________________________

**Medications (prescription or OTC)/Vitamins:** ______________________________________

**Medical Conditions**: ___________________________________________________________

**HAS YOUR INSURANCE CHANGED SINCE YOUR LAST VISIT WITH US? (Circle One) YES NO**

**NAME OF INSURANCE: ___________________________ ID NUMBER ____________________**

**EMPLOYER**____________________________________________________________________

Do you have flashes/ floaters/ headaches/ problems with glare/ light sensitivity/ eye pain?

Do you wear contact lenses? YES NO If not, are you interested in contact lenses? YES NO

Do you wear glasses? YES NO Do you wear sunglasses? YES NO

Do you work on a computer for long periods? YES NO

Would you like thinner lighter lenses? YES NO

Do you spend a lot of time outdoors? YES NO

Do you have difficulty driving at night? YES NO

Are there times you would rather not wear glasses? YES NO

### Consent & Authorization to Release Information

***I hereby authorize the release on any information or photographs acquired in the course of my examination or treatment, to my referring doctor or insurance company as necessary. I understand that I am financially responsible for services and materials provided to me at Clifton Eye Center.***

***I understand if I have an unpaid balance to Clifton Eye Center and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of any fees from the collection agency, including all cost and expenses incurred collecting my account, and possibly including reasonable attorney's fees if so incurred during the collection efforts. In order for Clifton Eye Center or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that Clifton Eye Center and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (messages and data rates may apply) or emails, using my email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and /or us of an automatic dialing device as applicable.***

**Signature: ________________________________________ Date: ____________________**

# ABOUT YOUR INSURANCE

Most people have vision insurance and medical insurance. They are very different in terms of the services they cover, and it is important for our patients to understand those differences.

Vision insurance (i.e.- Always, Spectera, VSP, etc.) is mainly designed to determine a prescription for glasses, to help pay for glasses or contact lenses, and to cover a routine evaluation of the health of the eyes in a healthy patient that has no particular problems or symptoms. It is not equipped to deal with and does not cover medical conditions and/or treatment plans.

When a medical diagnosis or condition is present that affects your eyes, such as high blood pressure, high cholesterol, or diabetes, etc. or if you have an eye problem such as an infection (pink eye), dry eyes, allergy, cataracts, etc., we must file with your medical insurance (i.e.-Medicare, BCBS, United Healthcare, etc.), and the co-pays and deductibles for that insurance will apply.

Insurance carriers set these rules and our office is obligated to follow them. In most cases, there is no way to know prior to the examination which type of insurance our office will be able to file for you. We make every effort to be on as many insurance company's panels for your convenience, and we will file those claims for you. In the event that we do not accept your medical or vision insurance, we will provide you with an itemized receipt so that you may file a claim with your insurance yourself for reimbursement. If you have any questions, please let us know.

I understand the information I have just read about the difference between vision and medical insurance and I authorize Clifton Eye Center to file my claim with the appropriate insurance based on the reason for my visit and the results of my examination.

**Sign: _________________________________________ Date: ________________________**

**(Parent signature if patient is a minor)**

# SHARING YOUR PERSONAL/MEDICAL INOFRMATION

PLEASE NOTE THAT DUE TO HIPAA LAWS WE WILL NOT SHARE YOUR INFORMATION WITH ANYONE WITHOUT YOUR CONSENT. THIS MAY INCLUDE YOUR SPOUSE OR CHILDREN. IF YOU WOULD LIKE ANYONE TO HAVE ACCESS TO YOUR INFORMATION PLEASE FILL OUT THE INFORMATION BELOW.

I, ___________________________________(pt. name), ALLOW CLIFTON EYE CENTER TO SHARE MY INFORMATION WITH THE PERSON(S) LISTED BELOW.

1) NAME___________________________________________________________
   RELATIONSHIP TO PATIENT__________________________________________
   PLEASE CHECK ALL THAT APPLY:
   HEALTH INFORMATION_____________ OK TO PICK UP MATERIALS______
   FINANCIAL INFORMATION__________

2) NAME___________________________________________________________
   RELATIONSHIP TO PATIENT__________________________________________
   PLEASE CHECK ALL THAT APPLY:
   HEALTH INFORMATION_____________ OK TO PICK UP MATERIALS______
   FINANCIAL INFORMATION__________

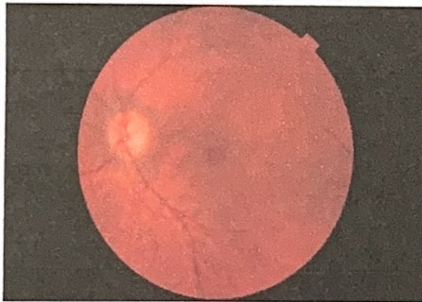
3) NAME___________________________________________________________
   RELATIONSHIP TO PATIENT__________________________________________
   PLEASE CHECK ALL THAT APPLY:
   HEALTH INFORMATION_____________ OK TO PICK UP MATERIALS_______
   FINANCIAL INFORMATION__________

4) NAME___________________________________________________________
   RELATIONSHIP TO PATIENT__________________________________________
   PLEASE CHECK ALL THAT APPLY:
   HEALTH INFORMATION_____________ OK TO PICK UP MATERIALS_______
   FINANCIAL INFORMATION__________

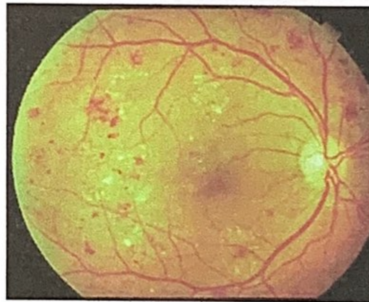
*****PATIENT SIGNATURE(no minors):___________________________________**
*****DATE: ____________________________________________________________**

Sight threatening diseases such as **glaucoma, macular degeneration, diabetic retinopathy and others often have no outward signs or symptoms**, which is why eye exams, including a thorough retinal evaluation, are important to protect vision. In an effort to provide a more thorough eye exam, our practice has incorporated the **iWellnessExam™ SD- OCT retinal scan** and **Digital retinal photography** as part of your eye exam today.

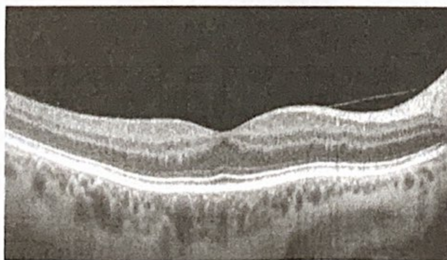
Our technician will perform these two tests before you go into the exam room and Dr. Clifton will review these with you during your examination today. These two tests will become a part of your permanent patient record. Any questions you have about these tests can be discussed during your examination with Dr. Clifton.



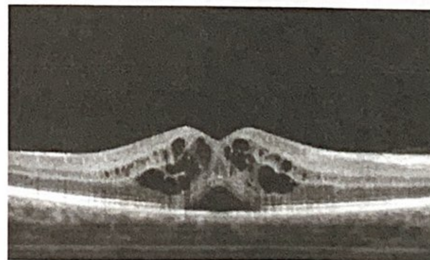
Normal retinal photo



Abnormal retinal photo



Normal retinal cross section iWellness OCT



Diseased retina visible to iWellness OCT exam

Insurance is designed to cover basic eye exams only. It does not cover procedures such as Digital Retinal Imaging or the iWellness OCT retinal scan. Dr. Clifton recommends this examination to patients to insure you receive the most thorough exam possible.

______ **Yes**, I choose to get iWellness OCT retinal scan AND Digital Retinal Photography as a part of my eye examination. **($44.00)**

______ **Yes**, I choose the iWellness OCT retinal scan ONLY. **($24.00)**

______ **Yes**, I choose the Digital Retinal Photography ONLY. **($24.00)**