New Patient Welcome Form

Reason for Your Visit Today (please mark all appropriate symptoms)

☐ Blurry vision ☐ Vision loss ☐ Double vision ☐ Headaches ☐ Eye strain ☐ Floaters ☐ Flashes of light ☐ Diabetic

☐ Dryness ☐ Redness ☐ Watery eyes ☐ Burning ☐ Eye pain ☐ Itchy eyes ☐ Family history ☐ Doctor recommended

Recommended Screening Tests

Visual Field: This central & peripheral vision test is extremely powerful in screening for early signs of eye disease. It is extremely useful in patients suffering from headaches, suspected vision loss, diabetes, hypertension. Studies have shown this test to be the most accurate early screener for glaucoma and forms of blindness. To date, our doctors have *saved* the lives of several patients by diagnosing tumors that presented with no symptoms by using this test. Recommended annually on ALL patients over the age of 18.

☐ I agree to the visual field screening ($30)

☐ I decline

Legal First Name	Legal Last Name
DOB	SSN
Address	Marital Status ☐ Single ☐ Married ☐ Divorced
City	Employment Status ☐ Full Time ☐ Part Time ☐ N/A
State Zip	Occupation
Home Phone	Employer
Daytime Phone	***How did you discover our practice?***
Cell Phone	
Email Address (your patient portal, eyewear pickup reminders, scheduling confirmations)	***Whom may we thank for referring you to us?***
Pharmacy & Location	

Privacy Policy & Signature on File

I understand that I am entitled to a copy of this notice upon request. I have reviewed, or been made available a copy of the notice of Privacy Practices regarding HIPAA policies. I understand that my medical records are confidential and that by signing this form I am allowing my information to be released to my insurance company upon request. I hereby authorize payment of health insurance benefits. I also authorize access to my medical records to the person(s) listed.

Signed: _____ Authorized Access (Print): _____

No Show Appointment Agreement

Our office observes a 'no show' appointment policy. Failure to arrive within 10 minutes of your scheduled appointment will result in a 'no show appointment' and you may need to reschedule to another time. We understand that sometimes a scheduled appointment cannot be kept, however we kindly request that you **notify** our office at least 24 hours in advance to cancel or reschedule your visit. If you do not show for your appointment, we will consider this in violation of our agreement and you will be charged a fee of $35 for the missed appointment.

Signed: _____

Financial & Insurance Consent

Our office provides an eye exam beyond a prescription check because our Doctors of Optometry treat, diagnose, and manage eye disease. Your eye health is our top priority, for that reason we ask for both medical and vision insurance. During your exam, if the Doctor recognizes conditions that affect your eye health, your medical insurance will provide coverage for your visit.

Your ***vision plan*** never covers medically oriented conditions or visits. Occasionally, a vision plan will also coordinate any uncovered charges from your visit today with your medical plan, and our office will be happy to coordinate the two plans to your advantage.

Your ***medical insurance*** always covers a comprehensive eye exam, or office visits as *many* times as needed throughout the year. Examples of when your medical insurance will apply to your visit include:

- headaches
- watery or itchy eyes
- eye pain
- red eyes
- dry eye
- contact lens overwear
- cataracts
- glaucoma
- flashes of light, or floaters
- retinal problems
- macular degeneration
- diabetes
- pre-existing ocular diseases
- anytime your doctor issues a prescription for medication

☐ ***Routine Medical Coverage & Vision Plan Benefits:*** My medical insurance will be billed primary today if I carry ***both*** routine vision coverage and a separate vision plan, since it will cover a comprehensive eye exam, and occasionally screening tests/contact lens evaluation fees.

☐ ***Office Visit Medical Coverage & Vision Plan Benefits:*** My medical insurance will be billed if a medical complaint/diagnosis is recognized today, and my vision plan will be coordinated to pick up remaining charges.

☐ ***No Medical Insurance, Vision Plan Benefit Only:*** I understand that if a medical complaint/diagnosis is recognized today, I am responsible for the fee of a medical exam.

Which insurance is responsible can only be determined at the completion of your exam. ***I understand this form*** and authorize/***consent*** to the Practice filing with either or both insurance carriers.

Estimated Exam Fee (due upon completion of visit): _____

_____ _____ _____

(Name) (Signature) (Date)

In the event of an overpayment from an insurance company, the excess amount will be posted as a credit to my account. In the event of underpayment, I am responsible for any amount not covered or paid for by my insurance for services/materials provided today, and full payment is expected within 30 days of such notice from the date the bill was mailed. I am responsible for all accounting, returned check or late fees and collection costs in the event of my non-payment.