ANGEL EYES VISION

We see you, so you see better.

Treatment Consent & Understanding of Financial Responsibility

I, by signing this form, consent to treatment for myself and/or my dependent whom the attached information describes. I give permission to the doctors and staff to examine me, conduct tests, and diagnose conditions as they deem medically appropriate, in accordance with their professional training, medical necessity, Angel Eyes Vision policies, and applicable rules and regulations.

I, furthermore, agree that I am financially responsible for the services and treatments the doctor and staff provide. I understand that payment for services must be provided for at the end of my visit. If I fail to pay my balance due today or at a later date, a $10 late fee may be applied for each 30 days payment is overdue.

I also authorize Angel Eyes Vision to bill my applicable insurance. Angel Eyes Vision staff will attempt to bill my insurance in ways consist with all laws, policies, and regulations. I understand, however, that such Angel Eyes Vision may not accept my insurance, or such coverage may be denied or my costs not covered in full, in which case I am solely responsible for paying for the goods and services I receive. I understand that if I have a preference for how my insurance benefits are applied, I should notify Angel Eyes Vision prior to check out.

If the reason for my visit today is an Eye Exam, I also understand that the exam may be medical or routine in nature. If an Eye Exam involves medical diagnoses or treatments — such as if I have diabetes, glaucoma, advanced cataracts, or other eye-related medical conditions — my exam is not routine and will likely incur higher costs. In such cases, Angel Eyes Vision will bill my medical coverage for the applicable services.

Angel Eyes Vision Standard Service Fee Schedule:

Routine Services
Routine Eye Exam w/ Refraction: $80
Retinal Scan (Prompt Pay Discounted): $20
Contact Lens Fitting: $40 - $75

Medical and Advanced Services
Comprehensive Exam w/ Refraction: $120 - $140
Retinal Scan (Medical): $40
Condition Evaluation & Management: $50 - $150

Not all of the above costs are required for your visit today. If you have any questions, please do not hesitate to ask. Any estimate of your out-of-pocket cost that we provide is our best guidance based on the information available to us at the time of estimate. Your charges will reflect the services you receive.

Angel Eyes Vision STRONGLY RECOMMENDS patients receive a retinal scan. This scan is not always covered by vision insurance; however, a 50 percent discount applies when paying at time of service.

_____ _____

Patient or Guardian Signature Date

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Appt:
Arrival:

Today's Date:_____

Patient Information & Medical History

Patient Name:_____ Date of Birth:_____

Social Security:_____ Sex: M F O Occupation: _____

Street Address:_____ City, State, Zip:_____

Cell Phone:_____ Email:_____

How Did You Hear About Us:_____

Insurance Information

☐ I want to use insurance ☐ I do not want to use insurance

Vision Insurance Company:_____ Member ID:_____

Medical Insurance Company:_____ Member ID:_____

Medical Information

☐ I currently wear glasses ☐ I currently wear contact lenses

Reason for Today's Visit:_____ ☐ I am interested in contact lenses

Last Eye Exam:_____ Last Medical Exam:_____

List Any Medications You Take:_____

List Any Allergies You Have:_____

Is There Anything Else We Should Know?_____

Do you or your immediate family have any of these conditions?

	Self	Family		Self	Family
Cancer	☐	☐	Diabetes, Type 1	☐	☐
Epilepsy	☐	☐	Diabetes, Type 2	☐	☐
Migraines	☐	☐	High Cholesterol	☐	☐
Depression/Psychiatric	☐	☐	Thyroid Condition	☐	☐
High Blood Pressure	☐	☐	Arthritis	☐	☐
Stroke	☐	☐	Lupus/Autoimmune Dis.	☐	☐
Heart Disease	☐	☐	Cataracts	☐	☐
Blood Disorders	☐	☐	Macular Disease	☐	☐
Asthma	☐	☐	Glaucoma	☐	☐
Hepatitis	☐	☐	Retinal Detachment	☐	☐
Emphysema	☐	☐	Eye Surgery	☐	☐
HIV/AIDS	☐	☐	Blindness or Vision Loss	☐	☐
Gonorrhea	☐	☐	Poor Color Vision	☐	☐
Syphilis	☐	☐	Crossed or Lazy Eye(s)	☐	☐

Do you have these concerns?

	Yes	No
Blurry Vision	☐	☐
Eye Strain or Fatigue	☐	☐
Eye Pain	☐	☐
Sensitivity to Light	☐	☐
Headache	☐	☐
Poor Night Vision	☐	☐
Itchy Eyes	☐	☐
Dry Eyes	☐	☐
Double Vision	☐	☐
Floaters or Flashes	☐	☐
Halos	☐	☐
Seizures	☐	☐
Eye Infection/Injury	☐	☐
Pregnant or Nursing?	☐	☐

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High-Resolution Retinal Scan

Angel Eyes Vision is proud to provide the latest technology in delivering to you top-flight eye and health care.

As a part of our commitment to excellent service, we include by default high-resolution digital retinal imaging as an integral component of our eye examinations. The retinal scan produces a detailed review of the back of your eye — the retina — often without sacrificing your time or comfort through a traditional dilation process.

The doctor will use the retinal scan to confirm your eye is healthy. The image, for example, might help detect disease without the use of dilation drops. It does this by producing a map of the retina, giving your doctor a wider and more-detailed view of your eye than what is typically possible through other methods. By examining this image and recording and tracking changes over time, your doctor can potentially identify even small shifts in eye health and function. The image also gives you and your doctor a chance to see and talk about your eye health and discuss potential problems. (Dilation may sometimes be necessary after a retinal image if your doctor suspects some types of eye pathology.)

Even if you see clearly now, your eyes may not be healthy. They may also already show the early, unnoticeable signs of common diseases such as glaucoma, diabetes, hypertension, macular degeneration, retinal tears, or even some forms of cancer. That is why your doctor HIGHLY RECOMMENDS you document your eye health today through a retinal image. Because of the benefits of a retinal image and the side effects of dilation that include light sensitivity and blurry vision, especially for close-up vision, your doctor believes retinal imaging is a crucial and convenient method for ensuring your eye function and your overall health.

By default, all patients will recieve a retinal scan as part of an Eye Exam. If you do not want the scan to be a part of your visit, please notify Angel Eyes Vision staff as you finalize your check in. If you opt out of the retinal scan, you may be required to schedule a return visit for dilation or waive medical liability.

Even if you opt out of the scan, your doctor may order the scan if the doctor suspects the presence of certain disease or pathology. In such cases, you will be financially responsible for the scan's cost.

Please note that insurance does not always cover the retinal scan.

Angel Eyes Vision provides a 50 percent Prompt Pay Discount to patients who pay for their retinal scan today. This reduces the cost of the retinal imaging to $20.00.

_____ _____

Patient's or Guardian's Signature Date

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HIPAA Privacy Practices

My signature below acknowledges that I have been presented with the option to recieve Angel Eyes Vision's "Notice of Patient Privacy Policy," describing my rights under the Health Insurance Portability and Accountability Act. I may recieve such policy in its entirety by asking any staff member for a copy.

I, furthermore, agree that Angel Eyes Vision may responsibly use and disclose my personal and health-related information to file insurnace claims, process any necessary corrective vision or device order, and to communicate with me, including exam reminders, post-appointment follow-ups, and product and service updates. I understand that Angel Eyes Vision may send me patient education and marketing emails and text messages. If I choose to opt out of such communications, I will notify the appropriate representative.

Should I wish to use my medical insurance or managed vision benefits, I authorize Angel Eyes Vision to share my health information, as necessary and appropriate, with insurance carriers and partners for authorization and payment of such claims. This will provide me with my insurance benefits and/or place a claim with the insurance carrrier for payment on my behalf.

I have read and understand this form. I am voluntarily signing this form and authorize use and disclosure of my personal and health information as described above.

_____

Print Patient's Name

_____ _____

Patient's Signature Date

_____ _____

Legal Guardian's Signature, if Patient is a Dependent Date

Please list any family members or other individuals whom Angel Eyes Vision may inform about or communicate with to discuss your medical conditions, diagnosis, treatment, and payment.

_____

_____ _____

Patient or Legal Guardian Signature Date