Lifetime Eyecare Associates *Welcome to our Office!*

Please completely fill out this form. We may ask you to review this form from time to time to ensure we have the most up to date information.

Patient's ***Full Legal*** Name: (Last) (First) (Middle Initial) Date of Birth: Month / Day / Year Sex: M / F

Address: Apt# City /State: Zip:

Home #: Cell #: Occupation: Employer:

Name of Parent / Spouse: Grade (if student): School Name:

Patient/Guardian E-Mail Address:

Medical, Social, & Visual History

Chief Medical Complaint

[] Blurred Vision [] Tearing [] Redness [] Light Flashes [] Floaters
[] Double Vision [] Eye Strain/Fatigue [] Eye Pain [] Itching/Irritation

Name of Primary Care Physician: **Name of Last Eye Doctor:** **Last Eye Exam:**

List any Medical Conditions you are being treated for, and for how long?

List any Medications or Drugs you are currently taking:

List any Medication Allergies:

Check off any Medical Conditions that Apply to YOU. [] Headaches [] Arthritis [] Diabetes
[] Head Trauma [] Allergies [] Cancer [] Seizures [] Asthma
[] Lung disease [] HIV/Aids [] High Blood Pressure [] Thyroid [] Heart Disease
[] Blackouts [] Hepatitis [] Autoimmune Disease [] Other; Please List:
Social History: Smoker? [] Yes; packs/day: __ [] Never a smoker []Previous Smoker; Date stopped: _____
Alcohol Use: []None []1-2 Drinks daily [] Social Use Only [] Above Average Use

Check off any eye conditions that apply to YOU.
[] Lazy Eye [] Glaucoma [] Cataracts [] Dry Eyes [] Keratoconus
[] Turned Eye [] Past Eye Injury: _____ [] Eye Surgery: _____ [] Other: _____

Check conditions that apply to your FAMILY and what relation they are to you.
[] Cataract [] Glaucoma [] Diabetes [] Heart Disease [] High Blood Pressure
[] Cancer [] Retinal Disease [] Other; Please List:

Contact Lens History/Interest*

***THERE IS A SEPARATE CHARGE TO BE EVALUATED FOR CONTACT LENSES. BY STATE LAW, A PATIENT MUST BE RE-EVALUATED EACH YEAR IN ORDER TO CONTINUE WEARING CONTACT LENSES REGARDLESS OF PRESCRIPTION AND/OR BRAND CHANGE.**

[] I would like to know my Contact Lens options **[] I am not interested in Contact Lenses**
[] I currently wear Contacts. Which Type? Brand (if known): _____
[] RGP Lenses (Hard) [] Soft [] Extended Wear [] Daily Wear [] Bifocal [] Monovision [] Disposables [] Toric/Astigmatism
How often do you replace your contacts? [] Daily [] 2 Weeks [] Monthly [] Yearly [] Other: _____
[] I would like to sleep in my contacts. Do you currently sleep in your contacts? _____
[] I am Interested in information about LASIK and/or other refractive procedures.

How Did You Find Out About Our Office? [] Mail out [] Phone Book [] Location [] TV/Radio [] Magazine (Review-It!)
[] Insurance/Insurance Website [] Internet [] Direct Referral: Name: _____

Insurance Information: Please **COMPLETELY FILL OUT** this section in order to for us to obtain benefits & file insurance claims.

Name of **Medical** Insurance: _____ **Type** [] PPO [] HMO* Name of **Vision** Insurance: _____

Note if Medical is an HMO, a referral from the Primary Care Physician is required for insurance to cover certain procedures.

Name of Primary Insured: _____ **Primary's Date of Birth:** _____/_____/_____

Primary's 9-Digit Social Security #: _____---_____---_____ **Sex:** [] Male / [] Female (Month) (Day) (Year)

OFFICE POLICY: **Please read and sign at the bottom. Doing so let's us know the patient/guardian has read and understood the office policy terms and conditions, and is authorizing Lifetime Eyecare Associates to provide treatment.**

1. All visits to the office are due and payable in full at time of service.
2. Fees paid for services (ex. examination, contact lens evaluation, etc.) are non-refundable.
3. By authorizing to receive treatment, the patient/guardian is aware that Lifetime Eyecare Associates cannot guarantee payment from their insurance company at this time. If it is determined that the patient is not eligible for services for any reason (i.e. lapse of coverage, exceptions in contract, etc.), I understand that I (the patient) is responsible for payment of all services that were not covered by the insurance company.
4. The OptoMap Retinal Exam may or may not be covered by your Medical Insurance. If insurance denies payment, patient is responsible for the fee for reviewing the images with the doctor.
5. There is a Re-Stocking Fee for all returned frames, lenses, & contacts. Materials must be returned within 30 days from the purchase date. Most frames have a One Year Warranty for defects by the Manufacturer only. Warranty is voided if the frame is discontinued. Only one remake of lenses is allowed with in 60 Days from the Date of Purchase. All other remakes will be at full charge to patient.

Authorization for Treatment: _____ _____/_____/20_____
Signature of Patient/Guardian **Date**

HIPAA PRIVACY
ACKNOWLEDGEMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES

I, _____ **[Please print full legal name]** (the "Patient" or "Patient's Legal Representative"), have been presented with the Notice of Privacy Policy (the "Policy") of Dr. Grisel Lagunas, and have been offered a copy of such policy to keep for my records.

(Please initial one indicating if you refuse or acknowledge receipt of the HIPAA Privacy Policy)

_____ **[Initial here]** I hereby **acknowledge** that I have been provided with a copy of the Policy.

_____ **[Initial here]** I hereby **refuse to acknowledge** receipt of the Policy. I understand that even though I may refuse to sign this acknowledgment, Provider may still provide treatment to me.

_____ _____/_____/20_____
Signature of Patient/Guardian Date

Medical Information Release Form

(HIPAA Release Form)

Patients Name: _____ Patients Date of Birth: _____/____/_____

Patients Guardian: _____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (day)_____ between (time)_____

Signed: _____ Date: ____/____/_____

Lifetime Eyecare Associates

Attention patients who are interested in and/or receiving a Contact Lens Evaluation.

Please read and sign at the bottom. Doing so let's us know the patient/guardian has read and understood the terms and conditions stated below.

If you are using Vision Insurance:

To avoid insurance filing issues when using Vision Benefits for contact lenses, we require payment for the Contact Lens Evaluation/Corneal Assessment at the time of exam. Doing this leaves the patient with full contact lens benefits towards the materials (boxes), instead of deducting the Contact Lens Evaluation Fee from the Contact Lens Allowance, or the option to use Material Benefits towards frames and/or lenses. The insurance company may discount the fee for the contact lens evaluation. Please do not hesitate to ask if you have any questions.

Many patients ask, "Why do I need to have a yearly contact lens evaluation after having an initial evaluation?"

By Texas State Law, prescriptions are valid for one year after the correct prescription has been determined, unless a shorter term is warranted by the health of the patient's eyes or by potential harm to the health of the patient's eyes. Contact lenses can sometimes cause serious problems for the eyes, so the doctor needs to make sure that a patient's current lenses fit properly over time and are not harming the cornea. The doctor may also need to change the contact lens material from time to time, based on the patient's lifestyle and needs.

Signature: _____ Date: ____/____/20____

Signature of Patient/Guardian

Please take a moment to answer the following questions about your current contact lenses.

1. Rate how your contact lenses feel immediately after you first put them in.

	1	2	3	4	5	6	7	8	9	10	
Poor	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	Excellent

Indicate what time you put your contact lenses in: _____

2. Rate how your contact lenses feel **just before** you take them out

	1	2	3	4	5	6	7	8	9	10	
Poor	[]	[]	[]	[]	[]	[]	[]	[]	[]	[]	Excellent

Indicate what time you take your lenses out: _____

3. Do you use contact lens rewetting drops? [] Yes [] No

   If so, how often? _____

4. Are you interested in possibly enhancing or changing your eye color? [] Yes [] No