Hillsboro EYE CARE

601 US Highway 206, Unit 36, Hillsborough, NJ 08844 ● Ph 908-359-7200 ● Fax 908-359-4075

Patient Information

Last Name _____ First Name _____ DOB ____/____/____

Address _____ Birth Sex Male [ ] Female [ ]

City _____ State _____ Zip _____ Married Yes [ ] No [ ]

Best Phone _____ Email _____ Occupation _____

Medical Information

Most recent eye exam and doctor: _____

Are you interested in (circle): Glasses / Sunglasses / Contact Lenses / Other: _____

Special visual demands (for work, sports, and hobbies): _____

Have you had any eye surgery? Yes [ ] No [ ] Type and when _____

Do you have (or have you had) any of these EYE conditions? *Please check*

Dry Eyes	[ ]	Glaucoma	[ ]	Cataract	[ ]
Retinal Detachment	[ ]	Keratoconus	[ ]	Blurred Vision	[ ]
Macular Degeneration	[ ]	Headaches	[ ]	Double Vision	[ ]
Inflammation	[ ]	Lazy Eye	[ ]	Strabismus	[ ]

Other: _____

Family history of eye conditions: _____

Do you have difficulty driving at night? Yes [ ] No [ ]

Computer and screen use Yes [ ] No [ ] How many hours a day _____

Do you currently wear contacts? Yes [ ] No [ ] Brand _____

Average amount of time wearing: _____ hours _____ times a week

Are you satisfied with the vision and comfort of your current contacts? Yes [ ] No [ ]

Are you pregnant? Yes [ ] No [ ] Are you nursing? Yes [ ] No [ ]

Do you smoke? Yes [ ] No [ ] Do you drink? Yes [ ] No [ ]

Do you have (or have you had) any of these medical problems? *Please check*

Diabetes	[ ]	Type _____ Recent A1C _____		Date of diagnosis _____	
Cancer	[ ]	Type _____		Date of diagnosis _____	
Allergies	[ ]	Type _____		Date of diagnosis _____	
High Blood Pressure	[ ]	High Cholesterol	[ ]	Thyroid	[ ]
Seizure	[ ]	Infectious Disease	[ ]	Cardiovascular	[ ]
Stroke	[ ]	Respiratory	[ ]	Hematologic/Lymph	[ ]
Gastrointestinal	[ ]	Endocrine	[ ]	Musculoskeletal	[ ]

Other: _____

Current Medication(s): _____

_____

Physician caring for medical condition(s): _____

Pharmacy Information: _____

Insurance Information

Vision Plan

Insurance Company _____ ID# _____

Policy Holder's Last Name _____ First Name _____ MI _____

Insured DOB _____/_____/_____ Patient Relationship to Insured: Self [ ] Spouse [ ] Child [ ] Other [ ]

Address Line 1 (if different from patient) _____

Line 2 _____City _____ State _____ Zip _____

Employer's/Business _____ Occupation _____

Primary Medical Insurance

Insurance Company _____ ID# _____

Policy Holder's Last Name _____ First Name _____ MI _____

Insured DOB _____/_____/_____ Patient Relationship to Insured: Self [ ] Spouse [ ] Child [ ] Other [ ]

Address Line 1 (if different from patient) _____

Line 2 _____City _____ State _____ Zip _____

Employer's/Business _____ Occupation _____

About Your Plans

Two types of insurance may help cover your eye care services: vision plans and medical insurance. You may have both. When applicable, certain services may be billed to one plan and others to the second plan. We will inform you in advance and coordinate benefits appropriately to help minimize out-of-pocket costs.

1. **Vision Plans** (i.e., VSP, EyeMed, Spectera): Vision plans are discount plans that typically cover routine eye exams and provide benefits for eyeglasses or contact lenses once a year. They do not cover the diagnosis, management, or treatment of eye diseases.

2. **Medical Insurance** (i.e., Aetna, Blue Cross Blue Shield, Medicare): Medical insurance is used for eye health conditions and ocular complications. The doctor will determine medical necessity based on your symptoms, diagnosis, and medical history. Testing and follow-up visits related to medical conditions are billed to medical insurance. While some plans may include routine eye exam benefits, the refraction fee is typically not covered. Patients are responsible for the $45 refraction fee.

Patient Acknowledgement

Insurance Authorization and Billing Policy

Patients are responsible for providing current insurance information at each visit and obtaining any required referrals prior to your appointment. As a courtesy, Hillsborough Eye Care will verify benefits and submit claims if we are a participating provider. Patients are responsible for all applicable payments (copayments, deductible, coinsurance, non-covered services) at the time of service, unless prior arrangements have been made. If a claim applies to your deductible or requires additional copay or coinsurance, you will be billed accordingly. Payments are non-refundable.

I certify that I and/or my dependent(s) are covered by the insurance plan(s) listed and authorize payment of insurance and/or Medicare benefits directly to Dr. Sam Lee, O.D. and Associates at Hillsborough Eye Care for services provided on or after today. I authorize the release of medical and billing information necessary to determine and process benefits and permit a copy of this authorization to be used in place of the original. I understand that I am financially responsible for any charges not covered by insurance and agree to pay any remaining balance.

Notice of Privacy Practices

I acknowledge that I have received, or have been given access to, Hillsborough Eye Care HIPAA Notice of Privacy. I understand how my protected health information may be used or disclosed, my rights regarding that information, and the practice's legal responsibilities. I understand that the practice may change its Notice of Privacy Practices and that the current version is available upon request.

Appointment Scheduling Policy

We ask you to provide at least 24 hours' notice to cancel or reschedule an appointment. Missed appointments within 24 hours will result in a $50 fee for both new and established patients. Missed appointments occur when a patient reschedules/cancels within 24 hours notice, does not show up for an appointment, or is more than 10 minutes late. This policy helps ensure timely care for all patients. I acknowledge that I understand and agree to this appointment cancellation policy.

Contact Lens Evaluation and Fitting Policy

A contact lens evaluation and fitting is a separate service from a routine eye exam and includes additional assessment of ocular health assessment, measurements, fitting, and follow-up care. Prescriptions may differ from eyeglasses and expire one year from the issue date. A non-refundable fee applies, due at the time of service, and includes follow-up visits within 90 days. Fees do not include the cost of contact lenses. If the doctor provides trials to ensure proper fit, patients must finalize their prescription within 90 days of the first trial lens dispense. I acknowledge receipt of my contact lens prescription and understand that fitting fees and lenses are an additional cost beyond the annual eye exam.

Patient Name _____ **Date**_____

× _____

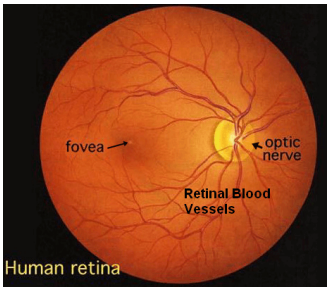
Signature of Patient, Parent, Legal Guardian or Personal Representative

Wellness Screening with Digital Retinal Imaging

As part of your comprehensive eye exam, Hillsborough Eye Care offers retinal imaging. This non-invasive screening captures a digital image of the back of the eye (retina, optic nerve, blood vessels), creating a visual record of your eye to detect early signs of eye diseases and monitor changes. Retinal imaging can help identify and be used to monitor:

- Diabetes
- Glaucoma
- Macular degeneration
- Cataract
- Hypertension and diabetes
- Stroke evidence
- Retinal abnormalities (bleeding, swelling, etc.)

Retinal imaging is safe, quick, and painless—suitable for children, pregnant patients, or anyone who prefers not to have their eyes dilated. In most cases, it can be used as an alternative to dilation, though some patients may require dilation in tandem. An applicable co-pay will be applied based on your vision benefits or medical insurance. For patients without coverage, the procedure is available at a discounted rate of $39. Please indicate below whether you elect or decline retinal imaging today and annually to monitor your ocular health.



____ **Yes**, I elect to have retinal imaging performed. I understand there is an additional fee of **$39** unless stated otherwise, and that my eyes may still have to be dilated depending on the results and my medical history.

____ **No**, I decline to have retinal imaging performed. I understand that I may be dilated today to assess my retinal health.

× _____ **Date**_____

Signature of Patient, Parent, Legal Guardian or Personal Representative