CEDAR PARK EYE CARE.COM

Patient Name:____________________________________ D.O.B:_____________Sex:______
Patient Email:____________________________________ Phone:___________________________
Address: ______________________________ City:________________________ State:______ Zip:_________
Preferred Pharmacy: ____________________Address:____

VISION PLAN

Insurance Plan Name:_____________________________ Member ID #:______________________________
Group #:______________________________________ Primary Card Holder:__________________________
D.O.B:______________________________
Primary Card Holder SSN:__________________________ Relationship to Patient:________________________

PRIMARY INSURANCE PLAN

Insurance Plan Name:_____________________________ Member ID #:_____________________________
Group #:______________________________________ Primary Card Holder:________________________
D.O.B:______________________________
Primary Card Holder SSN:__________________________ Relationship to Patient:_____________________

DILATION AND ADDITIONAL TESTS

We are pleased to provide our patients with an advanced scanning laser photo system called Optomap. This allows the doctor to screen for diabetes, glaucoma, and other diseases without dilation drops.

- □ **I agree to have Optomap photos instead of dilation. I understand the fee is $39.**
- □ **I agree to dilation**
- □ **I decline dilation. I understand my eye doctor is unable to assess my eye health.**

Please check the box below if you would like a peripheral vision field screening. This test is very helpful in detecting visual defects that may occur such as in glaucoma, diabetes, and/or macular degeneration.

- □ **I agree to the visual field screen screening. I understand the fee is $20.**

PRIVACY PRACTICES ACKNOWLEDGEMENT AND RECEIPT

Due to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the following information must be completed and updated annually by the patient or guardian:

In the event a family member or caregiver attends my office visits and is in the exam room at the time of my evaluation and/or treatment, I give Cedar Park Eye Care providers and employees my permission to discuss freely my condition, treatment or diagnosis with that person present.

□ **YES** □ **NO**

By signing below, I acknowledge that I have been provided a copy of this facility's Notice of Privacy Practices Form (Rev. 10/2019) for review and a personal copy to keep will be provided upon request. If you have any questions about this notice, please contact the Facility Privacy Officer at (512)249-0808.

Signature of Patient or Guardian: ____ Date: _____________
Relationship to Patient: _______________ (i.e., Self, Parent)

PERSONAL HEALTH INFORMATION RELEASE (PHI)

This release authorizes Cedar Park Eye Care to discuss medical information regarding my care, lab or imaging results, condition, treatment or diagnosis, and account information with the following:

□ Patient only □ Other:___________________________ Relationship:___________ Phone:__________

The following people may pick up medication samples and/or prescriptions on my behalf:

□ Patient only □ Other:__________________________ Relationship:___________ Phone:___________

Signature of Patient of Guardian:____ Date:______________
Relationship to Patient:_______________ (i.e., Self, Parent)

Name: ______________________________

Date: ________________________

Eyeglass and/or Contact Lens Rx Proof of release

By signing this form you acknowledge that you have received a copy of your eyeglass and/or contact lens Rx. You will be given this upon completion of your exam. Both are also available 24/7 on your patient portal (as well as your complete medical record).

X ____

Eyeglass Purchases & Contact Lens Wearers

Please be advised if you would like a prescription for contact lenses, you are responsible for a contact lens examination every year which includes 90 days of follow up care. This fee is an addition to your glasses examination & varies depending on the type of contact lens fitted and is assessed by the doctor during your examination. Glasses purchased have a 90 day remake policy from date of purchase for lenses only. A 25% restocking fee will be assessed for all cancelled orders.

X ____

Financial Responsibility

I authorize payment of my medical benefits to the undersigned physician / supplier for services rendered and/or products provided. I understand that Cedar Park Eye Care will make every effort possible to bill my insurance company and obtain all the necessary information for proper billing in advance of the services. I also understand that if Cedar Park Eye Care is unable to obtain authorization from my insurance company or if my insurance company fails to cover the services and materials, I WILL BE PERSONALLY FINANCIALLY RESPONSIBLE FOR SERVICES RENDERED AND PRODUCTS DELIVERED AND/OR PROVIDED. I am responsible for all accounting fees in the event of my non-payment. There is a $50 no-show and cancellation policy in effect if no notice given within 24 hours of your visit and $50 returned check policy.

X ____

Annual Contact Lens Agreement

- If your Rx changes, we will exchange contact lenses purchased from us. Boxes must be resalable, i.e. no marks, no writing, no torn or missing labels and must be factory sealed.

- Contact Lenses are medical devices which should be monitored by the doctor to determine the current prescription and health of the eyes to ensure successful contact lens wear.

- I understand that annual exams and sometimes 6 month corneal evaluations are necessary to continue replacing contacts.

- I understand that there is an increased risk of infection, corneal ulcers that can lead to loss of vision or blindness with contact lens wear. The risk increases significantly if the contacts are worn while sleeping, either 10 minutes or 10 hours. Complying with wearing times, care regimens and disposal schedules minimize this risk.

- I understand that if sudden or prolonged redness, pain or irritation of the eyes occurs, I should remove the lenses and call this office immediately.

- I understand that topping off the solution in my case every night instead of replacing it can lead to permanent vision loss.

X ____