EXAM DATE / /

BOYLE eye specialists

3 West Olive Street • Scranton, PA 18508 • (570) 558-5566

PATIENT INFORMATION

FIRST NAME | LAST NAME | ☐ MALE ☐ FEMALE | DATE OF BIRTH | AGE (YRS)

ADDRESS | CITY & STATE | ZIP CODE

PREFERRED PHONE NUMBER | ☐ HOME ☐ WORK ☐ CELL | SECONDARY PHONE NUMBER | ☐ HOME ☐ WORK ☐ CELL | EMAIL ADDRESS

SOCIAL SECURITY | EMPLOYER | SIGNATURE

INSURANCE INFORMATION

MEDICAL INSURANCE

PLAN NAME | ID #

ABOUT THE PRIMARY CARDHOLDER: (if self, okay to omit)

FIRST NAME | LAST NAME | ☐ MALE ☐ FEMALE

DATE OF BIRTH / / | SOCIAL SECURITY

EMPLOYER | RELATIONSHIP TO PATIENT ☐ PARENT ☐ CHILD ☐ SPOUSE ☐ SELF

SUPPLEMENTAL / VISION INSURANCE

PLAN NAME | ID #

ABOUT THE PRIMARY CARDHOLDER: (if self, okay to omit)

FIRST NAME | LAST NAME | ☐ MALE ☐ FEMALE

DATE OF BIRTH / / | SOCIAL SECURITY

EMPLOYER | RELATIONSHIP TO PATIENT ☐ PARENT ☐ CHILD ☐ SPOUSE ☐ SELF

SPECIALIST COPAY:

MEDICAL AND OCULAR HISTORY

WHAT IS THE REASON FOR TODAY'S VISIT?

ARE YOU PLANNING TO GET NEW GLASSES TODAY? ☐ YES ☐ NO | ARE YOU PLANNING TO GET NEW CONTACTS TODAY? ☐ YES ☐ NO | AGE OF PRESENT GLASSES | AGE OF PRESENT SUNGLASSES | YEAR OF LAST EYE EXAM

DO YOU OR ANY OF YOUR BLOOD RELATIVES (I.E. GRANDPARENTS, PARENTS, BROTHER, OR SISTER) HAVE ANY OF THESE CONDITIONS?

	SELF	RELATIVE	NONE
DIABETES			
HIGH BLOOD PRESSURE			
THYROID PROBLEMS			
HEART DISEASE			
ASTHMA			
CANCER			

	SELF	RELATIVE	NONE
GLAUCOMA			
CATARACTS			
RETINAL DISEASE			
EYE SURGERY			
EYE INJURY			
OTHER:			

	YES	NO
DO YOU SEE DOUBLE?		
FREQUENT HEADACHES?		
EYES FEEL DRY?		
EYES BEEN DILATED?		

PRIMARY CARE DOCTOR:

ARE YOU TAKING ANY EYEDROPS (PRESCRIPTION OR OVER THE COUNTER)? PLEASE LIST.

ARE YOU TAKING ANY OTHER MEDICATIONS (PRESCRIPTION OR OVER THE COUNTER)? PLEASE LIST.

DO YOU HAVE ANY ALLERGIES; MEDICATION OR OTHER? IF YES, PLEASE EXPLAIN.

PHARMACY:

CONTACT LENS FITTING GUIDELINES

Our goal is to provide you with the best available vision and comfort with your new contact lenses. To achieve this, we custom tailor your contact fitting experience using the best lenses and solutions in the industry. We expect you to be satisfied with the comfort and vision of your new contact lenses. Our standard fitting fee covers a period of **90 DAYS** and provides all routine and follow up visits needed in order to fulfill this commitment. Additional charges will apply if:

1) Medical complications arise that need treatment during and/or after the 90 day period.
2) The 90 day period has ended and the patient is unsatisfied with the contact lenses prescribed, and wishes to be refitted.

In order to assure that we have prescribed the best possible product for your eyes, we need your co-operation in returning for possible follow up visits. If deemed necessary by the doctor, follow up visits will be scheduled 1-2 weeks after the trial contacts are dispensed. Some cases may require that the patient sees the doctor again in order to dispense new trial lenses.

The purpose of the follow up visits are to:

1) Verify the fit and power of the lens
2) Verify the safety of the lens on the patient's eye
3) Make changes to the lens fit or solutions to achieve the best possible outcome

Unless physically impossible, you MUST have your contact lenses in for at least one hour before your appointment so that we can accurately evaluate the fit of the lens on your eye. It is imperative that you keep your follow up appointments as scheduled. Failure to do so will prolong and could possibly complicate the fitting process, and could result in additional charges. If follow up appointments are deemed necessary, appointment must be kept in order to receive the finalized contact lens prescription and purchase contacts.

I understand and agree to all the terms above.

Signature:_____ Printed Name:_____ Date:__/__/____

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ADDITIONAL REQUIRED PAPERWORK

Patient Name: _____ **DOB:** ____/____/_____

Acknowledgment of Privacy Policy and Practices

In accordance with HIPPA regulations, a copy of the Boyle Eye Specialists Privacy Policy has been available to me in the office today. Should I choose to obtain a personal copy; one will be provided for me at no additional charge.

___ I have read, understood, and acknowledge the Privacy Policies of Boyle Eye Specialists.

___ I have **NOT** elected to read the Privacy Policy and Practices of Boyle Eye Specialists

I HEREBY AUTHORZE THE FOLLOWING PERSON(S)
TO HAVE ACCESS TO MY FINANCIAL AND MEDICAL RECORDS:

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

Acknowledgment of Vision vs Medical Insurance

Most people have medical and vision and insurance coverage. They are both very different in the services that they cover, and it is important for our patients to understand those differences. Vision coverage (VSP,NVA, Eyemed. Etc.) is mainly designed to determine the prescription for the glasses and is NOT equuiped to deal with complex medical conditions and/or diagnoses. It does allow for screenings of such conditions, and if it is determined that a conditions exists, the patient's medical insurance will be used on those conditions.

Patient/Guarantor Signature _____ Date ____/____/_____

PLEASE TURN OVER

Boyle Eye Specialists

Statement of Patient Financial Responsibility

Boyle Eye Specialists appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to Boyle Eye Specialists, for providing services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Boyle Eye Specialists, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Self-Pay

I do not have health insurance and will be responsible for services rendered here at Boyle Eye Specialists. I agree to pay Boyle Eye Specialists, the full and entire amount of treatment given to me or to the above named patient at each visit.

Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment.

I understand if I no show for two consecutive appointments, no show for three appointments or cancel for a total of four appointments, I may be discharged from care.

The Practice will notify you in writing, via certified mail, if you are discharged from care.

I have read and understand the above information, and I agree to all the terms described:

Patient/Guarantor Signature _____ Date ___/___/_____