Date_____/_____/_____

WELCOME TO STONE CANYON EYE CARE

Patient Name: _____Mr. Mrs. Dr. Miss. Ms.
Address_____ City_____State_____ Zip_____

Cell Phone_____ Text ok? Yes No Work Phone_____

E-mail address _____Have you seen Dr. Smith before? Where?_____

How did you learn about our office? Referred by_____

If another patient referred you, may we have your permission to mention your name in a thank you card? Yes / No

Insurance listing Family member Internet search Physician/Eye Doctor Yellow pages

Patient's date of birth_____ Age?_____ Social Security Number_____

Patient's Occupation_____ Name of employer_____

Special visual demands (work or hobbies)_____

Name of spouse_____

Please list any members of your household who come to our office _____

Please circle if you have ever had any of the following: Dry Eyes Cataracts Glaucoma Lazy Eye Eye infections
Diabetes Macular degeneration High blood pressure High Cholesterol Allergies

Do you smoke? Yes / No Are you pregnant/nursing?_____

List any other medical problems_____

Who is your family physician?_____

Have you ever had any injury or surgery to your eyes? Yes No Describe_____

Previous eye doctor_____

Have any blood line relatives had glaucoma, or other loss of sight?_____

Are you allergic to any medications? Yes No
(List)_____

Do you presently wear glasses? Yes No How old are the glasses?_____

When do you wear them?_____

Do you presently wear contact lenses? Yes No If no, have you ever worn contacts? Yes No

Do you have **vision care insurance**? Yes No Insurance Name and ID number _____
Insured name_____Insured Date of Birth____/_____/_____Insured SS#_____

Do you have **health insurance**? Yes No Name and ID number_____
Insured name_____Insured Date of Birth_____/_____/_____Insured SS#_____
Primary Insured's Address (if differnt from patinet)_____

Please note: Insurance may cover only part of your charges. If we do not accept direct payment from your insurance plan, you will need to pay our office and submit your receipt for reimbursement from your insurance company. If your insurance does not pay as expected, you are ultimately responsible for all charges. We cannot be responsible if you are not eligible for benefits. We will be happy to assist you with your claims, please give any forms to the receptionist. **Signature:**_____

Stone Canyon Eye Care

SPECTACLE POLICY

As a service to our patients, we use only the highest quality frames, spectacle lenses, and lens treatments. **Each frame purchased from Stone Canyon Eye Care is protected with a 2-year warranty**, under which a broken or defective frame can be replaced at no cost to the patient. We cannot take any responsibility in any form for frames not purchased from our office. **Lenses protected with *premium* protective treatments (anti-scratch or anti-reflective) are also warranted for two years against normal wear & tear (scuffing/scratching), as determined by the lab** (which excludes negligent damage – caused by pets, for example). **Warranties do not cover loss**, nor do they cover scratched lenses on sun clips. All spectacle lenses are first custom-crafted with each patient's prescription, and then cut specifically to fit the frame the patient has selected. For these reasons, it is not possible to cancel an order or switch a frame after the job has been sent to the lab; and cash refunds are not offered. At the doctor's discretion, patients who are not satisfied with the vision in their new glasses may have their prescription checked and lenses remade **one time** into the original frame at no cost within 90 days of the date on which the order was placed. A second visit to check the prescription within 90 days, or any visit subsequent to the 90 day window will be subject to a $35 office visit fee. Any remake beyond the one-time doctor-redo will be done at a 50% discount to the patient. Patients unable to adjust to new progressive lenses (no-line bifocals) may have their lenses remade into a traditional bifocal or trifocal design, although the progressive upgrade fee is non-refundable. Payment is due for all spectacle orders at the time the order is placed, including lens options not covered by insurance (such as transitions, anti-reflective coatings, tints, etc). For those wishing to purchase a second pair please ask staff for current promotions. All patients will receive a copy of their prescription per the FTC's "Eyeglass Rule" (1992) unless he or she requests *not* to receive a copy.

Initial Here_____

CONTACT LENS POLICY

The contact lens process in eye care consists of three steps. The first step is the comprehensive exam, which includes an examination of the overall health of vision and the ocular structures, as well as a refraction (determination of spectacle prescription). If you have vision/health insurance, this initial step is what the insurance company covers under its once-a-year healthy eye exam. Following this step, you will receive a copy of your spectacle prescription.

The second step is the contact lens evaluation, the purpose of which is to determine the correct material, brand, power, and fitting parameters for each patient's contact lenses, **for which there is a separate fee**. The time required for this step varies depending on the complexity of the case and the patient's experience with contact wear, and fees are tiered based on that time factor. Because *first-time* wearers require an initial fitting, in-office insertion & removal training, and additional follow-up visits to determine which lens is most compatible with the patient's lifestyle, the fee is higher. The fee is lower when little or no change is made to the parameters of a patient's current contact lens. . It is always required in order to obtain a new contact lens prescription, renew an expired contact lens prescription (even when the process determines that no change is necessary in power or material to a patient's habitual contact lens), or modify an existing contact lens prescription. The evaluation fee covers follow-up visits for sixty days, after which subsequent office visits related to contact lens wear will be $30 per visit.

Based on the findings from the comprehensive exam, the doctor will either finalize the contact lens prescription today (if a patient's current contact lens brand and power are known), dispense a trial pair of contact lenses today, or place an order (depending on whether or not the lenses are available in the office inventory) for trial lenses that will be dispensed at a later visit. Once the trial lenses are dispensed, the doctor will take measurements to finalize the power, and will also assess the fit of the contact lenses. After the patient and the doctor are satisfied with the fit, vision, and comfort of the contact lenses, the patient will receive a copy of his/her contact lens prescription.

The third step is the actual purchase of contact lenses. Each patient is welcome to purchase contact lenses from this office, or from an outside vendor.

Initial Here_____

-I understand that the fees for professional services are due when services are rendered. If I am unable to make payment at this time a 15% service charge will be added to my account. Any exceptions will be made only by specific arrangements before services are rendered.-I understand that I am responsible for payment of this account regardless of insurance company action, and agree to pay a monthly finance charge applied to any amount not paid after 30 days.
-I understand that there will be a $20.00 returned check charge, and agree to pay all cost of collections, including 1/3 of any outstanding balance collection fee (up to 40%), plus attorney fee, if necessary, to collect any debt.

Patient Name (Please Print) _____

Signed: _____ ***Date*** _____

Stone Canyon Eye Care

HIPAA Notice of Privacy Practices

I acknowledge that I was offered a copy of the Stone Canyon Eye Care HIPAA Notice of Privacy Practices.

HIPAA Right of Access for Family Member or Friend

I authorize my optometrist to disclose and release my protected health care information as described below:

□ Do not release my information to anyone.

□ You may release to any immediate family member (spouse, partner, parent, child).

-- OR --

□ You may release to:

Name_____ Relationship_____

Contact Information_____

Health information to be disclosed:

□ All information in my health record

□ All information in my financial and insurance record

□ Other _____

This authorization is in effect until I revoke it by contacting Stone Canyon Eye Care.

_____

Print name of patient (or legal health care representative)

_____ _____

Signature of patient (or legal health care representative) Date