Look Optical

Giving You A Clearer View Of Colorado

Patient Information

First Name	Last Name	Date

Phone Number	Email Address

What brings to you to our office today?

O Want Glasses O Want Contact Lenses O Medical Reason:________________________________

Retinal Exam: Dilation or Optos

Dilation: Drops are used to enlarge the pupil, allowing the doctor to see a better complete view of the retina. The drops will cause light sensitivity and blurred vision, especially up-close, for approximately four to five hours.

Optos: Optos is a fast, painless, and comfortable digital imaging of the retina. The Optos provides a wide view allowing your doctor to confirm your retinal health, or discover signs of abnormalities. It provides a permanent record of your retia that can be compared and/or reviewed at next year's exam. Drops are not required in most cases. **Optos is an additional $20**.

Insurance Information (if any)

Insured's Name:____ **Insured's Date of Birth:**_________________________________

Insurance Provider:____ **Insurance ID #:**____

Please mark if you know your Vision Insurance:

O Eyemed O Medicaid O Spectera O CHP+ O Humana O RMUFCW O Avesis

Acknowledgements

Patient Notification – Consent to Treatment

Please be advised that if you are being seen today for a Routine Eye Exam that based upon any or a combination of the following concerns: family history, current medical disease and/or conditions, chief complaint, pre-test findings the Doctor may find it necessary to bill your exam Medically as well as order additional tests. You will be notified during the course of the exam if medical billing is necessary. Exams billed medically are not covered under your Routine Eye Exam benefits or Vision Insurance Plan. If a medical issue exists, your exam will be billed medically through your Medical Insurance Carrier and are subjected to their specific co-pays, deductibles, and co-insurance which will be due at the time or service. In the event you want a routine examination for your eyeglasses or contact lens prescription, I understand it is my responsibility to immediately inform the Doctor so that they can refer me to the appropriate Specialist for any medical concerns.

Financial Acknowledgement

I hereby authorize any person/institution rendering care to furnish all facts concerning this claim. I authorize payment for my vision benefits and/medical benefits to go directly to Look Optical. I authorize Look Optical to deposit checks received on my account made out to me for services rendered**. I agree that if my employer, Insurance carrier or plan sponsor denies payment to all or any portion of my claim, I will be financially responsible for all outstanding charges. Authorization obtained at the time of service does not guarantee payment and any denied services will be balanced and billed to the patient.**
Patients with insurance must present their information to us Prior to any service(s)/purchase(s). We will not bill the insurance after the service(s)/product ('s) are already performed, therefore, there will be no refund! You may send the receipt to your insurance company and try to get reimbursed yourself.
LOOK OPTICAL is NOT responsible for patients orders left here for more than 90 days! Any problem with contacts or eyeglasses prescription must be identified within 30 days from date of exam. No Refunds. Store Credit Only!

HIPPA Compliance and Release of Information

Look Optical is subject to State and Federal regulations. Look Optical and/or its doctor may disclose all or any part of the patient's record for this service to any person or corporation which is or may be liable under a contract to the Optometrist, or to a family member or employer of the patient for all or part of the provider's charges, including, but not limited to hospital or medical service companies, insurance companies, worker's compensation carrier, welfare funds and all authorized auditors as specified in the Insurance Carrier Guidelines and referring professionals. Look Optical follows HIPPA guidelines. A full detailed report of Look Optical Notice to Privacy Practices is available upon request.

Consent of Acknowledgements

I have read the "Consent to Treatment", "Financial Acknowledgement", and "HIPPA Compliance and Release of Information" as the Patient, or the Patient authorized representative or general Agent for the purpose of signing this document, herby accept it's terms.

Patient Name (*Please Print*) ____ **Date of Birth**:________________

Patient/Guardian Signature____**Date**:________________________