DATE: ____/_____/_____ **Please follow us on social media:** **preferredeye.com**

Name: _____ DOB: _____/_____/_____ Age: _____

Gender: Male / Female Marital Status: Single / Married Social Security# _____

Address: _____City: _____Zip: _____

Ph#: _____ Bus. Ph#: _____ Cell Ph#: _____

Email Address: _____

INITIAL BELOW AS APPROPRIATE:

_____ ***I AUTHORIZE*** *Preferred Eye Care* to contact me via text, email, phone, or postal service regarding appointments, recalls, orders and other general information.

_____ ***I ACKNOWLEDGE*** **UNCONFIRMED APPOINTMENTS ARE SUBJECT TO CANCELLATION. CANCELLATIONS MADE LESS THAN 48 HOURS IN ADVANCE, ALONG WITH FAILURE TO SHOW FOR SCHEDULED APPOINTMENT, COULD RESULT IN A $25 CANCELLATION FEE.**

Guarantor (if patient is under the age of 18):

Name: _____ DOB: _____/_____/_____

Social Security#: _____ Relationship: _____

Address: _____ City: _____ Zip: _____

Ph#: _____ Email Address: _____

REASON FOR TODAY'S VISIT: _____

IS TODAY'S VISIT TO BE FILED UNDER WORKERS COMPENSATION? _____YES _____ NO

TODAY I AM INTERESTED IN: GLASSES_____ CONTACT LENS _____ BOTH _____

IF INTERESTED IN CONTACT LENS, I HAVE READ THE CONTACT LENS AGREEMENT _____.

_____I authorize Preferred Eye Care to bill the appropriate insurance on my behalf. ***Medical Insurance vs. Vision Plan:*** If you have separate Vision insurance, this generally pays for an annual routine eye exam and contributes a certain amount of money toward glasses and contact lenses. Vision coverage **does not** cover an exam that involves a **medical diagnosis.** Your Medical insurance will be billed for the medical portion of your exam. You may then use Vision coverage for materials purchased

_____I consent to have my medication listed electronically into my health record. Dr. Williams can obtain my medications directly from my pharmacy. Our ePrescribing system allows us to view your medication history and securely sync your medications directly into your medical record. You may revoke consent at any time by providing written documentation. Once received, electronic access will cease.

Do you take any of the following medications: (please circle) Topiramate or Topomax / Plaquenil or Hydroxycloroquine / Cloroquine / Methotrexate / Tamoxifen / Oral Steroids / Nasal Steroid Spray

_____I am currently not taking any medications.

_____I am allergic to the following medications_____

_____I am allergic to the following environmental or other allergens_____

Refraction Authorization:

"Refraction is an important and mandatory part of a comprehensive eye exam that determines your best possible vision. This procedure aids the doctor in determining the health of your eyes. It is also required for the determination of your eyeglasses and contact lens prescription. Since its creation in 1965, Medicare considers refraction a ***non-covered*** service. As Medicare providers, we are required by law to collect a reasonable fee from the patient for this service. Most medical insurance plans consider Refraction a ***non-covered*** service as well. **The charge for this service is $25.00 (Twenty-Five).** If you have any questions, please contact your insurance provider."

_____ ***I CONSENT*** to Refraction and the associated charge.

Fundus Exam Consent:

One of the most important parts of your annual eye exam is a dilated fundus evaluation. Dilation allows Dr. Williams to examine your intraocular health which includes your retina, retinal blood vessels, optic nerve, and macula, among other structures. Glaucoma, cataracts, diabetic eye disease, high blood pressure eye disorders, macular degeneration and retinal disorders are some of the more common diseases detected with a fundus exam. Side effects of dilation can include high light sensitivity, difficulty seeing up close, increased glare and driving difficulties. If you choose to be dilated, you assume the risk of the possible side effects and will not hold *Preferred Eye Care*, its doctors and/or associates libel.

_____ ***I CONSENT*** to dilation drops. I understand it will cause light sensitivity and mainly blurred near vision for 4-6 hours.

_____ ***I DECLINE*** dilation drops. I understand by declining dilation that photographs will be taken of the inside of my eyes to aid in the determination of the health of my eyes. ***There is an extra charge of $25.00 for this service.***

_____ **Eye Wellness Exam:** The **iWellness exam** is state-of-the-art technology that lets the doctor see beneath the surface of your retina, where signs of disease first appear. The **iWellness** exam is a quick and non-invasive scan of your eye that lets the doctor see the layers of your retina to aid in the diagnosis of sight-threatening eye diseases. Traditional eye exams **do not** provide this level of detail. Regular **iWellness** exams can help the doctor detect common eye diseases such as Diabetic Retinopathy, which is damage to the blood vessels in the eye caused by complications of Diabetes, Glaucoma, which is a disease where the nerve fibers suffer damage, and Macular Degeneration, which is an eye disorder that damages the center of the retina (macula), making it difficult to see fine details. ***There is a $15.00 charge for the exam.***

_____ **CONSENT FOR CARE.** I hereby give my consent for treatment to *Preferred Eye Care.*

_____ **I have read the HIPAA Privacy Policy.**

How did you learn about *Preferred Eye Care*? Was it from one of our patients, insurance, media, live in the area, or referred? _____ If referred, by whom? _____

Please provide a list below of individuals you are allowing us to share your healthcare information with:

Name: _____ Relationship: _____ Ph# _____

Name: _____ Relationship: _____ Ph# _____

Name: _____ Relationship: _____ Ph# _____

Name: _____ Relationship: _____ Ph# _____

Statement of Financial Policy: It is customary to pay for all services and materials at the time of your visit unless prior arrangements have been made. This includes co-pays, deductibles, and any cost not covered by insurance. While it is your responsibility, we will prepare all necessary forms to help you obtain the benefits of your insurance company. I understand that I am responsible for any costs not paid by my insurance. I hereby acknowledge and agree that if my account becomes delinquent and requires the service of a collection agent or attorney, I will pay reasonable collection fees, attorney fees, and all court costs for said collection. Unless otherwise requested, any refunds to your account will remain as a credit for up to a year on your account. After a year, the credit will be refunded to you by check." I have read and understand all the above.

Signature of Responsible Party _____ Date: _____