Adult Patient Form

Patient Name: ____ Date: _____________________

Billing Address: _________________________________ City: _______________________State: _______Zip: _________

Cell Phone: _________________ Home Phone: _____________________ Email: ______________________________
Preferred Method of Contact: ☐Cell Phone ☐ Home Phone ☐Email

Patient's Date of Birth: _______________________________________ Social Security Number ______-____-_______

Sex ____M ____F

Occupation: ___________________________________ Name of Employer: ____________________________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Name of Spouse: _________________________________

Please list any family members of your household who come to our office. _____________________________________

Emergency Contact Information

Name:_____________________________________ Phone:___________________ Relationship: ___________________

Who referred you to our office?
Insurance Listing ☐ Family Member ☐ Physician/Eye Doctor ☐Website ☐Facebook ☐ Passed by Office
☐ Previous Patient of Dr. Frank ☐ Dr. Reynolds ☐ Friend/Family Member – Name: _____________________
☐ Other: ____________________

Special Visual Demands (work or hobbies): ____

Please check the box if you have ever had any of the following:
☐ Cataracts ☐ Glaucoma ☐ Lazy Eye ☐ Diabetes ☐ Macular Degeneration ☐ Eye Infections ☐ Dry Eye ☐ Migraines
☐ High Blood Pressure ☐ Allergies ☐Thyroid Disease ☐ Cancer ☐ Heart Disease ☐ High Cholesterol

Please list any other medical problems: ____

Who is your Primary Care Doctor? _______________________________ Date of last exam/visit: ___________________

Have you ever smoked? _________ Do you currently smoke? ________ How often? _______

Do you drink alcohol? ____________ How often? _______________

Please list current medications and/or supplements:
____

Are you allergic to any medications? ☐ Yes ☐ No Please List: ____

Your Preferred Pharmacy ____

Previous Eye Doctor: ___________________________________ Last Eye Exam: _________________________________

Have any bloodline relatives had glaucoma, macular degeneration or other loss of sight? ☐ Yes ☐ No

Have you ever had any infection, injury or surgery (including LASIK) to your eyes? ☐ Yes ☐ No

Please describe: ____

Do you presently wear glasses? ☐ Yes ☐ No If yes, how old are the glasses? ____________________________________

When do you wear them? ____

Do you presently wear contact lenses? ☐ Yes ☐ No
What type? ☐ Soft Disposable ☐ Hard ☐ Gas Permeable ☐ Other

If yes, how old are the contacts? _________________ If no, have you ever worn contact lenses? ☐ Yes ☐ No

INSURANCE INFORMATION

Primary Policy Holder Name: ____

Primary Policy Holder Date of Birth: _______________ Primary Policy Holder Last 4 Social Security Number: __________

Do you have vision care benefits? ☐ Yes ☐ No
If yes, what company and ID number: ____

Do you have medical health insurance? ☐ Yes ☐ No
If yes, what company name and ID number: ____

Patient Signature: ____

Contact Lens Agreement

Contact lenses (CLs) are medical devices that rest on the surface of your eyes, and they require a proper fitting in order to obtain a prescription to wear them. If you desire a CL prescription, our doctors will evaluate your eyes to determine the overall health and stability of your vision. This process is called the contact lens fitting. It has a separate fee from the comprehensive eye exam, and it is required every year you wish to wear CLs. That is because CLs require additional measurements, examination, time, and expertise.

The fee for your CL fitting will vary depending upon your prior experience with CLs, the complexity of the fitting, and your specific visual needs. All CL fitting fees are due before trial CLs or a prescription to wear them will be dispensed.

The initial CL fitting appointment will include measurements to determine the proper power and the fit of the CLs. If you require training, we will provide proper insertion and removal instruction. After your fitting and training are complete, you will be provided with trial lenses or a prescription.

Your specific CLs may require additional follow-up visits before your prescription is finalized. The fitting fee for CLs will cover any additional appointments for up to one year, permitting the reason for the visit is due to the CLs. However, if you require an appointment due to a medical concern that is affecting your ability to wear the CLs, then you will be charged a medical visit that can be billed to your medical insurance.

Our pricing for various lens types is as follows and is based upon the aforementioned variables. These fees may be reimbursable through some insurance plans, which require prior verification and authorization. If you do not have a plan that includes CL fitting coverage; you will be responsible to pay at the time of checkout.

Soft Contact Lens: $90 - $250 RGP Lens: $225 - $275 Scleral Lens: $800

- **I have read the CL fitting agreement and I understand the fitting procedure.**
- **I understand it is my responsibility to return for CL dispensing and follow-up evaluations at the intervals recommended by my doctor.**
- **I agree to pay the CL fitting fee and I understand my exam today and my final CLs are not included in this CL fitting agreement.**
- **I understand that if I am non-compliant with the care of my contact lenses, my doctor has the right to refuse dispensing CL trials or issue a final CL prescription.**
- **I understand that the CL fitting is a fee for services and is non-refundable, whether I choose to wear contact lenses or not, and that it does not guarantee a CL prescription.**

____Patient Name (Please Print)

____Patient Signature ________________Date

Financial Policy

Patient name (please print): ____

Our goal is to provide the very best and most complete care available. To provide this service in the most efficient manner, please be aware of the following office policies:

- Payment is expected at the time of service for treatment performed that day unless prior arrangements have been made. For your convenience, we accept cash, checks, major credit cards, and CareCredit.
- We will file an insurance claim on your behalf as a courtesy to you; however, you must supply, prior to the appointment, all the necessary information for filing.
- Any deductible as well as any estimated percentages your insurance does not cover, are to be paid on the date of treatment.
- It is the patient's responsibility to know the details of the insurance coverage, including percentages payable, waiting periods, deductibles, yearly maximums, services not covered under the plan, and any other related information.
- Not all services are a covered benefit. Some insurance companies arbitrarily select certain services they will not cover. While the filing of insurance claims is a courtesy that we extend to patients, all charges are your responsibility from the date the services are rendered.
- Balances left unpaid may result in being sent to collections, and/or termination from care at Lodestar Family Eye Care, PC.
- Services rendered in optical are highly customized and are **Non-Refundable,** and cannot be cancelled once we have placed your order. **We take no responsibility and assume no liability for glasses and contacts ordered online.**
- We require a 50% deposit for ordering frames, lenses and contact lenses.
- If you cannot keep your appointment, a 24-hour notice for rescheduling or cancelling appointments is required. A $75 fee may be applied for any missed appointment that is not cancelled in advance.

Signature: ______________________________________ **Date:** ________________________

Agreement to Receive Electronic Communications

- I agree that Lodestar Family Eye Care PC may communicate with me electronically at the contact information I have provided.
- I am aware that there is some level of risk that third parties might be able to read unencrypted emails.
- I am responsible for providing Lodestar Family Eye Care updates to my contact information.
- I may withdraw my consent to electronic communications at any time by calling 907.745.2273.

Signature: ______________________________________ **Date:** ________________________

If you are signing as a personal representative of the patient, please describe your relationship to the patient and the source of authority to sign this form.

Print Name: ____________________ **Relationship:** ______________ **Source of Authority:** ______________

Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA)

I acknowledge that I have received the *Notice of Privacy Practices* from Lodestar Family Eye Care, PC. I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations.

Date:____

Patient Name:_______________________________________Signature ____

If you are signing as a personal representative of the patient, please describe your relationship to the patient and the source of authority to sign this form.

Print Name:____Relationship:____

Source of Authority:____

Receipt of Notice of Privacy Practices

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office. The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our ***Notice of Privacy Practices***, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information. This information may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for the purposes of payment includes: (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our ***Notice of Privacy Practices***. Our policy will be updated whenever our privacy practices change. You can get an updated copy here at the office. When you sign this consent document, you signify you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform healthcare operations. You also signify that you have received a copy of our ***Notice of Privacy Practices***. You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment, or healthcare operations, but as described in our ***Notice of Privacy Practices***, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our ***Notice of Privacy Practices*** describes how to ask for a restriction.

Authorization for Disclosure of Information

I,____, authorize Lodestar Family Eye Care PC to disclose information regarding my health, medical records, testing, and procedures to the following individuals:

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:

- ○ *Individual refused to sign*
- ○ *Communications barriers prohibited obtaining the acknowledgement*
- ○ *An emergency situation prevented us from obtaining acknowledgements*
- ○ *Other (Please specify)*

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